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Anne-Lise Holmesland

Professionals' Experiences with Open Dialogues with Young People's Social Networks – Identity, Role and Teamwork

A Qualitative Study

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ABSTRACT

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This research explored the experiences of professionals participating in network meetings in the context of Open Dialogue. The professionals participated in a clinical pilot project, Project Joint Development, which was carried out in southern Norway in the period 2003-2005. The professionals were working across the boundaries of the health, social and educational sectors. The three studies reported on in this research focused on the emergence of professional identity in multi-agency teamwork, a professional role involving the adoption of a transdisciplinary role and aspects of dialogue. The data consisted of interviews conducted with two focus groups, the first comprising healthcare professionals and the second professionals from the social and educational sectors. The two groups met three times. Observations and audiotapes of network meetings were also included, in addition to the presentation of an innovative case. The data from the focus groups were analysed by means of content analysis. The findings from the studies suggest the following: (i) professionals are able to develop a transdisciplinary identity involving change in their professional role and understanding of teamwork; (ii) the professionals' ability to generate dialogue, including the ability and willingness to listen to others and provide authentic feedback, may be a challenge; (iii) other professionals than trained therapists may be able to integrate skills and knowledge related to an Open Dialogue and thus develop their role in a more therapeutic direction; (iv) professionals adapt to each other in network meetings by dwelling on the same topics and adapting their utterances to what was previously said. To increase collaboration between professions and agencies, a unified definition and understanding of the different modes of collaboration, as well as a clear role understanding, should be emphasized. The different expectations that the various actors might have should be focused on and aspects such as the professionals' motivation to collaborate and participate in joint dialogues should be explored.

Keywords: identity, role, teamwork, dialogue, focus groups, case study

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TIIVISTELMÄ (FINNISH ABSTRACT)

Ammattilaisten kokemuksia Avoimen Dialogin mallista nuorten sosiaalisissa verkostoissa: Identiteetti, rooli ja tiimityö. Laadullinen tutkimus.

Tutkimuksessa tarkasteltiin ammattilaisten kokemuksia Avoimen Dialogin verkostotapaamisiin osallistumisesta. Ammattilaiset osallistuivat kliiniseen pilottiprojektiin nimeltä Project Joint Development, joka toteutettiin Etelä-Norjassa vuosina 2003–2005. Ammattilaiset toimivat niin terveydenhuolto-, sosiaali- kuin opetussektoreilla. Tutkimuksen kolme osatutkimusta keskittyivät ammatti-identiteetin syntymiseen monialaisessa yhteistyössä, monitieteisen roolin omaksumiseen liittyvään ammatilliseen rooliin sekä dialogin eri osa-alueisiin. Tutkimusaineisto koostui kahden kohderyhmän haastatteluista. Ensimmäinen ryhmä koostui terveydenhuollon ammattilaisista ja toinen sosiaali- ja opetussektorin ammattilaisista. Ryhmät kokoontuivat kolme kertaa. Innovatiivisen tapaustutkimuksen esittelyn lisäksi aineisto sisälsi myös havaintoja ja äänitteitä verkostotapaamisista. Kohderyhmistä kerättyä aineistoa analysoitiin sisällönanalyysin keinoin.

Tutkimusten tulokset näyttävät osoittavan, että (1) ammattilaiset pystyvät kehittämään monitieteisen identiteetin, johon sisältyy ammatillisen roolin ja tiimityön ymmärtämisen muutokset; (2) ammattilaisten kyky saada aikaan dialogia, mukaan lukien kyky ja halukkuus kuunnella toisia ja antaa aitoa palautetta, voi olla haastavaa; (3) muutkin ammattilaiset kuin koulutetut terapeutit voivat integroida Avoimeen Dialogiin liittyviä taitoja ja tietoa ja näin ollen kehittää rooliaan terapeuttisempaan suuntaan; (4) ammattilaiset mukautuvat verkostotapaamisissa toisiinsa paneutumalla samoihin aiheisiin ja mukauttamalla kommenttinsa aiempien puheenvuorojen mukaan. Eri ammattien ja virastojen välisen yhteistyön lisäämiseksi yhteistyön eri muotojen yhdenmukaista määritelmää ja ymmärrystä sekä selkeää ymmärrystä rooleista tulisi korostaa. Eri toimijoiden erilaiset odotukset tulisi huomioida, ja esimerkiksi ammattilaisten motivaatiota yhteistyöhön ja yhteisdialogiin osallistumiseksi tulisi tutkia.

Asiasanat: identiteetti, rooli, tiimityö, dialogi, kohderyhmät, tapaustutkimus

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Taking into account the instructions given and comments made by the co-authors, the author of the thesis collected the data, conducted the analyses, and wrote the reports of the three publications.

TABLES

APPENDICES

CONTENTS

1 INTRODUCTION

Over recent years there has been growing interest in various family, and network-centred collaborative models which particularly are applied in the healthcare and social welfare sectors (e.g. Klefbeck & Ogden, 2003; Open Dialogue Practices, 2014; Rolland & Walsh, 2005; Speck, 1998; Vigrestad & Hellandshølen, 2012,). These collaborative models entail greater inclusion of various actors in the work that is to be carried out. Relevant participants may be professionals representing different professions and agencies, the client, the clients' family members and perhaps also representatives from his or her extended social network, such as friends and colleagues. This development has been followed by an increased focus on the interaction between the various participants, as this may have major impact on how the collaboration unfolds (Kodner & Spreeuwenberg, 2002; Piippo & Aaltonen, 2004; Ødegård & Bjørkly, 2012). An example of the increased focus on social network intervention is the Network of Dialogical Practices (www.opendialoguepractices.eu) and a Nordic network called Norsnet (Nordic Research on Social Networks). Network intervention in the context of the Open Dialogue Approach is mainly applied in the mental healthcare services, but is also used in close connection to other sectors, such as the social services, the Norwegian Labour and Welfare Administration (NAV) (Vigrestad & Hellandshølen, 2012), youth care and human resources management (Open Dialogue Practices, 2014), and as later presented, in close partnership with the educational system and the child welfare services (Studies I–III).

In recent years, what Bauman defines as the transition "*from the "solid" to a "liquid" phase of modernity*" (Bauman, 2007:1) has arisen. This concept reflects that the world seems to be increasingly out of our control. Rapid changes influence traditional structures, institutions and patterns of behaviour. Followed by this, society reduces the possibility of strategies to consolidating norms, habits and routines (Bauman, 2007). At the same time, an epistemological shift has occurred as to how problems in families and the extended network can be understood. This shift can be referred to as first- and second-order perspectives (Ødegård & Bjørkly, 2012). In a first-order

perspective, the problem can be referred to as an "*out-there unit*" (Hoffman, 1985: 386). By this is meant that one or more of the parties, i.e. the family or other members of the private network or the professionals, will perceive the problem as something wrong with someone in the family or extended family system. In such cases the therapist is seen as a detached expert who is able to fix the problem (Ødegård & Bjørkly, 2012). In a second-order perspective, the therapist will be seen as a part of the system (Hårtveit & Jensen, 2004). In this case, "*the problem creates the system*" (Hoffman, 1985: 386) as the family dialogue contributes to the difficult family behaviour. The meaning is socially constructed, that is, new meanings can be generated through new dialogues (Anderson & Goolishian, 1988). Bearing this perspective in mind, the treatment unit consists of everyone who is a part of the system, including the professionals, the client and the clients' private network (Hoffman, 1985). Because of different modes of communication and interaction, the difference in the professionals' position and role may to a great extent produce different collaborative relationships, particularly in situations where the participants have different expectations as to how the collaboration should unfold. This becomes especially evident, for example, in situations where the family is searching for an expert, while the professionals are focusing on joint dialogues and thus are aiming for a shared understanding (Ødegård & Bjørkly, 2012).

Family and network-oriented approaches may to some extent be understood as a mode of integrated care. The term integrated care has become a buzzword but has different meaning depending on who is using the term (Kodner & Spreeuwenberg, 2002). The aim in integrated care is to improve coordination and integrate services. Some proposed strategies are to increase the use of teams consisting of professionals with different backgrounds and/or to integrate different sectors (Gröne & Garcia-Barbero, 2001). This implies that the focus should be on how professionals work together and how they relate to the clients and the private network. It also means developing a joint understanding of the patients' needs, as well as developing a shared professional language (Kodner & Spreeuwenberg, 2002).

1.1 Social network intervention and the Need-Adapted Approach

A growing number of studies support the relevance of social network approaches to crises characterized by a variety of complex problems (Brottveit, Søndergård, Hopfenbeck, Holmesland, & Thylstrup, 2014). Social network interventions originated in the US in the mid-sixties and have primarily been used as a method for helping people experiencing crises when other treatment methods have failed. The main principle of network intervention is that the social network is given an important role as "a helper" (Speck, 1998). This may contribute to making the person in need of help more connected to his natural relationships and surroundings (Alanen, Lehtinen, Lehtinen, Aaltonen, & Räkköläinen, 2000). Involving the social network may create solutions for the

social, emotional or practical problems that are rooted within the person in need of help and the social network (Attneave, 1990).

The social-network approach, which was utilized in the project presented below, Project Joint Development (PJD), was originally based on the "Turku Schizophrenia Project", which was followed by the Need-Adapted Approach in the 1980s. In short, the goal of these projects was to focus on community psychiatry and to minimize the use of inpatient wards, in particular by developing a treatment approach for patients with schizophrenia (Alanen, 1990; Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991; Piippo, 2008). The approach was organized around treatment meetings which aimed to 1) collect information about the difficulties, 2) build a treatment plan based on the joint conversation and 3) generate a psychotherapeutic dialogue (Seikkula, Alakare, & Aaltonen, 2001). Bearing these principles in mind, the social network approach called Open Dialogue (OD) was developed as a form of psychiatric crisis intervention in Finnish Lapland (Seikkula, Aaltonen, Alakare, Haarakangas, Keränen, & Lehtinen, 2006; Seikkula, Alakare, Aaltonen, Holma, & Rasinkangas, 2003). PJD has been highly inspired by this particular approach.

1.2 Mental healthcare in Norway

About 25% of the European population will have mental health problems in its lifetime (World Health Organization, 2005). The prevalence of mental disorders in Norway is at about the same level as in other Western countries and large studies indicate that no major changes in prevalence have occurred over the last decade. In Norway, the most common problems in the adult population are anxiety disorder, depressive disorders and alcohol dependency (Norwegian Institute of Public Health, 2009). About 8% of the child and adolescent population in Norway will have psychiatric problems meeting diagnostic criteria for one or more psychiatric disorders. Three per cent receive help from the specialized mental healthcare services (Norwegian Institute of Public Health 2009; Norwegian Ministry of Health and Care Services, 2005). At any point in time about 15-20% of these young people are having so severe psychiatric difficulties that their quality of life is detrimentally affected. At some time during their childhood, one in three 16-year-olds will fill the criteria for a psychiatric diagnosis. The most common disorders in the late teens are anxiety disorder, depression, disruptive and conduct disorders, learning disabilities, eating disorders, substance abuse and deliberate self-harm (Norwegian Institute of Public Health, 2009). Of the patients in the child and adolescent mental healthcare, about 17% of them also received help from the child welfare services (Norwegian Research Council, 2009).

Mental health difficulties arise through a complex multilayered interaction including biological, psychological, social and genetic factors. Environmental factors in a larger sociocultural context are also significant, such as parents, children, siblings and family relations, peers and neighbours, school,

workmates and community factors (Grøholt, Sommerschild, & Garløv, 2008; Norwegian Institute of Public Health, 2009).

However, treatment capacity is limited for both children and adolescents and treatment is often not available before the illness is quite severe. A national report on mental healthcare published in 1996-97 in Norway stated that the treatment for Norwegians with mental health problems was flawed at all levels. Consequently, an important aim in the field was to create methods that could be more adapted to the patients and to provide better continuity in the services (Norwegian Ministry of Health and Care Service, 2005; Sosial- og helsedepartementet, 1996-97). The National Programme for Mental Health, which operated between 1999 and 2008, favoured a paradigmatic shift in mental healthcare, calling for a much greater effort being put into the prevention perspective in the mental healthcare sector, as well as the user perspective, including facilitating for clients participating in a normal life despite being treated for mental health difficulties. Another focus should be on how structural conditions in mental healthcare organizations influence the treatment offered to patients (Norwegian Research Council, 2009; Sosial- og helsedepartementet, 1996-97). The results from the National Programme for Mental Health showed that there has been an increase in collaboration between the specialist mental healthcare sector for child and adolescents, as well as adults and the primary services. However, there is still a need to improve the interaction and continuity between the services (Norwegian Research Council, 2009).

1.3 Project Joint Development

During the work with the revised plan for adult psychiatry in the Vest-Agder region of Norway in 2001, focus was placed on the rise in lifestyle related problems, illegal drug abuse and complicated psychosocial problems among young people (Vest-Agder Fylkeskommune, 2001). In an attempt to address this problem a new treatment and organizational method was implemented. In August 2003, the pilot project, Project Joint Development (PJD) was started. The project was anchored in the Clinic for Drug Abuse and Psychiatry and the leaders of the child and adolescent mental healthcare clinic particularly welcomed PJD (Ulland, Andersen, Larsen, & Seikkula, 2014) and showed great enthusiasm for it.

In an organizational perspective, the aim during the PJD period was to create more flexibility and integration between professionals working with people with mental health problems. This includes boundaries *between* the different sectors in the field, as well as *within* the mental healthcare sector, with regard to the age limits that exist.

PJD followed another project which had had the same focus, namely to promote a dialogical approach. The project "Dialogue in context" lasted from 1999 to 2001. The aim of “Dialogue in context” was to improve mental

healthcare for adults suffering from mental health problems and the professionals involved represented the mental healthcare sector. The overall goal was to understand the patient within his or her particular context and to increase the involvement of the social network. Moreover, the aim was to provide sufficient help and assistance to the individuals in the person's private network. The evaluation of the project indicated that almost no dialogical practices emerged. Hence, the project did not lead to the desired change in paradigm. Moreover, the study also revealed that the participants understood the dialogical approach differently (Ulland et al., 2014).

The aim of PJD and "Dialogue in context" was to change mental healthcare. Instead of an understanding focusing on diagnoses and the patients' shortcomings, the focus was to be on the patients, where the intention was to increase their network's resources. Both projects were highly inspired by the Open Dialogue Approach (ODA)[1] (Ulland et al., 2014).

1.3.1 The educational program

To develop the new practice in PJD a two-year post-graduate training programme was implemented. The training programme included about 40 professionals working in the health, social and educational sectors in the specialist services and in primary services for two different local authorities. Moreover, some other professionals attended the project after a while because of their growing interest and enthusiasm. Due to the need to spread knowledge of the dialogical approach as widely as possible, other professionals not participating in the educational program but who showed interest in the approach also participated in network meetings as team leaders. Professionals representing the local university and the mental health clinic at the local hospital led the training programme. The group of supervisors comprised eight persons who were trained psychologists, nurses and social workers. None of them were trained in social network intervention but several of them were trained as family therapists or they had shown particular interest in the OD approach previously. All the supervisors participated in the educational program and were also given extra supervision by the main clinical supervisor Jaakko Seikkula.

The educational programme focused on skills and knowledge the professionals should be able to integrate into their professional roles, such as dialogues and processes. The educational programme included participating in network meetings through role-play and discussions. The discussions concerned real cases (anonymous discussions) as well as network meetings in general, e.g. the processes and procedures, significant factors, personal approaches and possible contributions. Furthermore, during each semester, supervision of real help-seekers was carried out. The team responsible for treating a particular help-seeker, together with Jaakko Seikkula, conducted

[1] The terms Open Dialogue Approach (ODA) and Open Dialogue (OD) are used interchangeably in this thesis.

network meetings with real cases. During the supervision the other members of the supervisory group observed the network meeting from behind a mirror. Some of those who were seated behind the mirror were given the task of making reflections during the meetings. Furthermore, in the summer of 2004, an intensive one-week seminar was arranged abroad where the focus was on this approach. Although this was not a mandatory part of the education, most of the participants in PJD attended. The next year (the summer of 2005) a similar seminar was held. In this seminar, fewer participants from PJD attended, while professionals representing other municipalities in southern Norway, as well as other parts of Norway, were included.

1.3.2 Theory and practice

PJD can be seen as an inter-organizational approach in the sense that it covers some kind of co-ordinated collaboration between different agencies. A reference group was involved, representing the various organizations involved and helping to work out a referral process and case navigation that was adjusted to PJD. The reference group has helped to increase the agencies' ability to share goals and joint decision-making and thus enhance the integration between the various services (Ahgren & Axelsson, 2005; Horwath & Morrison, 2007). The impression was that the involved agencies showed great loyalty to the project. The leaders were generous in terms of allowing their employees to have wide frames and great opportunities in order to work in accordance with the project objectives.

Persons included in PJD were referred by a range of professionals working in a variety of agencies. The help seeking persons could also be in contact with a health visitor, teacher, other professionals in the municipalities or a doctor. Moreover, people in need of help and were living in the municipalities covered by the project were, when the project had been running for one year, given a telephone number (24-hour service) that could be used if they felt the need to seek help.

Open Dialogue (OD) consists of two central principles. One is related to the organizational model and organizational structure and underscores the basic principles of network-centred approaches that are to take into account the user's network in all kinds of situation. The other principle involves the treatment approach where language and interaction are considered to be key elements (Seikkula, 2000; Seikkula et al., 2001).

In an early phase of the development of OD the approach was theoretically inspired by social constructionism (Seikkula et al., 2001) and how subjective knowledge is seen as a socially accepted "reality". Through intersubjective action and interaction we create "*a shared reality that is experienced as objectively factual and subjectively meaningful*" (Wallace & Wolf, 1995:262). Berger and Luckmann (1966) describe a dialectical process where a person creates, recreates and maintains his view of himself and society in an ongoing process between himself and those he interacts with. The interaction process that is developed during the network meetings implies that the focus should be

on the person in need of help as well as the network and the different perspectives that are represented *within* them. Rather than changing the psychological or social structure of the family, the approach aims to construct a joint dialogue between the people present and to clarify the problems by looking into different aspects of the help-seeker's life (Seikkula, 2000; Seikkula & Arnkil, 2013). The theoretical and clinical framework is related to dialogism and in particular the Bakhtinian idea that language and dialogues are the primary factors in creating a shared social language reality (Seikkula & Olson, 2003; Seikkula & Trimble, 2005). The concept of dialogue can be understood as a co-evolving process of listening and understanding in which the aim is to provide response to every statement, both verbal and non-verbal, as well as embodied utterances. It is this response that contributes to making it a joint dialogue rather than a monologue (Anderson, 2002; Seikkula & Olson, 2003). As a result of all the voices participating in the dialogue, a polyphony of multiple voices will emerge where there is no particular object to be changed. Instead, multiple subjects are forming a polyphony of multiple voices (Seikkula & Olson, 2003).

1.4 A phenomenological-hermeneutic approach

Exploring how the professionals participating in PJD experienced the ODA calls for an understanding of certain aspects and phenomena that may have significant impact on the ODA. Instead of being seen as "objective facts", a substantial understanding of aspects such as identity and role should be developed, involving the professionals' meaning, their attitudes, reactions and actions. These kinds of knowledge represent "lived experience" and may be understood through the exploration of a person's "life world". A person's "life world" is a phenomenological term referring to the description of people's personal experiences in relation to a certain topic (Bengtsson, 2005; Korsnes, Andersen, & Brante, 1997; Kvale, 1997; Lindseth & Norberg, 2004).

The aim of hermeneutics is to search, through interpretation and understanding, for the meaning that is to be expressed. Texts as well as actions can be interpreted. Thus, the transcripts of the focus groups and observation of network meetings can be interpreted, and this can help us to achieve a substantial understanding of important topics in the ODA. Hermeneutics can be seen as a general philosophical theory about what understanding is and how we are able to understand (Føllesdal, Walløe, & Elster 1996; Korsnes et al., 1997).

The German philosopher Hans Georg Gadamer refers to the concept of prejudices. By this he means that all kinds of understanding presuppose a kind of pre-understanding. Interpretation and understanding require that we are striving towards an open approach to the other person's opinions. According to Gadamer (2003), meanings can never be fixed but are always contextual and historical, and this implies that we always need to take into account our own

situation. This includes taking our personal perspectives and assumptions into account in order to open for new meaning. Thus, for researchers it is important to be aware of their pre-understandings and how they may interfere with the research process. Instead of being led by our pre-understandings we should be reflexively self-aware and explore the meaning, content and impact of our perspectives and assumptions as a source of insight. When sharing our accounts and their possible role in how we understand our data, this may help the reader to understand the data and to consider possible alternatives. Moreover, when I as a researcher am aware of my understanding, this may help me to better understand my informants' experiences and actions (Elliott, Fisher, & Rennie, 1999; Finlay, 2008; Gadamer, 2003). Therefore, to help the reader to understand my results and understanding of the data presented below it might help to give some information about my personal and professional background.

1.4.1 Background and pre-understanding

I am a Norwegian sociologist, married for six years and with two young children, born in 2011 and 2012. I also have a brother two years older than me who is suffering from severe mental illness. While he has only been hospitalized a few times, they have been for long periods. Because of the severity of his illness, I have been in contact with the healthcare system several times. Thus, I have my own personal, mostly positive, experiences from the assistance system. My position as a researcher with personal experience from mental healthcare may or may not be a limitation. It has helped me to recognize the strong need for collaboration between professionals in order to help people in need. But there is also a risk that I have been too biased.

During my sociological studies I became interested in different kinds of deviation, such as illness and crime. My master's thesis dealt with people with schizophrenia who were affected by the reform aimed at reducing the number of beds in mental hospitals. By using a qualitative approach, I focused particularly on the possible identity change this reform could cause for persons suffering from schizophrenia (Holmesland, 1999). Thereafter, I worked as a project leader aiming to evaluate the inter-disciplinary post-graduate education for professionals (medical doctors, psychologists, social workers and special educators, among others) working in child and adolescent psychiatry in eastern and southern Norway. In this quantitative study, the main topic was to evaluate the post-graduate educational program, rather than focusing on the potential collaboration this education could lead to. This was when I for the first time noted difficulties in trying to achieve a joint understanding of what could be understood as collaboration and joint goals among different professionals. Through the evaluation of the post educational programme it became clear to me that it may be a challenge to conduct joint education with groups that had great variations in professional backgrounds. Based on this study, I published an article concerning interdisciplinary postgraduate education focusing on professional jurisdictions in the Journal of the Norwegian Psychological Association (Holmesland, Danielsen, & Grøholt, 2004). I did not, however,

understand just how vague the concept of *collaboration* was before I went to southern Norway to evaluate PJD. Even though I had evaluated the interdisciplinary postgraduate education, I had never before observed collaboration consisting of various professionals in practice. Thus, I had no idea of how different types of collaboration could be understood and appear and how differently the understanding of the concept could be interpreted.

During the two years of implementing PJD I worked as a researcher, participating in network meetings and following the educational program, including being a member in one of the supervision groups. I was also a member of the project group connected to PJD.

It seemed to me that most of the professionals participating in PJD saw me as a researcher who encouraged them to conduct network meetings and who was eager to explore how these were carried out. They also observed me working as a researcher in the network meetings we joined together. Because I was participating in the same education, I spent a great deal of time with all of them, becoming quite familiar with some of them, and talking and interacting to a lesser degree with others. I felt there was a mutual positive attitude between me and most of the professionals. Many of them wanted to discuss aspects of the ODA with me, from both positive and negative perspectives. Sometimes, however, I experienced my position as challenging. As the aim was to implement the new OD approach, the professionals had to have a positive attitude towards the work they were supposed to carry out. For me as a researcher, I felt that it was sometimes difficult for the professionals to understand that it was important for me to have an open approach to what I saw and heard: the negative as well as the positive. In general, I felt that most of the professionals had a positive attitude to my research project, but I cannot deny that some professionals might have felt it difficult to have a researcher observing the way they carried out their job.

The help seekers and their families may have had a more unclear understanding of my role in general and relationships to the professionals in particular. When the network meetings were held, e.g. at the outpatient clinic, the help seeker may have seen me in rooms reserved for the staff. I also used to arrive at meetings held in the help-seeker's home together with the professionals. Thus, they must have realized that to some extent I was familiar with the professionals. However, I think that this has only had minor impact on how the network meetings were carried out, and on my relationship with the help seekers and their private network.

During the years PJD was running I also participated in several seminars, congresses and Ph.D. courses nationally and internationally and presented my research process and preliminary findings to these larger groups. I moved to Oslo in 2006 and was on sick leave for one year. In the beginning of 2007 I started to work on the analysis, which continued until I was on maternity leave in January 2011. (Between January 2011 and April 2013, I worked only for a total of about eight months.) During this period and until I finished my thesis I had my office in the premises connected to the Institute of Clinical Medicine,

the University of Oslo and Oslo University Hospital, Division of Mental Health and Addiction, Department of Research and Development, Child and Adolescent Mental Health Research Unit (all located together). These institutions focus mainly on quantitative research, primarily conducted by medical doctors. In addition to myself, one other researcher was using a qualitative research approach. So, in order for the two of us to gain more insight into qualitative approaches we participated in a forum for qualitative research initiated by the Regional Centre for Child and Adolescent Mental Health, region east and south. This group met monthly and offered me the possibility of discussing my findings and presenting drafts with other qualitative researchers within my field. The strong influence of the group of quantitative researchers that I joined may have increased the risk of bias in the sense that I have been strongly influenced by statistical approaches, even though I tried to avoid this influence or at least be aware of it. In addition to the meetings at R-BUP focusing on qualitative methods, I also had meetings with my supervisors in Finland and much contact by e-mail (mainly with Jaakko Seikkula) on how to understand the project and the findings during my work with the analysis and writing.

Finally, one may ask how the choice of Jaakko Seikkula as my primary supervisor has affected the study findings and the presentation of the results and particularly if the relationship has made me uncritical. None of the studies of this research can, in my opinion, be characterized as unambiguously positive with respect to the implementation of ODA. Rather, they contribute to showing how very demanding ODA can be for achieving successful collaboration. It cannot be denied that Seikkula has influenced my research but I believe that this influence has had only minor impact on the interpretation of the results and how they are presented.

1.5 Defining concepts of professionals who are working together

"Collaboration" and "teamwork" have at times been rather uncritically described in positive ways and as a good idea, even though this attitude seems more often to be based on assumptions rather than evidence (Reeves, Lewin, Espin, & Zwarenstein 2010; Willumsen, 2009). No fixed definition exists as to what collaborative work actually entails (Ødegård & Strype, 2009). There are, however, many alternative definitions denoting professionals who are working together, and what they all have in common is the attempt to capture the complexity of professional interaction (Leathard, 2003; Reeves et al., 2010). One example of a set of definitions is represented by Leathards' (1994) classifications of terms denoting working together: 1) concept-based, 2) process-based and 3) agency-based. The terms *"multi"*-, *"inter"*-, and *"transprofessional"*, *"multi"*-, *"inter"*-, and *"transdisciplinary"*, *"holistic"* and *"generic"* can be seen as concept-based terms. Process-based terms include *"joint working"*, *"teamwork"*, *"collaboration"* and *"coordination"*, while examples of

agency-based terms are *"inter-agency"*, *"inter-sectorial"*, *"trans-sectorial"*, *"consortium"* and *"healthy alliances"* (Leathard, 1994: 5; 2003: 6). The use of all these various terms may be called a *"terminological quagmire"* (Leathard, 1994: 5). Nearly a decade later the situation remains nearly unchanged (Leathard, 2003), and even a decade later, this assessment is repeated (Perreault & Careau, 2012; Reeves, Goldman, Gilber, Tepper, Silver, Suter, & Swarenstein, 2011). [2]

Put simply, the prefixes connected to the concept-based terminology *"multi"*,- *"inter"*,- and *"trans"*, can be translated to *"many"*, *"between"* and *"across"*, respectively (Leathard, 2003: 5). Even though the prefixes "multi" and "inter" can be understood differently by different actors (Leathard, 2003), the prefix "trans", used in articles explicitly focusing on this mode of work, is used with less agreement than what is the case for the other prefixes. Most frequently, transdisciplinary teams may be defined in two ways (Oandasan & Reeves, 2005): 1) as a team approach characterized by role release and thus in a way that separates the concept from interdisciplinary teams (e.g. King, Strachan, Tucker, Duwyn, Desserud, & Shilington, 2009; Lyon & Lyon, 1980; Reilly, 2001; Shahmoon-Shanok & Geller, 2009) and 2) as an approach almost equal to interdisciplinarity but with increased levels of integration and increased synergy (e.g. Cartmill, Soklaridis, & Cassidy, 2011; Connolly & Novak, 2000; Ruddy & Rhee, 2004).

Process-based terms, such as joint working, teamwork, collaboration and coordination are also understood differently by different people. The terms "team" and "collaboration" are used as if they have a transparent and easily understandable meaning. The understanding of the terms, however, varies enormously and conveys varying levels of interaction (Bleakley, 2013; D'amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; Payne 2000; Pollard, Sellman, & Senior, 2005), such as on a continuum from tightly knit units to ad-hoc decisions involving less interaction and integration (Pollard et al., 2005). Coordination may be one of the characteristics that denotes a team (Payne, 2000). Collaboration is often defined in terms as "*sharing, partnership, interdependency and power*" (D'Amour et al., 2005: 118). When the term "collaboration" is related to a contingency approach to interprofessional work it differs from teamwork in the sense that shared identity and integration are of less significance (Reeves et al., 2010).

The Norwegian term *"tverr-etatelig samarbeid"* is translated into *"interorganizational collaboration"*. Internationally, the prefixes "multi" and "inter" are also used on an organizational level. When used, "inter", represents a higher integration between the agencies involved, compared to what is the case in "multi-organizational collaboration" (Willumsen, 2009). A common mode of presenting models of integration is in terms of a continuum (Ahlgren & Axelsson, 2005). As an example, Ahlgren and Axelsson (2005), referring to

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2 The basis for Leathard (1994, 2003) and Reeves et al. (2011) are the terms used for interprofessional work and education.

Nies (2004), show how different levels of integrated care may be described, in which 1) full segregation refers to complete absence of integration, 2) linkage refers to the importance of good communication and clear responsibilities of the professionals involved, 3) coordination networks represent a more structured mode of integration, but the agencies remain basically independent, 4) co-operation involves network managers who aim to improve the contacts between the agencies involved, and 5) full integration implies that the different agencies should merge into a new organization.

Included in the concept of collaboration is the idea that different professionals adapt their roles according to their work and mode of collaboration with the case in hand (Payne, 2000). While the professionals in a multi-disciplinary collaboration work sequentially or in parallel, the interdisciplinary roles need to be more adjusted to each other and with increased mutuality and integration (Thylefors, Persson, & Hellström, 2005). Transdisciplinary role behaviour will often entail a role-release process (Studies I & III), which implies that some professionals teach other professional or non professional team members to conduct professional work that are primarily theirs (King et al., 2009; McGonigel, Woodruff, & Roszmann-Millican, 1994; Woodruff & Shelton, 2006).

While there is terminological confusion concerning concepts related to professionals who are working together, a corresponding debate exists in relation to the terms "*professional*" versus "*disciplinary*". Some attempts to clarify the concepts have been made and internationally, the trend is moving towards using the suffix "professional" (Oandasan & Reeves, 2005). While disciplines can be understood as academic disciplines, such as psychology and economics, professions can include health and/or social professions such as nursing and social work (Reeves et al., 2010). Satin (1994) considers the crucial factor to be whether a discipline (a profession or occupation that shares knowledge and skill) can be separated from other disciplines in terms of theory and practice. If two healthcare workers or even two different specialties within a single profession have difficulties in communicating with each other, this may be an indication that they are representing two different disciplines. In contrast, professionals representing different professions but who can still easily understand each other are not representing different disciplines.

In Study II and here, the most important authors who have been referred to use the term profession. Moreover, because the majority of the participants in PJD were representing professions in the healthcare, social or educational sector, I use the term "profession" in the following. The term "discipline", however, was used in Studies I and III. This is because the authors who wrote on transdisciplinarity used the suffix "disciplinary" and thus I chose the same nomenclature. I use the term "agency" to refer to an organization such as the child and adolescent mental health-care outpatient clinic, the school or the primary mental healthcare unit. In Study I the term "multi-agency" was used, while in Studies II and III the term "inter-agency" was used. After having reflected more on how PJD was carried out on the organizational level, I found

that the different agencies involved interacted on such a level that the term inter-agency was more appropriate. Unless otherwise specified, I use the term "collaboration" to denote work that is carried out in a group involving two or more professionals (both inter- and intra-profession) and/or agencies working together to help the patient and his or her private network. When I'm referring to Studies I–III, I may use the term team or teamwork, as the main authors referred to in these studies use these terms. The term "help-seeker" was used in all three studies. I have gradually found the term to be somewhat inappropriate. Sometimes the persons included in network meetings were invited by professionals and sometimes the real help-seeker was someone in a private network. Thus, not all of the help-seekers in the network meetings were help-seekers of their own initiative. However, for the sake of simplicity, I also use here the term help-seeker about the person who can be considered as the principal person in the network. Furthermore, in Study I there was a distinction between the term role release and role expansion, while Study III used the term role release throughout after having presented the different stages of the process. Both study reports should be read in the way the terms role release and role expansion are defined here: professionals release their role when they transfer specific skills to other team members who expand their role through this transmission (Doyle, 1997). And finally, professional work in the context of network meetings diverges from professional work in other meetings, such as review or case conferences (in Norwegian: ansvarsgrupper) (Willumsen & Skivenes, 2005). The basic idea of review meetings is to have an arena in which to share information, coordination of services, open communication and equal partnerships (Willumsen & Skivenes, 2005; Ødegård & Bjørkly, 2012). In network meetings there is a strong incitement to encourage the help-seeker and the private network to take the lead and set the agenda. The aim for the professionals is to generate a joint dialogue focusing on new perspectives (Seikkula, 2000).

To meet the demand from an increasingly and rapidly changing work structure, teams are more and more established on an ad-hoc basis. Instead of focusing only on routines and stable group membership, the focus on team processes should be increased. The traditional focus on the goal of the groups may represent a "*will-to-stability*" (Bleakley, 2013: 21). They are characterized by a focus on maintaining continuity of the team in order to reduce complexity and uncertainty. In contrast to this, "*will-to-adaptability*" (Bleakley, 2013: 21) focuses on complexity and ambiguity and the need to tolerate uncertainty in teamwork. Tolerance for complexity and uncertainty are taken as a resource of the teams. Because team members still need to integrate, they still need to learn skills and tools to achieve both stability and adaptability (Bleakley, 2013).

1.6 Facilitators and impediments in collaboration

To promote good health, all sectors of society need to be accountable individually or in interaction with each other. This involves, for example, the social welfare services, schools and workplaces (World Health Organization, 1999). Other literature has also cited the importance of interagency collaboration and/or collaboration among professionals with different backgrounds in the delivery of various services for children and /or family (Collins & McCrey, 2012; Darlington & Feeney, 2008; Darlington, Feeney, & Rixon, 2005; Darlington, Healey, & Feeney, 2010; Maslin-Prothero & Bennion, 2010; Sloper, 2004; Spath, Werrbach, & Pine, 2008; Suter, Arndt, Arthur, Parboosingh, Taylor, & Deutschlander, 2009; Ødegård, 2005) and collaboration between school systems and health care (Anderson-Butcher, 2004; Dwyer, 2002; Lynn, Mary, & Atkins, 2003; Power, Blum, Guevarea, Jones, & Leslie, 2013). This literature often focuses on factors that facilitate or impede collaboration between professionals within a particular sector or between different sectors. Such factors include, but are not limited to the following: i) collaborative processes, including an openness to and respect for others' ideas, views and perspectives, a shared understanding of mutual expectations of collaboration, understanding of each other's roles and goals, an ability to foster relationships, trust related to self-competence and in others and mutual respect for other helpers, also including those of the patients and the private network; ii) attitudes, such as commitment and individual willingness to collaborate, an interest in learning, and to work towards collective goals; iii) communication skills through ongoing, responsive communication and ability to negotiate (Darlington & Feeney, 2008; Hall, 2005; Molyneux, 2001; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; Sloper, 2004; Suter et al., 2009).

Most previous studies on OD involve teams consisting of professionals working in the primary and/or specialist mental healthcare sector (Brottveit, 2013; Bøe, Kristoffersen, Lidbom, Lindvig, Ulland, Seikkula, & Zachariassen, 2013; Grosås, 2010; Guregaard, 2009; Holloway, 2009; Lian, 2006; Lidbom, Bøe, Kristoffersen, Ulland, & Seikkula, 2014; Søndergaard, 2010; Thylstrup, 2009). Projects inspired by ODA also solely consist of mental health clinicians (Borg, Karlsson, & Kim, 2010) or a combination of representatives from the mental healthcare and social sectors (Piippo & Aaltonen, 2004). Only a few studies focus on teams and roles particularly. In many cases, the teams are not labelled in a manner that indicates the level of collaboration in a precise way. Other researchers refer to the teams as multi-disciplinary (Søndergaard, 2010), multi-agency (Seikkula et al, 2001; Ulland et al., 2014) and multiprofessional treatment teams (Piippo & Aaltonen, 2008b). Lian (2006) discusses various kinds of competence, such as interdisciplinary and transdisciplinary competence. Because mainly nurses were involved, the ability to develop interdisciplinary (according to Lian's definition of inter- and transdisciplinary) competence was limited (Lian, 2006). The majority (55%) of the professionals included in the

study by Holloway (2009) reported that network meetings have contributed to improved collaborative routines within the healthcare sector. Both Lian (2006) and Holloway (2009) also focus on aspects related to role understanding. More specifically, the confusions that arise in connection with understanding roles depending on whether they represent primary or specialist services. Another study found that out of six informants who were asked, three different perspectives of the role as a team leader were presented (Nilsen, 2011). Most studies focus on aspects of the dialogues that are developed among different members of the network, such as the development of trust (Piippo & Aaltonen, 2008a), the dialogue as a communicative incident (Brottveit, 2013), inner and outer dialogues (Grosås, 2010; Lidbom et al., 2014; Seikkula, 2008), factors that facilitate dialogue, such as shared emotional experience and creating a shared language (Seikkula & Trimble, 2005; Søndergaard, 2010), dialogical principles, such as tolerance of uncertainty and dialogism (Borg et al., 2010; Seikkula & Olson, 2003), and indicative versus symbolic language (Guregård, 2009; Seikkula, 2002). Another study focused on PJD and thus represents a focus involving a broader variety of professionals and agencies. This study explored how six help-seekers had experienced the network meetings they had participated in during PJD (Hauan, 2010). No other studies concerning OD that I know about involve such a broad group of professionals and agencies as the one presented in this thesis. Thus, PJD provides us with a great opportunity to explore how different professionals representing different agencies experience working together side by side with professionals representing other professional backgrounds and a variety of sectors. Moreover, because of the broad inclusion of all these professionals and agencies in PJD, it is reasonable to believe that challenges linked to collaboration have been more salient in PJD compared to other projects involving only healthcare professionals. Thus, topics such as the development of professional identity, teamwork and professional roles may come clearly into focus in a setting such as this one. The lessons we might learn from PJD are important precisely because of this great variety; the rapid changes and society's increased complexity most likely will continue and thus the need for advanced modes of collaboration will remain.

1.7 Aims of the research

The main aim of this research was to explore the experiences of professionals who were included in PJD and are working in the healthcare, social and educational sectors.

The first study aimed in particular to explore the challenges connected to the transformation and emergence of professional identity in transdisciplinary multi-agency network meetings and the use of OD. More specifically: 1) how professional identity was related to the development of professional roles in multi-agency network meetings and 2) the development of transdisciplinarity in multi-agency network meetings. To answer these questions, two focus

groups were created, one comprising healthcare professionals and the second professionals from the social and educational sectors. Each group met three times, once in the middle of the project, and twice when the project had come to an end. Thus, the gradual development and transformation of professional identity, including the development of the professional role and teamwork, emerges through the different times when the focus groups were arranged.

Study II was based partly on the same material, but only on the first data sampling point. To illustrate the findings from the focus groups, observations and audiotapes of inter-agency network meetings were included. The study was more focused on particular skills related to OD and explored the professionals' understanding of what promotes or impedes dialogue in inter-agency network meetings and how this is related to their professional backgrounds.

Study III was a case study of an innovative case and looked into the development of a teacher's role-release process and how professionals adapt to each other in network meetings. The empirical data material was collected through observation of network meetings and an interview with one help-seeker. The focus was on the inherent potential in involving professionals outside the healthcare system to conduct and contribute to joint and healing dialogues. Through the expansion of skills and knowledge, which other professionals than trained therapists may manage to incorporate into their regular repertoire, the case explored the development of how these professionals may improve their ability to generate joint dialogue and shared understanding with other professionals, as well as representatives from the private network.

2 METHODOLOGY

When the original project plan was initially implemented, the overriding aim was to conduct an explorative study, using both a quantitative as well as a qualitative approach, and focusing on a variety of topics related to PJD.

When it came to the qualitative study, the aim was to explore how the various actors experienced OD. More specifically, to find out about social interaction, about the provision and reception of help and about issues relating to stigma and identity. To do so, it was decided to include help-seekers, professionals and representatives from the private network to participate in individual in-depth interviews, and in addition conduct a group interview during the final network meetings that included the most significant persons in each network. Planning to observe network meetings was done only to use the information as a background source for the preparation of the interviews. It was also believed that the information obtained through observation could provide deeper insight into how the various actors interacted with one another, how they acted and how things were said (Wadel, 1991). Interview guides based on the OD principles and inspired by theories of identity were written. The aim of the qualitative study, on this initial stage of the process, was to identify more precise research questions for further research rather than to find answers to particular questions. Thus, this original qualitative study can be seen as an explorative study focusing on the overall perspective of the OD which was used in PJD and which involved a variety of people, professions and agencies. However, by participating as an observer in network meetings it became clear that interesting differences emerged. This was mainly connected to the professionals' different understandings of the concept of collaboration in general and how the professional work was supposed to be carried out in relation to OD in particular. Some network meetings seemed to be like review meetings. Several times I noted that some professionals, quite often representing the primary services, put much faith in rapid action and concrete solutions. This created situations where one of the professionals was attempting to develop a slow dialogue, whereas the others stressed "quick solutions" or "good advice". Such observations indicated different understandings of this

particular kind of professional work. Some professionals seemed to be really adept in dialogues and highly motivated for collaboration. They focused on the group process and tried to involve all the persons present and, if necessary, also persons who were affected by the situation but who were not present (Seikkula, 2000). On the other hand, others seemed to have difficulties maintaining a fruitful and open dialogue and some seemed to act just as usual. Instead of spending time searching for new perspectives, they suggested traditional solutions based on guidelines and standardized approaches. After a meeting held in a network consisting of professionals representing the health, social and educational sector and involving the primary and specialist services, I reflected over the fact that the representatives from the primary services were not focused on emotions but only on practical difficulties. In cases where actors representing the school participated, the meetings were often highly school related which seemed to disturb the process in terms of reflection and slowly developing dialogue. Likewise, the meeting venue seemed to affect the meeting. It seemed to me that the mental healthcare workers in particular had an easier job, compared with professionals in school and social care because of their meeting facilities and established traditions. And finally, some professionals seemed to focus much on what they and the agencies they represented were responsible for, more than aiming to generate a joint dialogue. I wondered if this contributed to distancing the various professionals from each other and that this could be more important than only looking at the different professions they represented.

While taking into account that these differences are crucial, I found it most important to focus more on factors that influenced the interaction between the professionals in the network meetings. Hence, the qualitative focus was altered towards an exploratory and descriptive study concerning interaction, mainly focusing on the professionals in network meetings. Furthermore, the pre-planned interviews with the help-seekers were conducted, while interviews with the professionals and members of the private network, together with the final group interview, were omitted from the study.

The change of the study design was significant with regard to the voices that were focused on. One could argue that the most interesting voices were those of the help-seekers or of the whole network, given the importance of the network perspective inherent in ODA. However, because of the collaboration and role understandings that were observed during the network meetings, I assumed that the voices of the professionals alone would be of great importance. This is because I believe that the professionals' have great influence on how the meetings develop and how they are conducted in terms of shared understanding and a slowly developing dialogue. This choice provides us with another picture than if the whole network had been the main subject of the study. Nonetheless, as we gain knowledge of how professionals may influence the network meetings and thus how network meetings in the context of OD may be improved, I believe that this study will provide us with important information.

2.1 Qualitative study design

The research had a qualitative approach that aimed to explore and describe how professionals representing different professions and agencies experience the utilization of OD in cases with adolescents and young adults. Qualitative research is a suitable approach when the aim is to understand and explore the experiences of people engaged in various activities (Elliott et al., 1999). Descriptive studies aim to describe a phenomenon on the basis on how it appears in the real world, while explorative studies could be used when the goal is to identify new questions to be used in subsequent studies or to innovate the existing literature (Yin, 2014). Thus, by choosing a qualitative approach, this could help me to explore the professionals' experiences in terms of dialogue, processes and interaction through identifying and mapping their own understandings and perspectives (Richardson, Baker, Burns, Lilford, & Muijen, 2000). By using multiple methods through collecting complementary data, such as observation along with focus groups and individual interviews with help-seekers, this may result in more compelling findings compared to what can be accomplished by any single method alone (Lincoln & Guba, 1985; Yin, 2014). A naturalistic inquiry, however, such as this one, includes an assumption that there are multiple realities and that the different "parts" of a reality are interrelated, i.e. that the researcher and the informants influence each other (Fog, 1994; Guba, 1981).

2.2 Participants

2.2.1 Description of the sample in the focus groups

Focus group interviews were the primary method used in Studies I and II. The data material for the first two studies consisted of 12 professionals participating in PJD[3]. Six professionals represented the healthcare sector and thus participated in the healthcare group (HCG). The others represented the social and educational sector and participated in the social and educational group (SEG). (See Tables 1 and 2 on the following page.)

Those with experience from absolutely none or only a few network meetings explained this by having difficulties in recruiting patients due to the limitations they have in their current employment position. Usually, this was either because of the agencies' catchment area, which resulted in few potential help-seekers, or because the agencies they represented were so far out of the range of possible agencies that could take action. One professional without experience from network meetings in the context of OD pointed out that prior to this project he had experience of network meetings in other settings.

[3] One person withdrew her consent in 2010, but is included in the sample description.

Moreover, because of the training programme, also those without experience from participating in network meetings had observed and/or reflected as a part of their education in two and four real network meetings prior to the first and second focus groups, respectively.

TABLE 1 Participants, Studies I and II[4]

Professional No.	Gender	Age[5] (2004)	Profession	Duration of current position (2004)
1	Female	41-50	Nurse	2-4
2	Female	41-50	Child welfare officer	5-10
3	Female	31-40	Nurse	5-10
4	Female	41-50	Social worker	2-4
5	Male	31-40	Other bachelor degree	2-4
6	Female	41-50	Social worker	--------
7	Male	51-60	Teacher	21-30
8	Male	51-60	Theologist	2-4
9	Female	41-50	Teacher[6]	---------
10	Male	31-40	Social worker	2-4
11	Female	51-60	Teacher	11-20
12	Female	41-50	Child welfare officer	2-4

TABLE 2 The number of network meetings the members of the focus groups had participated in prior to the 1st and 2nd focus group

	Healthcare Group						Social and Educational Group					
Informant	1[7]	2	3	4	5	6	7	8	9	10	11	12
1st meeting	1	3-5	3-5	3-5	6-10	>25	0	0	3-5[8]	5[9]	-	16-25
2nd meeting	1	3-5	6-10	>25	>25	>25	1-2	-	-	6-10	>25	>25

My goal was to invite the professionals to discuss how they understood the concept of network meetings within the context of OD. All of the professionals were attending the educational program and according to this they were constantly encouraged to include persons who they thought could benefit from

4 The number of the informants (Tables 1 and 2) differ from the numbers used in the studies.
5 Information about age and duration of current position is somewhat imprecisely specified due to anonymity.
6 The education background is somewhat uncertain.
7 Informant no. 1 has participated in several meetings equal to network meetings, but they have not been designated as network meetings.
8 The number of network meetings related to informant no. 6 and informant no. 9 are based on the verbal reporting during the first focus group and there is an uncertainty factor here.
9 The number is based on the verbal reporting during the first focus group.

network meetings. Hence, they should possibly be good at exploring the challenges and benefits of network meetings. Followed by this, I believed that the theoretical knowledge and the practical skills they gained through education, observation and participation in network meetings made them competent to think and reflect on aspects related to participating as professionals in network meetings.

2.2.2 Observation

Observation was used as a data source in Studies II and III. I observed 16 cases where two cases were excluded due to lack of renewal of consent.[10] Four patients were over 18 years of age, while the rest were minors. Five boys and nine girls were included (see Appendix 2). Six patients under 18 years of age lived with their married parents, while three had divorced parents. One person did not live with his family. Two of the persons over 18 years of age were living with their boyfriends, one person was living alone and one person was living together with one of his parents. All of them were suffering from problems connected to their social network, such as school friends, workmates, family members or their extended social network. Twelve of them were also suffering from different levels of mental healthcare problems. Eight help-seekers were registered in the specialist services before they were offered network meetings and for three persons, referral was sent to the specialist services prior to the first network meetings. For two persons, no such referral had been sent (one missing). Five help-seekers were referred to PJD from the children and adolescent mental health outpatient clinic, while two persons were included by the child welfare agency, the school (including the school medical officer) and the psychiatric outpatient clinic, respectively. The Family Centre and the Primary Mental Healthcare Services included one person each (one missing). Eight informants participated in less than ten network meetings while three participants took part in ten meetings or more. Three informants participated in 15 meetings or more. The observations were made on those who acted as regular participants and supervisors in the project.[11] Permanent teams consisting of professionals representing at least two or more agencies led the meetings[12] (see Appendix 2). One team started as an inter-agency team but gradually became an intra-agency team. One team started as a mixed team but gradually became a healthcare team, while another team went in the opposite direction.

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10 One informant withdrew his consent in 2010 and another withdrew his consent in 2012.

11 At least three supervisors were not in a position in which they could conduct network meetings due to agency or municipality.

12 In two cases, the permanent team consisted, in some (initial) meetings, of a team member who did not participate in PJD.

2.2.3 Individual interviews

Study III included extracts from an individual interview with a help-seeker. Individual interviews with 14 help-seekers were conducted after their final network meeting. One interview was excluded because consent was not renewed. The 13 interviews were conducted at the child and adolescent clinic, the adult outpatient clinic, the adolescents and young adults home and at the child welfare services. The interviews lasted between 35 minutes to just over one hour and a half. The interviews were all audio-recorded.

2.3 Data collection procedures

2.3.1 Multi-stage focus groups

Focus groups (Studies I and II) are seen as appropriate for generating information about under-researched topics, as in an explorative study like this (Bloor, Frankland, Thomas, & Robson, 2001). Because focus groups are suited for exploring group meanings and norms (Bloor et al., 2001; Halkier, 2002; Kitzinger, 1995), I considered this kind of data collection to be sensitive for the potential differences that could exist between and within the different focus groups. Moreover, in a situation where it is beneficial that the participants themselves explore issues of importance to them, such as generating their own questions, focus groups may be an appropriate method because of the possible increase in unexpected perspectives and topics (Kamberelis & Dimitriadis, 2008; Kitzinger, 1995). A group process based on dialogue and mutual interaction may contribute to exploring perspectives that may be less easily accessible by using other methods, for example individual interviews. The challenge for the researcher is to accept having less control and to include dissenting voices (Bloor et al., 2001; Kitzinger, 1995; Morgan, 1997).

According to Kitzinger (1995), the ideal group size varies between four and eight people. The participants should represent sufficient diversity to encourage discussion and should not be too heterogeneous so the discussions lead to conflict or silence on particular views (Bloor et al., 2001; Kitzinger, 1995). Because the aim was to maximize the exploration of different opinions among the various professionals, it was decided to run separate groups to make them more homogeneous according to our previous observations.

In multi-stage focus groups (Study I), the same group meets several times to explore a particular topic and to stimulate a deeper process. Multi-stage focus groups may benefit from having common history and increased familiarity with each other, which can make it easier for them to share stories and experiences (Morgan, 1997).

The first focus-group interviews in each group were carried out in October 2004, in the middle of PJD (Studies I and II), while the second

interviews in each group were held in October and November 2005 when the project had come to an end (Study I). The final meetings were held in May and October in 2007 (Study I).

The first meetings in each group started with an introduction to the aims of the focus groups and a description of how I wanted them to interact. In order to produce a vital group dynamic, they were encouraged to present their personal experiences, including practical examples of network meetings in an anonymous form and respond to each other's questions and utterances. I emphasized that I wanted to hear about different perspectives, and pointed out that their varied experiences were equally important to me (Halkier, 2002; Morgan, 1997;). Such a "*share and compare*" (Morgan, 1997:20) approach relating to personal experiences may help to make the discussion more nuanced and deeper than if they had only provided information about their opinions (Morgan, 1997). I also collected information about their practical experiences of network meetings, i.e. the number of cases and network meetings. This information, in addition to some personal background material, was confirmed in writing prior to the second meeting in each group.

Then the meetings discussed a vignette, which may be defined as a short concrete description of a realistic situation. The vignette worked well as a broad discussion starter and served as a bridge to the three subsequent topics (Appendix 1). The focus interview guide was inspired by the interview guide for the in-depth interview with the professionals and the interview guide that was prepared for the entire network.

Because the focus-group participants belonged to a pre-existing social group, i.e. PJD, this may have helped them to mention concrete and shared experiences from their joint education and practice. Because of their familiarity with each other, this made it easier for me and the other participants to assess their utterances in relation to their actual behaviour in network meetings. This may contribute to an understanding of the utterances from another angle, and furthermore, contribute to strengthening the findings (Bloor et al., 2001; Kitzinger, 1995). Although their communication was characterized by a fairly high degree of joint agreement, as intimated by body gestures and small expressions, such as nodding and "hmmm", they also challenged each other in their understanding of certain concepts, such as when the professionals in SEG discussed courage in relation to the concept of authenticity (Study II). Such exchanges of views may contribute to deepening the participants' understanding of the different concepts.

The discussion developed somewhat differently in the two groups. The first meeting in both groups was conducted in a stricter way compared to the second meeting and was controlled by the semi-structured interview guide which was equal for both groups in the first meeting. The initial analysis of the focus-group transcripts indicated that the first meeting in HCG were conducted in a somewhat more direct form. This was possibly a result of their greater level of knowledge about processes compared to the professionals in SEG and hence, some of the questions could have had a more reflexive form. In situations

where SEG needed to expand on their explanations of their situation and experiences on the topics under discussion, the healthcare professionals developed their reasoning in a much more precise way, indicating another level of skills and a different relationship with the core competencies that OD demands. Bearing this in mind, the discussions in HCG were more specific on the topics, and the participants themselves introduced topics that they found particularly relevant, such as sense of security, power and equality. I was thus able to adopt a more active role during the meeting. Regardless of this, the data from the first meeting is rich and was very helpful in demonstrating aspects related to professional roles and teamwork relevant for network meetings, and this also served as important input for the focus of the second meeting in both groups. Moreover, in the second meeting, HCG was asked directly if they recognized and accepted the summary, and clearly confirmed this.

The initial analysis from the first focus groups in SEG revealed that some utterances about the difference between review groups and network meetings could have been followed up better. If so, it is likely that this would have given more specific information about how the professionals regard and understand the differences between network meetings and review meetings.

The second meeting in both groups was characterized by a lower moderator involvement, which is considered to be positive in explorative research (Morgan, 1997).

Based on a preliminary analysis of the first meeting in each group, in the second meeting the participants were provided with a summary of three important topics discussed in the first meeting. Topics including professional role and reflection were included in both groups, while the third topic was collaboration in HCG and dialogue in SEG. Each topic was followed by a question, such as "*How would you describe the experiences you have had in connection with the role expectations from the help-seeker and his or her private network*" (HCG second meeting) or "*How would you describe your experiences of the use of reflection in network meetings*" (SEG, second meeting). More concrete questions, both pre-planned and some that were rather spontaneous in response to the focus group's members, followed these open questions. Because both groups had discussed the topic "reflection" during the first meeting, this topic was also included in the second meeting as I found it very relevant for the ODA. Furthermore, because HCG had spent much time discussing mutual trust during the first meeting, some questions related to this were included in the guide for SEG. Prior to the final meeting, a more rigorous but tentative analysis had been carried out, and the professionals were given the document, including my preliminary interpretations supplemented with their most relevant quotations. During the final meetings they were also given a summary (as in the second meeting) and encouraged to respond to the open question at the end of the summary and to reflect on their process of understanding. This feedback from the informants on my preliminary analysis also functioned as a credibility check (Elliott et al., 1999; Graneheim & Lundman, 2004; Hummelvoll, 2008). As

in the second meeting, the open questions were followed by more concrete questions.

2.3.2 Observation

In contrast to interviews where the informant can talk about how he interacts with others, observation makes it possible to explore how the situation really is. Wadel (1991) describes four sub-categories of participating observations: participation in activities and dialogues and observation of activities and dialogues.

During my participation in the network meetings, I acted first and foremost as an observer of the dialogues. The network meetings were held at home, at school, in the child and adolescent outpatient office, the adult outpatient clinic and the child welfare agency facilities. My role in the meetings was to observe the participants and to stay silent. Some of the professionals and participants called me "Silent Birgitte" ("Tause Birgitte"). This is a reference to a well-known television show in Norway in the 1990s with a male presenter supported by a woman who never said a single word, namely "Silent Birgitte". She was always present, but no one had ever heard her voice. Although I used to stay silent, I responded to the questions I was asked. They were usually presented by the professionals at the end of the meeting and were usually concerned with my opinions about the meetings. Otherwise I used to indicate my presence by nodding, smiling and giving other "accepting" signals to what the network members were talking about. I tape-recorded my comments sometimes, but not systematically after a number of network meetings. My focus was mainly on the network's relationship with the patient and observations of the professionals' collaboration.

2.3.3 Individual interviews

Study III includes extracts from an individual interview with a help-seeker. The aim of the interviews was to gain an understanding of how the help-seekers experienced their participation in network meetings, how they coped with the meetings and how they thought and felt. This reveals that I was aiming for their subjective meanings. Because of the interaction between the interviewer and the informant, the situation provides the possibility to explore certain terms more in-depth and to add supplementary questions. This implies that the dialogue often appears as a joint construction of meaning. Thus, the qualitative interview with its possibilities for elaboration and clarification of a given topic was found to be a good alternative compared to other methods (Fog, 1994; Kvale, 1997).

The interview started with me informing the informant that no information would be given to their helpers or others and that he or she could refuse to answer and could withdraw at any time without giving a reason. A semi-structured interview guide was used. I introduced the interviews with an

introductory question related to the particular network meeting that the informant had participated in. The interview guide focused in general on the organizational and treatment model and more specifically on how the informant had experienced the network meetings, the atmosphere and how and why he or she had been included. Also the social interaction within their social network prior to and during the network meetings was of interest. The informants were then encouraged to retell stories about certain events, experiences and turning points on the basis of the OD principles and situations that led to their participation in the network meetings (Coffey & Atkinson, 1996).

2.4 Data analyses methodology

2.4.1 Content analysis

Content analysis provides us with the possibility to create a condensed description of what is important in a text when it comes to latent and manifest content (Mayring, 2000). Manifest content deals with the easily available material. Latent content deals with the more overriding perspectives requiring an interpretation of the underlying meaning of the text (Graneheim & Lundman, 2004).

The very first phase of the analysis took place during the interviews when I summarized my understandings during the focus-group meetings to check if my understanding was in accordance with the participant's understanding. I started to work out a more rigorous analysis of the first and second focus groups during the spring of 2007 so I could present preliminary findings in the final meetings in each focus group. At the same time, I commenced with a more detailed analysis to explore what could form the basis for the first study. Because of the elapsed time since the data collection, I spent much time listening to the material and reading through the transcripts to recall and to obtain an overall understanding of all the focus-group meetings. In this very first phase I focused on an inductive approach (Mayring, 2000), asking the material what it could tell me through a kind of naive way of reading the transcripts. I searched for descriptions, reflections and statements that were related to the aims of the study. I identified broad topics in the material such as "workplace/competence" and "sense of security". During the subsequent analysis I collected the various text parts relating to the different topics together and then separated these into more narrow categories. "Sense of security" was divided into eight other categories; among these were "relationships" and "actions" ("handlinger") (Coffey & Atkinsson, 1996; Halkier, 2002). Color pens were used to mark key and recurrent topics in the margin. Then, I started to follow some theoretical propositions that had played a role both at the outset of

the original study and when the focus was turned towards the professionals alone (Kohlbacher, 2006; Yin, 2014).

I then continued to read and re-read the transcripts from the first two meetings in each group and started to identify and group meaning units such as "*words, sentences and paragraphs, containing aspects related to each other through their content and context*" (Graneheim & Lundman, 2004: 106). During this phase, I started to identify codes, subcategories, categories and main themes (Studies I and II). In order to have both the text as is and the context in which the text was produced (Mayring, 2000) we identified discussion sequences linked to each topic. This was done so that the core of the meaning units was highlighted and the context around the meaning unit shortened. The condensed meaning units were grouped together into tentative codes during the analysis of Study I. One code could consist of several meaning units followed by tentative subcategories and categories, which represents a way of condensing the material and lifting it to a higher level through abstraction (Graneheim & Lundman, 2004). See Appendix 3 for an illustration. To improve the credibility of the categories, some small extracts from the dialogues between the participants were included (Studies I and II) (Kitzinger, 1995).

When identifying labels for the categories during the analysis the process of "feedback loops", i.e. moving back and forth between the whole and parts of the text, was practised (Kohlbacher, 2006). The analytical process carried out in Study I lasted for several years and was developed in several stages. The categories were developed during this process and were mainly created by the author of this thesis. The ongoing analysis, however, went back and forth between myself, my co-author Mark Hopfenbeck and my supervisor Jaakko Seikkula who were used as outside evaluators[13] and discussed how categories and themes covered the data (Graneheim & Lundman, 2004). Both of them had full access to the transcriptions and the categories were credibility checked against the transcribed interviews. They also had access to the preliminary analysis that was presented to the focus-group participants during the data collection. Their involvement contributed to a continuous adaption and developmental process of the categories and codes, which also contributed to the inclusion of several new perspectives (Kvale, 1997). Their feedback helped me to reflect around an appropriate level of generality and detail in the analysis (Coffey & Atkinson, 1996). I finally labelled the manifest and latent content, the main theme and categories, sub-categories and codes developed in the analysis according to data from the two first meetings in each focus group (Graneheim & Lundman, 2004). To compress the information, several categories were merged together and the sub-categories were excluded. The final trustworthiness of the analysis and interpretation of the focus-group analysis was reached through a consensus process by mail between myself and Mark Hopfenbeck (Elliott et al., 1999; Graneheim & Lundman, 2004). Study I includes

[13] None of them were involved in the interview process, except for Mark Hopfenbeck's participation in the final interview. In this interview, the goal was to have our preliminary analysis discussed.

some utterances from the third meeting in the focus groups. The analysis related to the final meeting was less rigorous than for the two first meetings and it was led by the findings from the first and second focus-group meetings. The analysis carried out in Study II was undertaken in substantially less time. The final analysis in this study was carried out by myself and Mark Hopfenbeck independently and final agreement was reached during a consensus meeting on Skype.

3 OVERVIEW OF THE ORIGINAL STUDIES

3.1 Study 1

Open Dialogues in social networks: Professional identity and transdisciplinary collaboration

The study explored challenges connected to the transformation and emergence of professional identity in transdisciplinary multi-agency network meetings utilizing OD. The aim was to explore how professionals who had participated in PJD perceived network meetings. In exploring how professional identity was related to the development of professional roles and the development of transdisciplinarity in multi-agency network meetings, 12 professionals were invited to participate in focus groups. Six professionals were working in the social and educational sector (SEG) and six professionals were working in the healthcare sector (HCG). One of the three focus-group meetings in each focus group was carried out in the middle of PJD, while the other two meetings were conducted after PJD had come to an end. The groups were analysed through content analysis and compared according to the two first meetings in the two focus groups. In addition, some findings from the third meeting were included. The findings are discussed within a framework of professional identity involving identification and negotiation.

In the first meeting in the focus groups the professionals in HCG searched for role release by reducing the impact of therapeutic skills while members of SEG emphasized role expansion and communication guided by the help-seeker. They all experienced stereotypes introduced by participants unfamiliar with network meetings. The participants working in the social and educational sector were also often searching for practical solutions instead of aiming for a slowly developing dialogue.

In the second meeting, some professionals in HCG claimed that they had more focus on following the help-seeker's utterances, while others found it more difficult to deal with the help-seeker's expectations as to the professional's

role as expert. Some of the professionals in SEG defined their role more towards a therapeutic approach while others were focused on the vague responsibility structures that arose and hence more towards interdisciplinarity. They were all still struggling with stereotypes. In the second meeting the professionals within each group had rather different experiences, and discrepancies relating to role transformation became stronger. This may have contributed to making the identity transformation difficulties more apparent.

Professionals in HCG had experienced an increased sense of professional insecurity through their practice prior to the first meeting in the focus groups because of the multi-agency perspective. The professionals working in the social and educational sector were placed in a marginalized position by the healthcare professionals, but they also seemed to place themselves in that position according to the medical paradigm that may influence mutual identification and negotiability.

During the second meeting, the professionals in HCG discussed the impact of familiarity with each other. Although mutual reliance had emerged during the project, difficulties still existed because of the multi-agency approach. The professionals in SEG pointed to difficulties caused by different interpretations of the situation, and they discussed how the exercise of authority linked to their different mandate affected the collaboration. The professionals in SEG stated that their sense of security was closely linked to their team partners' attitudes and personalities. Some professionals were still being marginalized through the questioning of their competence.

Professionals in HCG pointed to difficulties in arriving at a common understanding during the first meeting, whilst this is illustrated by the SEG professional during the second meeting. It seems that the realization of transdisciplinary teamwork is dependent upon the professionals' mutual reliance. The professionals' participation seems to be affected by stereotypes and differences in their sense of belonging to a certain network, and thus their identity transformation seems to be strongly affected.

To encourage the use of integrated solutions in mental healthcare, the professionals' preference and motivation for teamwork, the importance of familiarity with each other and knowledge of cultural barriers should be addressed.

3.2 Study 2

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

This study explored what professionals find promotes or impedes dialogue for generating inter-agency network meetings and how this is related to their professional backgrounds. The professionals participated in a project using OD to increase the use of inter-agency network meetings with young people

suffering from mental health problems or who were at risk of developing such problems. The empirical data was collected when the professionals had participated in PJD for about a year. The data collection methods consisted of interviews conducted with two focus groups, the first comprising healthcare professionals (HCG) and the second professionals from the social and educational sectors (SEG). To illustrate the findings from the focus groups, examples from real network meetings illustrated through audio-taped transcripts and more general observations of inter-agency network meetings were included. Content analysis was used and the main category that emerged was dialogue. The findings describe the significance and challenges of listening and authenticity.

All of 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. SEG also pointed to the importance of silence. Regardless of sector affiliation, the professionals claimed that they sometimes did not respect the time it took to really listen to the different perspectives and instead they went too quickly into attempts to create 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.

When HCG discussed authenticity they mainly discussed this in terms of reflections with colleagues and emphasized the need for self-disclosure. Observations and results from the focus groups indicated that professionals working in the mental healthcare sector seem to be aware of their own emotions and how they can be presented in a way that promotes dialogue. SEG 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 patient. While the healthcare professionals found their major challenge within a mutual dialogue, the others seemed to search for particular techniques outside the dialogue, such as their possibility of offering special techniques, for example supervision and advice.

Inter-agency network meetings may be improved if more awareness is placed on the significance of the 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.

3.3 Study 3

Transdisciplinary collaboration and role release in Open Dialogue with adolescents' social networks

This case study explored a teacher's transdisciplinary role-release process and how professionals adapt to each other in transdisciplinary inter-agency network meetings. Professionals working in the health, social and educational sectors

participated in a clinical pilot project entitled Project Joint Development. The project aimed to improve the assistance system for people between 14 and 25 years of age suffering from mental health problems or at risk of developing such problems. The empirical data material was collected through observation of network meetings and an interview with one young person. An analysis of the case was used to illustrate the role-release process and the professionals' adaptation to each other. The case was an innovative one, and selected because of its power to illustrate aspects of the role-release process and how other professionals than trained therapists can acquire dialogical skills.

The findings indicate that through a role-release process, other professionals than therapists are able to facilitate a dialogical approach. This is due to a number of factors: they incorporate knowledge about the significance of the family's language, they pay attention to the family and accept the help-seeker's personal experience and they listen carefully and dwell on feelings. Their use of words connected to emotions may indicate that they are triggered by inner voices that enable them to become more personally involved. The various team members also listen carefully to the unspoken and what is difficult to grasp. The professionals' adapt to each other by utilizing reflexive questions, responding to each other's utterances and dwelling on the same topic. In this way the professionals can explore what the exact meaning of the person seeking help is and thus increase the dialogical space by dwelling on the same topics and adapting their utterances to what was previously said. The professionals' intonation may indicate that their response is triggered by inner voices, and due to this, the vertical and horizontal dialogue increases, followed by a co-evolution of a polyphonic dialogue which may represent increased opportunities to generate new explorations and perspectives. The role-release process and the professionals' adaptation to each other are challenged by the private network's resistance to seeing the teacher as someone other than a teacher. A transdisciplinary, inter-agency approach may be easier to facilitate if there is more awareness of the significance of unspoken expectations, significant factors in cases with minors and of the significance of horizontal and vertical dialogues.

4 DISCUSSION

4.1 The main findings

The main aim of this research was to explore the experiences of professionals working in the healthcare, social and educational sectors who were included in PJD and their use of network meetings in the context of OD. In this chapter I will discuss the findings from Studies I–III in the light of the research questions and the findings. The findings of the studies suggest that i) the professionals were able to develop a transdisciplinary identity involving change in their professional role and understanding of teamwork; ii) the professionals' ability to generate dialogue, including the ability and willingness to listen and provide authentic feedback, may be a challenge; iii) other professionals than trained therapists may be able to integrate skills and knowledge related to an ODA and thus develop their role in a more therapeutic direction; iv) professionals adapt to each other in network meetings by dwelling on the same topics and adapting their utterances to what was previously said.

The three qualitative studies examined how professionals representing various agencies and professions understand various aspects of network meetings, in particular, aspects connected to the processes that involve collaboration and joint dialogue, and how processes can be understood according to different modes of collaboration, including aspects of the professional role.

The first study dealt with how professional identity may change and emerge in multi-agency network meetings aiming to achieve a transdisciplinary approach in the context of OD. The findings indicated that professionals representing HCG were striving for role release, while professionals representing SEG were leaning more in the direction of role expansion at the point in time when the first meeting was conducted. When the second meeting was held there was greater variation within the different groups. In SEG some professionals were increasingly searching for clarity. This can be interpreted as a search for an increased interdisciplinary approach in the sense that they

preferred to reduce the blurring of roles. Others were still searching for role expansion in the sense of defining OD as somewhat similar to therapeutic work. They were all struggling with stereotypes.

When the professionals discussed teamwork during the first meeting, the healthcare professionals reported an increased sense of insecurity, while during the second meeting they discussed the impact of familiarity with other professionals. During the first meeting the professionals in HCG placed the professionals in SEG in a marginalized position in accordance with a medical paradigm, while the social and educational professionals also placed themselves in such a position at the same time. During the second meeting they pointed to difficulties caused by different interpretations and different exercises of authority. These professionals also discussed the impact of familiarity with each other during this meeting. The study argued in favour of the importance of the professionals' preference and motivation for teamwork and the importance of familiarity and knowledge of cultural barriers.

The second study dealt more specifically with aspects of dialogue, which may be influenced by the professionals' background, i.e. their profession or their belonging to a particular agency. The findings indicated that the ability to listen and to promote authentic response was considered to be of significance by all the professionals. However, it was also considered to be a challenge. If the professionals' ability to promote authentic dialogues is to be increased, more focus should be placed on knowledge and skills that facilitate curative dialogues involving reflectional practice.

The third study focused on aspects of the transdisciplinary role-release process and how professionals adapt to each other in network meetings. There was a focus on horizontal and vertical voices. The study findings suggest that others than trained therapists may be able to facilitate dialogicity. Through their focus on horizontal and vertical voices the professionals are able to create a polyphonic dialogue. The study findings suggest that it is especially important in cases involving minors to be aware of creating enough safe space and spending enough time on elaborating their statements closely. The professionals should be aware of how their horizontal and vertical dialogues can represent important contributions to the dialogue as well as how the unspoken expectations of participants may influence the dialogical process.

In the course of writing this summary, a process of synthesizing the findings in the three studies has been salient. The discussion of the three studies is not presented separately, but in connection to the key topics that emerged and which were of relevance in all the studies. The main topics discussed are identity associated with different modes of teamwork, more specifically, inter- and transprofessional, and inter-agency teamwork, professional role and aspects of dialogue, including listening, dwelling and having courage.

4.2 Identity and different modes of teamwork

The main theme that emerged in Study I was "professional identity, professional role and transdisciplinary collaboration in network meetings" where the findings suggested that some professionals changed their professional identity in a transdisciplinary direction. Study II discussed how aspects of dialogue could promote or impede inter-agency teamwork in the sense of shared team identity, integration of common goals, clarity, interdependence, shared responsibility and team tasks (Reeves et al., 2010).

Due to socialization into different professions the professionals develop a cognitive map including their own language and values. Thus, if they are to promote effective collaboration, the collaborating professionals should aim to have greater focus on the same idea rather than their particular professions (Hall & Weaver, 2001; Hall, Weaver, & Grassau, 2013; Petrie, 1976). Petrie's concept of "*Idea dominance*" (Petrie, 1976: 32) addresses the importance of professionals reducing the emphasis on their particular profession and instead focusing on and highlighting one particular idea so that successful collaboration can be achieved more easily. Furthermore, if success is to be achieved, the particular idea needs to be clearly perceived by all participants (Petrie, 1976).

For professionals, the idea and principles that underlie OD are apparently easy to follow and seem quite like ordinary tasks needed in collaborative processes, such as aiming for a dialogue, professional responsibility and continuity. In contrast, OD also represents a non-standardized approach, and aims to avoid standardized procedures (at least as a starting point) (Seikkula, 2000). This implies that other skills than only those that are demanded in traditional collaborative work are required. In PJD, professionals without joint clinical practice (a number of them were also not clinicians) were sometimes supposed to work and lead the network meetings together. Due to the inclusion of different parties, the help-seekers' difficult situation and the need to harmonize a variety of perspectives, network meetings often represent highly complex situations. Thus, professional practitioners of OD should "feel safe enough to swim", that is, to feel secure in their original profession and, in addition, have a taste for adventure (Petrie, 1976) and be able to tolerate personal discomfort and uncertainty (Bleakley, 2013). This is demanded because of the reduced possibilities to hide behind a defined professional role, standardized hierarchical structures and standardized approaches. An awareness of such factors may help them to tolerate increased levels of uncertainty and complexity, including blurred roles (Bleakley, 2013; Hall, 2005). Thus, experiencing a strong sense of self-confidence in their own profession as well as having the ability and will to tolerate a number of different and perhaps rather exotic or contradictory perspectives may contribute to generating greater integration and a sense of mutual interdependence. Such personal and professional skills may contribute to

increasing professional flexibility that may increase the sense of integration and team identity, both of which are important aspects of teamwork.

A study focusing on Crisis Resolution/Home Treatment teams using the OD approach in clinical practice found that the healthcare professionals considered it important to keep the dialogues open and to have tolerance for uncertainty. Keeping the dialogues open with respect to clinical judgement meant taking into account the impact of the various clinical contexts, the other professionals' personal skills and knowledge and the extent to which a team could reach a common understanding. Tolerance of uncertainty in clinical practice was characterized by flexible thinking and a positive attitude in dealing with the unexpected. These factors were found to be crucial to improving team integration and team identity and were also understood as the professionals' willingness to deal with situations involving multiple interpretations (Borg et al., 2010).

Because of the potential benefits followed by a positive attitude towards the unexpected, unusual and extraordinary situations, professional practitioners of OD should strive towards an increased tolerance for such factors and hence factors that promote adaptability more than stability. An increased tolerance for the unexpected can be important factors in the generation of new ideas and knowledge (Bleakely, 2013) and hence new and need adapted solutions. Moreover, because of the complexity that should be solved by the team, the team as a whole should be able to tolerate a sense of insecurity, including the various perspectives that may be presented by the various professionals. Focusing on a will-to-adaptability may involve an increased focus on different perspectives and the ability to improvise which may be followed by an achieved integrated teamwork (Bleakley, 2013). Thus, when selecting professionals for OD teams, their motivation to deal with unexpected situations and to be flexible in collaboration with others should be taken into consideration. Hence, the professionals working in OD teams should strive for a professional identity that includes being flexible when it comes to collaboration. This suggests that if teamwork is to be improved, the team members must be willing and motivated to engage in collaboration something that may vary among professionals (Reeves et al., 2010).

The concepts we are using influence the participants' expectations and understanding of goals (Mariano, 1989). Thus, to generate a joint understanding of the goals for the participants and to achieve a shared understanding of the ODA, it may be beneficial to increase the focus on the use and definition of concepts. In OD this may be related to 1) a language that distinguishes between the different modes of collaboration (see Choi & Pak, 2006; Reeves et al., 2010; Payne, 2000), and 2) developing a language that focuses on important collaborative factors, such as mutual trust and professional self-confidence (San Martín–Rodríguez et al., 2005).

If this can be achieved, perhaps the number of "mature teams" in which the professionals have great willingness and ability to adapt to their personal and professional behaviour according to the particular help-seeker and the

private network would increase. The professionals' understanding of a particular family's potential level of participation and decision-making could characterize mature teams. When the professional is familiar with different modes of teamwork and shifting between different levels of collaboration in a flexible way, the possibility of achieving the best possible solutions at any point in time may increase. To achieve this, the professionals need to know when a meeting should be like a network meeting and when it would be more adequate to conduct other kinds of meetings, e.g. a review meeting or an even looser mode of collaboration, such as involving different professionals on an individual basis (see D'amour et al., 2005; Reeves et al., 2010). When doing so, the team or the group they are a member of, and the other professionals they are collaborating with, may improve the sense of collectivity and interaction due to the joint understanding of how to interact at every stage of the process.

4.3 Roles

If we know a person's position and title we are able to draw certain inferences about what we can expect from him or her and how he or her most likely will behave according to a particular context (Aubert, 1979). The findings of Studies I and III suggest that the different members of the network may have some difficulties in knowing how their and the others' roles should be understood in the ODA. Holloway (2009) and Lian (2006), who explored projects involving only healthcare professionals, also emphasized the professionals' understanding of each other's roles. On the other hand, in PJD, other professionals, such as teachers, were presupposed to work as team leaders in the same manner as trained therapists. In a role developing perspective, the inclusion of the various professions in PJD may be even more confusing for other professionals, the help-seeker and his or her private network because of the increased differences between the professions and the inclusion of multiple agencies.

Roles are usually complementary (Aubert, 1979) and we assume that the other professionals who are attending have other roles than ourselves so that the help-seeker is provided with a variety of help and services. In situations when one does not realize or is unable to deal with the significant differences that may exist between the professionals, there is a risk that they will retreat to the common-sense level, which is shared by all of the professionals. If that happens, they will not make any use of the powerful insights represented by the various professionals (Petrie, 1976).

The findings in the first meeting in the focus groups (Study I) suggest that the roles the professionals aim to adopt are rather unclear. One professional in HCG expresses that he does not want to be an expert, while another states that network meetings are not therapy. Professionals in SEG aim for a non-prescriptive behaviour where they really listen to what the families are saying. The various understandings continue in the second meeting. SEG

argues that OD is approaching therapy; while a member of HCG states that they focus on experience but not on the members' particular knowledge of roles. These differing expressions point out potential collaborative challenges due to the vague understanding the professionals have in relation to what ODA should provide for people in need of help. Followed by this, there is a risk when understanding an expert as a non-expert and instead put an emphasis on the equality and negotiations of meanings involving all participants may reduce the use of the professionals' privileged knowledge (Laitila, 2009). As a consequence, it may be difficult to achieve the goals because this confusion impedes the objective of uniting the different resources. Thus, instead of encouraging professionals with high levels of competence and expertise, the knowledge and skills every one of them should contribute may become unclear. Instead of representing a highly skilled network, there is a risk that in their interaction the professionals will retreat to the common-sense level.

In Norway, teaching is to some extent a caring profession in the sense that teachers are responsible for creating an environment in which the pupils can achieve a sense of empowerment (Stephens, Tønnessen, & Kyriacou, 2004). The importance of including teachers involved as a potential source of support has been emphasized previously (Lynn et al., 2003; Ødegård, 2005). This was also emphasized in the other study exploring PJD. In this study, the school was identified as an important arena. Teachers know the pupils well and they may have great impact on their daily lives and may provide daily and continuous support (Hauan, 2010). The findings of Study III suggest that the teacher is having difficulties due to her ordinary role. Teachers can easily integrate ODA into their ordinary role, but a change in focus from being an ordinary teacher towards an increased focus on therapy may contribute to widening the gap between the normal role of the teacher and the increased focus on therapy. The family sees the teacher only as a teacher who should be able to provide them with concrete actions. The fact that the teacher aimed to change her behaviour towards a more therapeutic approach and increased her awareness of dialogical skills did not sit that well, particularly with the parents. However, because of the importance of including teachers in network meetings due to their potential significance for the pupils' well being, there is a need to continue the focus on this group. Even though or perhaps precisely because the teachers are representing an agency quite far away from the health and social sector, the potential benefits may be very high if success is achieved.

In situations where the professionals' focus is on exploring the meaning system in accordance with ODA, the help provided to the network is a dialogue. In cases where the help-seeker and the private network feel in need of an expert and see themselves as more passive receivers, there is a conflict between the first- and second- order perspective (Ødegård & Bjørkly, 2012). In situations involving a lack of common understanding of the professionals' attitude to these approaches, difficulties may emerge. The concept of role helps to emphasize the need for clear communication in terms of clarifying the participants' expectations of the ODA and the help they receive. Thus, even

though professionals are focused on the ability to be led by the help-seeker, the other persons present may focus on stability by displaying resistance to new approaches and perspectives. Because the collaboration is not based on routine, but instead on the particular context and need-adapted treatment, there is a deeper need for dialogue and communication on the processes (Bleakley, 2013).

4.4 Dialogue

In general, dialogue and communication are important in all kinds of collaboration, but often the focus is on sharing information about the case, and on discussing the professional tools and perspectives in order to achieve certain goals and to facilitate coordination (Darlington & Feeney, 2008; San Martín-Rodríguez et al., 2005; Suter et al., 2009). In the ODA, the aim of the dialogue is to respond to every utterance, including verbal, non-verbal and embodied utterances, as both the means and end of the approach. Even trained therapists may experience this as a challenge (Seikkula, 2008). In the same vein, the findings of this research indicated that the generation of dialogues led by the help-seeker and private network could be a challenge both for trained therapists and for those who were working in the social and educational sector in different ways (Studies I–III). This often involves the professionals' courage and listening skills, their ability to dwell on certain topics and to stay silent together, as well as the stereotypes that exist.

In a study on how mental health workers relate to patients with severe mental illness, the findings indicated the importance of "*being accepting and inclusive, being emotionally involved and searching for each client's perspective*" (Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013: 885). The professionals sometimes found that emotional involvement was challenging. To cope with their own reactions and distinguish their emotions from the clients they sometimes had to distance themselves from the client (Eriksen et al., 2013).

Trained healthcare workers may be more skilled in dealing with their own and others' reactions in difficult situations compared to professionals working in the social and educational sector. Even though PJD showed that there are variations within the different groups of professionals, the educational professionals and some of those belonging to the social sector have to a lesser extent been socialized into a culture focusing on how to deal with their own and others' emotional difficulties. Moreover, an interest in one's own and others' emotional reactions may demand some kind of personal effort and thus be especially demanding for professionals working in the social and educational services who suffer from a lack of motivation to deal with such phenomena.

Furthermore, Eriksen et al. (2013) found that the healthcare professionals sometimes felt that they were suffering from a lack of courage because the client could sometimes refer to experiences as shameful or shocking and the professionals did not always know how to deal with that. Thus, to be able to

generate an open dialogue including difficult perspectives, the professionals stated that courage was an important quality for coping and dealing with their patients' challenges.

To a certain extent, this agrees with the findings of Study II. Here, the findings suggested that there were differences in the professionals' ability to deal with the help–seekers' difficulties through reflections in a way that promoted dialogue. Challenges related to reflection are also one of the findings in Nilsen's (2011) study. In this study, the informants reflected over the inherent insecurity and dilemmas connected to the goal to be personally open. In situations in which they had much professional knowledge about the situation, this could be a challenge (Nilsen, 2011). Moreover, the findings of Study III indicated that the professionals' way of adapting to each other was related to their ability to dwell on topics and respond to what was previously said. This implies that the professionals who make up a team are able to share their emotional involvement to some extent with each other and with the help-seeker in a way that facilitates an open dialogue.

These studies may indicate that the courage to talk about difficult issues in situations with other persons present may be a challenge. Although the study by Eriksen et al. (2013) is related to severe mental illness, the same type of challenge may be relevant in such situations as network meetings with adolescents who have relatively moderate mental problems. Even though such settings may be easier to deal with for both parties, awareness about sensitivity and authenticity in a dialogue and how the interactions should develop is needed in order to facilitate a shared dialogue.

The findings of Study I indicate that familiarity to a certain extent is a precondition for generating dialogues. It could, however, be argued that the dialogue in itself is a process leading to a feeling of security. In situations in which the parties are able to show disclosure and honesty and can allow the help-seeker really feel that his or her opinions are being taken into account (Piippo & Aaltonen, 2008b), the feeling of trust may also increase. Nonetheless, Lian (2006) and Guregård (2009) suggest that some kind of familiarity towards each other as team partners is needed to achieve successful collaboration. Guregård (2009) goes even further and recommends that co-therapy should be taught explicitly, as the professionals who make up a team need to be in tune with each other.

Seikkula (2008) points out the importance of having a slow pace in the meeting and of giving space for silence and dwelling. The findings of Studies I–III indicate that listening and dwelling may be challenging tasks. In Studies I and II, the professionals claimed that they might move on too rapidly to the process of creating solutions so that they do not spend enough time dwelling on the various perspectives. In another study focusing on OD, the professionals claimed that they usually had shorter deadlines. This influenced their interaction with the participants because they spent more time on developing the dialogue (Nilsen, 2011). This touches on the professionals' ability and courage to dwell on certain topics for an extended period of time. It is also

related to accepting and facilitating the co-therapists particular choices when it comes to how they respond and their choice of response to the clients and the private network (Study II; Guregård, 2009).

Breuneau (2008) claims that silence seems to facilitate interpersonal closeness or the opposite: it seems to generate stress and uncertainty. For trained therapists, silence may have a clear goal and can be interpreted in different ways. Søndergård (2010) claims that silence contributes to making the OD collective. In situations where the silence is unexplained, this may lead to speculation on the part of the family and reduce the level of openness in the meetings (Guregård, 2009). For professionals who are using another approach, silence may be considered as a factor delaying a process (Study II). Although social workers are educated in working with families and networks, both in emotional and practical ways, the agency and the culture they are socialized into may influence how they relate to these kinds of skills, such as seeing silence as a particular skill and having focus on dwelling.

Implementation of a humanistic approach such as OD often encounters barriers because of the strong parties involved, such as trade union subjects. These barriers are rooted in the old medical paradigm characterizing the traditions of mental healthcare. Thus, the implementation of OD and other similar approaches have suggested that the shift from a medical paradigm to a more holistic mental health approach involving a sharper user focus have been challenging (Karlsson, Borg, & Kim 2008; Søndergård, 2010) and may contribute to the very slow alterations in roles and teamwork in the mental healthcare services.

The findings of Studies I and III, however, indicate that the professionals are striving for a change in approaches to assisting the help-seeker to focus on the relations he or she is surrounded by. They report resistance not only from other professionals, but also from the help-seeker and the private network. Thus, if the process of altering the paradigms is to be improved, the focus on communication and dialogue between all the parties in a network meeting must be increased. In order to reduce the existing stereotypes found in the processes of collaboration involving different actors, the initial expectations each participant has for the network meetings must be clarified repeatedly. This is also emphasized by Nilsen (2011) and Foley (1990) who state that information about the principles of the particular mode of intervention is important for all parties if the entire team is to be mobilized and function. Ødegård & Bjørkly (2012) have the same message. According to the findings of this research, this message cannot be promoted strongly enough.

4.5 Ethical considerations

In terms of ethical issues, the approval for the research was given by the Norwegian Data Inspectorate (NSD) and the Regional Research Medical Ethical Committee (REK) on 11 and 17 February 2004, respectively. The anonymized

consent form (Appendix 4) was signed by all the participating help-seekers and their parents, if they were under 18 years of age. Also help-seekers over 18 years of age as well as the professional who acted as team leader and who was the one who had been contacted by the help-seeker or who had taken the initiative to include the help-seeker in network meetings signed consent forms. Note here that the permission from NSD presupposed that the person who wanted to include a help-seeker in the network meetings should initiate the first contact with the help-seeker to invite him or her to participate in network meetings. Thus, it was important to inform the professionals in PJD thoroughly about the research project connected to it and particularly their responsibility to provide the necessary information in the informant recruitment procedures. This was done for the first time in a meeting held at the beginning of 2004. In this meeting, the participants were instructed on the need to inform the help-seeker, and his or her parents if the help-seeker was under 18 years of age, both orally and in writing, of his or her rights, and to obtain written consent, preferably prior to the first network meeting. This was particularly important if they agreed to participate in the observational part of the study. If the help-seeker was under 18 years of age, the parents should be orally informed by telephone and the consent form should be sent by post. Moreover, the professionals were regularly, usually during the lessons, reminded about how to inform the help-seeker and the private network about the research project, with a reminder of the help-seeker's right to refuse to participate and the right to stop the intervention after first having agreed to participate. The professionals were also informed about their potential participation in the research project through participation in the pre-planned group interviews with whole networks and the individual interviews with various actors. The professionals were presented with the existing versions of the various consent forms. They were assured that they could withdraw from the project at any time although REK, in their first conditional acceptance of the project, wondered at how any professionals could consider refusing to participate.

The changing focus emerged slowly, and during the summer/autumn of 2004 it was decided to organize focus groups with professionals instead of conducting group interviews with whole networks and individual interviews with professionals and the private network. NSD was informed about the changes in an e-mail dated 3 September 2004, including the information that no sensitive topics would be included. Thus, the information of interest could be considered as less confidential for the participants compared to the information I had already obtained permission to collect. NSD was also provided with a short overview over the topics of interest, which were all inspired by the previously accepted interview guides for the group interview with whole networks and the individual interviews with the professionals. The formal approval for the focus groups was given on 19 March 2008. The professionals were informed verbally about the focus-group study for the first time during a teaching session. The selected focus-group participants were all invited orally

by me. They were informed verbally and in writing at the beginning of the focus-group meetings about the project and gave their written consent.

As my focus on the audio-recorded network meetings increased during my work with the analysis of the focus groups, approval from REK to transcribe and analyse the audiotapes was given on 13 April 2010. At the same time REK also gave its approval for storage of all data, the focus-group data included,[14] until 2020. One person withdrew from the focus group and two help-seekers withdrew from the observational study.

The raw data were locked up in secure facilities. The personal information about the informants was at all times stored securely at Sørlandet Hospital and/or at Oslo University Hospital/University of Oslo.[15] The transcripts and data were rendered anonymous. In the reporting of the focus groups, numbers referring to the informants have been used, and in the observational study, pseudonyms have been used throughout. To guarantee anonymity, some personal details that emerged in the material were blanked out, particularly in Studies II and III. According to the declarations of consent, the data will be deleted in 2020.

4.6 Trustworthiness of the focus-group study

Trustworthiness for qualitative research is composed of four factors (Lincoln & Guba, 1985), which will be discussed below.

Credibility refers to how well data and the analytical processes address the intended research focus. The concept includes such topics as focus of the study, the participants, data-collection approach and data analysis, including considerations relating to the choice of meaning units (Graneheim & Lundman 2004; Lincoln & Guba, 1985).

The sample consisted of professionals with a varied background and provided us with a rich body of knowledge. I have, however, wondered if a sharper focus on the professionals' practical experience with network meetings could have been positive instead of my focus on including an equal number of professionals from all of the supervision groups. Because the development in the two municipalities was rather different, the criterion calling for an equal number of participants from each municipality should have been maintained.

Moreover, the choice of splitting the professionals into two focus groups can be discussed. By selecting the professionals in such a way, I may have contributed to confirming existing differences instead of providing them with

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14 At this time, all questions related to the project, also research involving professionals only, had been transferred to REK alone. Hence, no approval was necessary from the NSD after 2009.

15 Oslo University Hospital and University of Oslo (child and adolescent mental healthcare) are located in the same campus area.

an opportunity to demonstrate real transdisciplinarity. Because the interaction in focus groups may contribute to changing the existing situation through the negotiations that take place (Halkier, 2002), joint focus groups could have had stronger impact on the implementation of PJD itself. However, due to the emphasis on the generation of a fruitful dialogue, together with the observations I had made, I chose to split the professionals into two groups in order to attain sufficient homogeneity.

A particular behaviour needs to be considered in connection with the particular context in which the behaviour occurs and should be observed for some time. Thus, "*prolonged engagement*" (Guba, 1981: 84) is an important factor for credibility. I followed and observed all the network meetings in 16 cases. I believe this has given me a deeper understanding of how network meetings involving a broad range of professions and agencies develop and are being carried out. This provided me with special knowledge as to how processes can unfold depending on the professionals' level of familiarity with each other, their motivation to work together and how they negotiate their different professional roles. Moreover, it also contributed to the development of trust between the informant and me. This may have reduced the risk of distortions because the participants got used to my attendance and got to know me better (Lincoln & Guba, 1985), and the information could be used in the focus-group interviews.

One improvement in the study procedures would have been to include a co-moderator in all of the focus groups. Because of the lack of potential candidates I decided to conduct the two first focus groups alone. In the final meetings carried out together with my co-author Mark Hopfenbeck, I experienced, however, that when having two focus-group leaders the one doing the interviewing did not have to focus on all aspects alone. This would probably have made the other focus groups easier to conduct as well.

At the outset of the analytical process I conducted much of the analysis work independently. In the beginning I had meetings primarily with Jaakko Seikkula, who evaluated the work and commented on it. Thereafter, Mark Hopfenbeck became more and more involved in the analytical process. However, no calculation was made of the content analysis in Study I with respect to consensus between the coders. While credibility checking we reached a common agreement that was considered as adequate screening for research credibility. Moreover, the communication I had with supervisors, co-authors and with other colleagues to discuss my thoughts and beliefs and to crosscheck my developing insights should contribute to strengthening trustworthiness. During the project period I discussed my evolving insights both with the project group and with some project participants who in some respects can be labelled as key informants. The analysis was also checked by including the participants in the focus groups in meetings two and three, and thus a sufficient level of triangulation should have been reached (Elliott et al., 1999). Moreover, to facilitate the reader's personal judgment of the credibility of the findings (Elliott et al., 1999), an illustration is presented in Appendix 3 showing how meaning

units, compression and abstractions were made. As Study I contained much information, one could ask if the most empirical level, the meaning units, should have been presented more closely. However, as the analyses and identification of meaning units and the abstraction of the meaning units into codes and categories that covered the data were carried out in a very thorough (and time consuming) manner, this should ensure that the codes mirror the meaning linked to the lowest empirical level. Thus, in addition to my presentation of the research process above, including the shift towards the focus on professionals alone and thereby changes in my own orientation, I have tried to provide a detailed presentation of the analytical process, which in addition, underwent multiple credibility checks (Elliott et al., 1999; Guba 1981).

Taking into account the dialogical aspect of ODA, the choice of content analysis as the methodology can be discussed. As I wanted to gain an overview over the professionals' perceptions, content analysis seemed to be a good choice, also because it allows me to emphasis on the interaction that took place during the focus groups. However, one may argue that if I had chosen dialogical analysis, for example, it would have provided me with more detailed (Halkier, 2002) knowledge. I assume that this would have given me other kinds of knowledge than what I was searching for.

Transferability refers to the extent to which the findings generated from PJD can also be applicable in other contexts or for other groups (Graneheim & Lundman, 2004; Guba, 1981). Because of the small sample size in the focus groups, this research had no intention of being representative. To help other professionals, researchers and teachers to form their own opinions about the fittingness and relevance of these findings to other cases and situations, I aimed to present thick descriptions (Geertz, 1973) about the context of PJD, the focus groups and how the focus groups were carried out. This should permit comparison of this particular context to other relevant contexts (Elliott et al., 1999; Guba, 1981).

Dependability refers to factors of instability versus consistency within the focus groups (Graneheim & Lundman, 2004; Guba, 1981). Because of the adjustments made in the two focus groups, the focus in the second meeting differed somewhat in terms of topics. Even though low moderation involvement makes it more difficult to make comparisons across different groups, two of the topics in the second meeting were rather similar between the groups, while one topic differed. Nevertheless, it was possible to make comparisons (Study I) (Morgan, 1997). Nor did the heterogeneity of the professionals' background within the focus groups create particular problems; although the first meetings in the two groups were led somewhat differently (see p. 35).

Confirmability refers to the neutrality of the data and how it has been produced and interpreted (Guba, 1981). The audit trial of this study was strengthened by the analytical process, which was carried out in collaboration with co-authors and supervisors and presented to colleagues and informants. Based on the presentation of the different stages in the research and analytical

processes, containing detailed documentation of each process, the trustworthiness of the study should be sufficient (Guba, 1981). The fact that I carried out the focus-group interviews, participated as an observer in the network meetings and conducted most of the analysis may be considered to be a shortcoming. However, others carried out the intervention itself and taught the post-educational program. Although I participated in the project group during the project period, I was involved in the planning of this project at a late stage. Therefore, as I was not one of the initiators of the project, I did not have any particular need to document how successful or not the project was. This offers protection from bias.

The supervisor of this research, Jaakko Seikkula, and my colleague Mark Hopfenbeck, are co-authors of the two papers on the focus-group study and have been used as external evaluators of the findings. Jaakko Seikkula has functioned as the clinical main supervisor in PJD. Seikkula was not involved in the interview process, but was shown my preliminary analysis and the focus-group interview guide, and he has been used as an external evaluator for the initial analysis I conducted. Seikkula's area of expertise is mainly in psychotherapy. His supervisor background is connected to network and family oriented treatment. Hopfenbeck has degrees in anthropology and geography. He is a research fellow studying emotional exchange processes in Open Dialogue in a mental healthcare setting. Hopfenbeck is the program director for postgraduate education in network meetings and relational skills at Gjøvik University College.

4.7 Trustworthiness of observations

When judging the quality of a case report (Study III), Lincoln and Guba (2002) refer to four criteria: the *resonance criterion*, that is, satisfactory overlap and fitness between the case and the paradigm (ODA); *the rhetorical criterion,* which deals with form, structure and other characteristics of the case; the *empowerment criterion,* which aims to encourage actionability and educativeness;, the *applicability criterion,* which refers to the extent of inferences followed by the case study (Lincoln & Guba, 2002). To enhance the reader's ability to judge how the case corresponds to OD and transdisciplinarity I have thoroughly presented the ODA approach in Study III. This also includes the educational program inherent in PJD as well as the collaboration demanded in a transdisciplinary approach. Concerning the rhetorical criterion and the overall organization, I have made an attempt to describe as clearly as possible who did and said what in the network meetings and thus present the case so thoroughly as possible. By using the transcripts and thus the families' own language, I aimed to present their personal style as accurately as possible. The selected extracts were chosen because they represented what I considered would best illustrate the case and the underlying theory. In this way I have tried to present the readers with authentic insight into what happened between the participants. Because the

clients often will anticipate the course of the approach as a whole during the first session, I presented the initial dialogue rather thoroughly (McLeod, 2010). The empowerment criterion is illuminated by suggesting how different professionals' behaviour in network meetings could possibly facilitate dialogue led by others than trained therapists. I have also tried to illustrate the potential for ways of generating dialogue led by others. This could encourage actionability for those who believe in dialogues as well as provide arguments for actions for those who believe in collaboration. The applicability criterion of this case is shown by how it can be used as a basis for increasing the reader's understanding for the potential inherent in collaboration. Through this presentation of a new way of thinking and acting, it could provide the readers with more nuanced and sophisticated knowledge, understanding and perspectives on different modes of collaboration (Lincoln & Guba, 2002).

4.8 Final reflections on the research

The results concur with earlier studies focusing on collaboration in the context of OD (see e.g. Guregård, 2009; Holloway, 2009; Lian, 2006). Nonetheless, some considerations should be made about factors that may have affected the study in one way or another.

In PJD, the term interdisciplinarity (interprofessionalism) was used instead of the term transdisciplinarity. It is reasonable to assume that the use of the term interdisciplinarity may have had some implications on the study. Working in an interdisciplinary manner does not demand awareness or knowledge of a transdisciplinary role-release process. However, as pointed out in the introduction, transdisciplinarity may be equal to interdisciplinarity except for the increased mutual trust and interaction that should be developed. In that sense, one could argue that it is of less significance how we term the collaboration that was carried out in PJD. What are important is that the participants all received the same education and that they were all placed in a position where they were able to *integrate* the new knowledge and skills in their ordinary repertoire (McGonigel et al., 1994). Hence, the professionals were to some extent placed in a position in which they themselves could decide the extent to which they wanted to alter their role towards a transdisciplinary role, including role release, or if they wanted to focus on developing a close interaction inherent in the network meetings. Studies I and III were based on analyses focusing on the extent to which the participants' behaviour and utterances can be analysed with respect to the more specific aspects of transdisciplinarity, which they can. Thus, even though the participants were not presented the particular aspects of role release explicitly, some of them were able to change their role in this way. On the other hand, if the educational program had offered particular knowledge about the role-release process, it is reasonable to assume that this would have increased the development of the professional identity in a greater transdisciplinary direction. This is due to the

fact that the term and the knowledge linked to it offered the professionals a clearer goal (Mariano, 1989) as to how to interact with each other in the network meeting.

At the outset of the research I was very positive about the ODA. At the present moment, as I am putting the finishing touches to this thesis, I am not that focused on such a particular approach. Rather, I think that people who have the necessary motivation, ability and willingness to work together will succeed in collaboration without having to follow a specific template. Professional actors who are good at collaborating are often good at communication and respect the other people they are dealing with, something that is essential for successful collaboration. Thus, because I have realized the challenges (and benefits) of collaboration, I have come to agree with Guregård (2009) who found that achieving OD could be more demanding than suggested in some papers.

4.9 Future aspects and clinical recommendations

As indicated above, the aim of this research has not been to derive absolute truths about how professionals experience participation in network meetings involving a broad variety of professions and agencies. The generative purpose has been to explore and look into how the collaboration unfolds. What possibilities exist with regard to involving a great variety of professionals in network meetings and, through the data collected, produce knowledge that can be used in subsequent studies to foster innovation in integrated care, in general, and ODA, in particular. Thus, in spite of its limitations, the present research may point to some new ways of developing collaboration in network meetings involving a great variety of professionals and agencies. The ideas posited in this research could be used to emphasize the need to continue the development and research of integrated services in the sense of OD as well as the challenges linked to this by focusing i) on the different modes of collaboration, including the aim to achieve a unified definition of concepts; ii) on clear roles, including the acceptance of blurred roles when necessary, by emphasizing a continuous discussion concerning roles to guarantee powerful professionalism; iii) on aspects such as the professionals' motivation to collaborate, their level of tolerance for uncertainty and their willingness to adapt; iv) on aspects of dialogue such as the need for listening skills and spending time dwelling on topics; v) on the different expectations that may exist between the different members of the network. This research suggests that the inclusion of a great variety of professionals and agencies may provide the help-seeker and the private network with improved help. When the professionals develop a relation to each other, this may generate synergetic effects concerning their ability to provide help to other help-seekers in other settings with advanced modes of teamwork. The findings also suggest that it is possible for other professionals than trained therapists to implement a dialogical approach in their ordinary

role. Because of the inherent stereotypes and fundamental traditions that are so deeply rooted in society, the patience and continuous efforts dedicated to changing the focus and paradigm in mental health need to be continued.

YHTEENVETO (SUMMARY)

Ammattilaisten kokemuksia Avoimen Dialogin mallista nuorten sosiaalisissa verkostoissa: Identiteetti, rooli ja tiimityö. Laadullinen tutkimus.

Tutkimuksessa tarkasteltiin terveydenhuolto-, sosiaali- ja opetusalan ammattilaisten kokemuksia Avoimen Dialogin -verkostotapaamisista Project Joint Development nimisen kliinisen pilottiprojektin yhteydessä, joka toteutettiin Etelä-Norjassa vuosina 2003–2005.

Ensimmäisessä osatutkimuksessa tarkasteltiin ammatti-identiteetin muuttumiseen ja kehittymiseen liittyviä haasteita eri tieteenaloilla ja sektoreilla toimivien ammattilaisten verkostotapaamisissa, joissa hyödynnettiin Avoimen Dialogin kokemuksia. Tutkimuksessa pohdittiin ammatti-identiteetin suhdetta ammatillisten roolien kehittymiseen monialaisissa verkostotapaamisissa ja monitieteisyyden kehittymistä monialaisissa verkostotapaamisissa. Näihin teemoihin paneuduttiin muodostamalla kaksi kohderyhmää, joista ensimmäiseen kuului terveydenhuollon ja toiseen sosiaali- ja opetusalojen ammattilaisia. Ryhmätapaamisia oli kolme: yksi projektin puolivälissä ja kaksi sen lopussa. Ryhmiä tarkasteltiin sisällönanalyysin avulla ja vertailemalla niitä keskenään kahden ensimmäisen tapaamisen perusteella. Lisäksi tutkimukseen sisällytettiin kolmansien tapaamisten relevantteja tuloksia.

Kohderyhmien ensimmäisessä tapaamisessa terveydenhuollon ammattilaiset pyrkivät irtautumaan omasta roolistaan pitämällä terapiataitojen vaikutusta vähäisempänä, kun taas sosiaali- ja opetusalan ammattilaiset korostivat roolin laajentamista ja avunhakijan ohjaamaa viestintää. He kaikki kohtasivat roolistereotypioita verkostotapaamisiin tottumattomien osanottajien kautta. Sosiaali- ja opetusalalla työskentelevät myös etsivät yleisesti käytännön ratkaisuja hitaasti kehittyvän vuoropuhelun sijasta.

Toisessa tapaamisessa jotkut hoitoalan ammattilaiset sanoivat keskittyvänsä lähinnä seuraamaan avunhakijan kommentteja. Toisista oli vaikeaa käsitellä avunhakijan asiantuntijaroolia koskevia odotuksia. Jotkut sosiaali- ja opetusalan edustajista määrittelivät roolinsa lähes terapeuttiseksi, toiset taas keskittyivät epäselviin vastuurakenteisiin. Kaikki kuitenkin taistelivat stereotypioita vastaan. Toisessa tapaamisessa ryhmien jäsenten kokemukset erosivat melkoisesti toisistaan, ja roolin muutokseen liittyvät ristiriidat olivat selvempiä.

Tiimityöstä keskusteltaessa hoitoalan ammattilaiset kertoivat kokeneensa lisääntynyttä ammatillista epävarmuutta ennen ensimmäistä tapaamista monialaisen lähestymistavan vuoksi. He näkivät sosiaali- ja opetussektoreilla työskentelevien osallistujien aseman marginaalisena, mutta jälkimmäiset näyttivät itsekin asettavan itsensä lääketieteen näkökulmasta vähemmän merkitykselliseen asemaan. Toisen tapaamisen aikana hoitoalan edustajat keskustelivat tuttuuden merkityksestä. Vaikka osallistujien keskinäinen luottamus oli lisääntynyt projektin aikana, monialainen lähestymistapa aiheutti

vielä vaikeuksia. Sosiaali- ja opetusaloilla työskentelevät toivat esille tilanteiden erilaisten tulkintojen aiheuttamia ongelmia ja pohtivat, kuinka erilaisiin tehtäviin liittyvät auktoriteettiasetelmat vaikuttivat yhteistyöhön. He totesivat itsevarmuutensa olevan yhteydessä tiimitoverien asenteisiin ja persoonaan. Osaamisen kyseenalaistaminen asetti jotkut osallistujista sivustakatsojan asemaan.

Toinen osatutkimus pohjautui ensimmäiseen, kohderyhmistä projektin puolivälissä kerättyyn aineistoon. Ryhmissä saatuja tuloksia havainnollistettiin liittämällä artikkeliin esimerkkejä aidoista verkostotapaamisista, muun muassa litteroituja äänitteitä ja yleisluontoisempia havainnointeja. Tutkimus keskittyi lähinnä tiettyihin Avoimeen Dialogiin liittyviin taitoihin ja kartoitti ammattilaisten käsityksiä siitä, mikä edistää tai estää dialogia verkostotapaamisissa sekä millä tavalla tämä liittyy ammatilliseen taustaan. Sisällönanalyysissä pääkategoriaksi muodostui dialogi. Tulokset kuvastivat kuuntelemisen ja autenttisuuden merkitystä ja haasteita.

Kaikki osallistujat painottivat, että oli tärkeää luoda ilmapiiri, jossa kaikki osallistujat voivat aktiivisesti kuunnella toisiaan. He myös totesivat joskus unohtaneensa, kuinka paljon aikaa erilaisten näkökulmien kuunteluun tarvitaan ja sen sijaan jatkaneensa liian ratkaisuhakuisesti eteenpäin.

Hoitoalan ammattilaiset keskustelivat autenttisuudesta pääasiassa työtovereiden väliseen ajatustenvaihtoon liittyen ja korostivat avautumisen tarpeellisuutta. Kohderyhmien havainnoinnit ja niistä saadut tulokset osoittivat, että hoitoalan ammattilaiset näyttävät tiedostavan omat tunteensa ja osaavan esittää ne dialogia edistävällä tavalla. Muutkin ammattiryhmät painottivat henkilökohtaista uskallusta, mutta vaikuttivat kokemattomammilta esittämään ajatuksensa tavalla, jota potilas ei kokisi negatiivisena. Hoitoalalla työskentelevien suurimman haasteen liittyessä keskinäiseen dialogiin muut osallistujat näyttivät kaipaavan erityisiä dialogin ulkopuolisia apukeinoja, esimerkiksi ohjausta ja neuvontaa.

Kolmas osatutkimus käsitteli innovatiivista tapaustutkimusta, joka liittyi opettajanroolista irtautumisprosessiin ja siihen, kuinka ammattilaiset mukautuvat toisiinsa verkostotapaamisissa. Pääpaino on luontaisissa mahdollisuuksissa ottaa terveydenhuoltojärjestelmän ulkopuolisia ammattilaisia mukaan yhteisiin dialogeihin. Tietoja ja osaamista laajentamalla he voivat kehittää kykyään tuottaa yhteistä dialogia ja jaettua ymmärrystä muiden verkostotapaamisten osallistujien kanssa. Tulokset osoittivat, että roolista irtautumisprosessin kautta muutkin ammattilaiset kuin terapeutit pystyvät edistämään dialogista lähestymistapaa. Tämä tehdään tuomalla mukaan tietoa perheen kielen merkityksestä, huomioimalla ja hyväksymällä avunhakijan henkilökohtaiset kokemukset, kuuntelemalla tarkkaavaisesti ja paneutumalla tunteisiin. Tunteisiin liittyvät sanavalinnat saattavat osoittaa, että niiden motivaationa on sisäinen ääni, joka lisää henkilökohtaista mielenkiintoa asiaan. Tiimin eri jäsenet myös kiinnittävät erityistä huomiota vaikeaselkoisempaan sekä sanattomaan viestintään. Ammattilaiset mukautuvat toisiinsa esittämällä refleksiivisiä kysymyksiä, vastaamalla toistensa

kommentteihin ja käsittelemällä aiheita perusteellisesti. Näin he saavat enemmän tilaa dialogille. Ammattilaisten intonaatio saattaa osoittaa vastausten kimpoavan sisäisestä tarpeesta, minkä seurauksena vertikaalinen ja horisontaalinen dialogi lisääntyy. Tästä seuraa samalla moniäänisen dialogin kehittyminen, joka puolestaan voi lisätä mahdollisuuksia tuottaa uusia selvityksiä ja näkökulmia. Roolista irtautumisprosessi ja ammattilaisten mukautuminen toisiinsa ovat haasteellisia ilmiöitä, koska verkoston yksityiset toimijat eivät mielellään näe opettajaa jonakin muuna kuin opettajana.

Tutkimustulosten perusteella voidaan päätellä seuraavaa. Ammattilaiset pystyvät kehittämään itselleen monitieteisen identiteetin, johon sisältyy ammatillisen roolin ja tiimityön ymmärtämisen muutos. Haasteena voi olla ammattilaisten kyky tuottaa dialogia, johon sisältyy kuuntelemisen ja autenttisen palautteenannon taito ja halu. Myös muut ammattilaiset kuin koulutetut terapeutit saattavat pystyä integroimaan Avoimeen Dialogiin liittyviä tietoja ja taitoja eli kehittämään rooliaan terapeuttisempaan suuntaan. Ammattilaiset mukautuvat toisiinsa verkostotapaamisissa paneutumalla yhteisiin aiheisiin ja mukauttamalla kommenttejaan aiempien puheenvuorojen perusteella.

Tutkimuksessa esitettyjä ajatuksia voidaan hyödyntää korostettaessa integroitujen palveluiden jatkokehittämisen ja -tutkimuksen tarvetta yleisesti sekä erityisesti Avoimen Dialogin kontekstissa. Keskeisiä haasteita ovat (1) erilaiset yhteistyömuodot ja yhtenäinen käsitteenmäärittely; (2) selkeät roolit, mutta tarvittaessa epäselvienkin roolien hyväksyminen korostamalla jatkuvaa roolikeskustelua vahvan professionaalisuuden varmistamiseksi; (3) ammattilaisten yhteistyömotivaatio, epävarmuuden sietokyky ja mukautumishalu; (4) dialoginäkökulmat, esimerkiksi ajankäyttötarve, aiheissa viipyminen ja (5) verkoston jäsenten mahdollisesti toisistaan eroavat odotukset.

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APPENDICES

Appendix 1 Discussion guidelines – focus groups 19th and 28th of October 2004.

The aim of the study is to investigate some aspects of Project Joint Development from the professional participants' point of view.

This part of the study focuses on three central issues, where especially the first and second are interrelated. The first issue concerns the professionals' role as it relates to their experience of them selves on the background of a given professional status within a given professional milieu. The second issue concerns how Project Joint Development may contribute to improved collaboration at an interdisciplinary and multi-agency level. The third issue integrates issues one and two and concerns the implications these perspectives may have for the patients' situation.

Roles

1. Describe/explain how you experience your own professional role/position during network meetings: with regard to network meetings as such, to other professionals present, to the social network and with regard to the patient.

2. In particular, how do you understand your professional role/situation/expertise in regard to employees in the health sector/the social and educational sectors? (Depending on the group interviewed)

3. Has your participation in network meetings lead to changes in your understanding of your professional role compared to your ordinary job? (In which direction, how, give examples)

4. How do you make use of your expertise now in contrast to earlier?

5. How would you like your professional role/situation to be in network meetings on the background of your own profession? (Imaginations of an ideal role/ideal network meeting)

Interdisciplinarity/ Multi-Agency Cooperation

1. How are your expectations towards the other professionals? Describe.

2. What expectations do you meet from the other professionals, the social network and the patient?
3. Describe the impact Project Joint Development has had/may have for the cooperation between professionals and between sectors within your municipality.

4. In what way has the collaboration changed? (In which direction, how, give examples)

5. What do you think are the advantages and disadvantages with this way of working?

User participation

1. What do you think are the most important advantages and disadvantages regarding Project Joint Development from the patients' point of view?

2. To what extent to you believe that Project Joint Development may contribute to a change of perspective regarding mental health?

3. To what extent do you experience that Project Joint Development is suited to mobilize the patient's or the families' own resources?

4. What kind of expertise have you learned through the lessons which have an impact on the patient?

Reflections and summary

1. What would you say has been most important in this dialogue?

2. How did you experience your contribution?

Appendix 2 Overview of the observed cases.

Gender	Age	Network Team	Other participating professionals	Private network members in network meetings	Team type
Boy	<18	Social worker/Mental health care nurse		Mother/Father/Brother	HC
Girl	<18	Social worker/Social worker/Psychologist	Psychologist	Mother/Father/Sister/Friend	HC
Boy	<18	Child welfare officer/Public health nurse/Counselor	Mental healthcare Nurse/Teacher/Teacher	Mother/Brother	M
Boy	<18	Social worker/Social worker Psychologist	Teacher/sivilarbeider[16]/Counselor/Milieu therapist	Mother	HC
Girl	<18	Social worker/Social worker	Teacher	Mother/Father/Sister/Brother	HC
Girl	<18	Child welfare officer/Teacher/ Mental health care nurse	Child welfare officer	Mother	M
Boy	<18	Teacher/Social worker/Teacher/ Teacher	Family therapist/Family therapist/ Family therapist/Police/Student/Student	Mother/Father/Brother	M
Girl	<18	Social worker/Teacher		Mother/Father/	M
Girl	<18	School medical officer/Psychologist/Teacher		Mother	M
Girl	<18	Teacher/Health care worker	School Medical Officer/ Teacher/Teacher	Mother/Father/Cousin/Friend	M
Girl	>18	Social worker/Mental health care nurse		Father/Brother/Boy friend/	HC
Girl	>18	Mental health care nurse/Mental health care nurse		Boyfriend	HC
Girl	>18	Psychologist/Psychologist	Executive officer in The Norwegian Labour and Welfare Administration/MD	Mother	HC
Boy	>18	Occupational therapist/Psychologist		Mother	HC

HC=Health care teams, M=mixed teams.

[16] A person doing civilian work rather than the compulsory military service.

Appendix 3 An example on how the analytical process was carried out.

On the basis of these identified and condensed meaning units/quotations in the Health Care Group (first meeting) in Study I, I abstracted to the code: Being what?.....and then to the subcategory , category and main theme.

Main theme	**Professional identity, expertise and multi-agency teamwork**
Group	**Health care group**
Categories	**Professional expertise**
Sub categories	**What kind of helper do the users encounter?**
Codes	**Being what? A fellow worker, fellow being, therapist or expert?**
Condensed meaning units/quotations	**Condensed meaning units in 1st sequence:** allowed to release expert role cooperation partner versus therapist **Condensed meaning unit in 2nd sequence:** don't be an expert **Condensed meaning unit in 3rd sequence:** does not like being called expert cooperates, wasn't there a proposal about… **Condensed meaning unit in 4th sequence:** there are experts so we'll send you to the experts **Condensed meaning unit in 5th sequence:** it's important to find another term than therapist

Appendix 4 An anonymized consent form concerning the original research project provided to children under 18 years of age and their parents.

INFORMASJON TIL DEG SOM ER UNDER 18 ÅR OG FORELDRENE DINE OM DELTAGELSE I ET FORSKNINGSPROSJEKT

Når det gjelder ungdom og utvikling av psykiske problemer vet vi at det ofte tar for lang tid fra problemene starter og til hjelpen kommer. A og B kommune vil derfor i samarbeid med Sørlandet Sykehus HF og Høgskolen i Agder prøve ut en ny arbeidsmetode som vi tror gir raskere og bedre hjelp. Metoden går ut på å samle viktige personer i ungdommens liv til nettverksmøter, for å få belyst ulike sider av problemene. Forhåpentligvis virker dette positivt, slik at ungdommen og nettverket selv finner egne muligheter for å gjøre noe med vanskelighetene.

Fordi det ikke er gjennomført noen grundig undersøkelse av hvordan denne metoden virker i Norge vil jeg invitere deg som ungdom til å delta i et forskningsprosjekt som jeg håper kan gi oss noen svar på dette. *Vi trenger å vite hva som kjennetegner dere som søker hjelp, og hva dere synes om metoden*. Nedenfor forteller jeg hva jeg vil gjøre i forskningsprosjektet mitt. Som du ser er det mye jeg trenger hjelp til, men du behøver ikke å delta på alt hvis du ikke ønsker det.

Det jeg har skrevet nedenfor er skrevet til deg som ungdom, men for at du kan delta må jeg også ha tillatelse fra dine foreldre. Det betyr at også dine foreldre må lese dette.

A. KARTLEGGING AV HJELPEBEHOV

1. Kartleggingsundersøkelse

Først og fremst ber jeg om at du besvarer noen spørreskjema i tillegg til at en ansatt fra barne- og ungdomspsykiatrien får fylle ut noen skjema som handler om din livssituasjon og dine problemer. Utfyllingen av alle skjemaene vil skje i et møte mellom dere to og samtalen tas opp på bånd. De som deltar i nettverksmøtene vil ikke bli informert om hva som blir sagt i møtet mellom dere to.

Jeg ber også om at du sammen med dine hjelpere i nettverksmøtet tegner et ”kart” over hvilke mennesker du har mest kontakt med. De andre som deltar i nettverksmøtet vil hjelpe deg med dette.

2. Spørreskjema til foreldre og lærer

En av dine foreldre og en av dine læreres vurdering av din situasjon kan gi oss mer kunnskap. Vi ønsker derfor at også de besvarer et spørreskjema. Dere kan selv få være med å velge hvilken lærer dette skal være.

3. Oppfølgningsundersøkelse etter 12 måneder.
Jeg håper at jeg kan kontakte dere, evt. også læreren, etter 12 måneder for å be om at noen av de samme spørreskjemaene blir utfylt på nytt.

B. VURDERING AV HJELPEN DU MOTTAR

Fordi du er en av de som deltar i nettverksmøter har jeg behov for å få snakke med deg, for å få vite hva du synes om hjelpen. Alle skal ikke delta i denne delen av forskningsprosjektet. Det er ikke sikkert at det blir aktuelt i ditt tilfelle, men hvis du og dine foreldre tillater det, vil jeg gjerne ha en bekreftelse på at jeg kan gjøre det som er beskrevet nedenfor, for å vurdere den hjelpen du får.

1. Tilstedeværelse på nettverksmøter
Jeg vil gjerne delta på de nettverksmøtene som du deltar på. Dersom jeg deltar, vil jeg bare være tilstede, men ikke delta i samtalen. Gjennom å være tilstede vil jeg, som forsker, få mer kunnskap og forståelse av behandlingsmetoden.

2. Gruppeintervju

Dersom det blir aktuelt å delta i nettverksmøtene ber jeg også om at jeg i det siste nettverksmøtet får ha en samtale med deg og noen av de som har deltatt i nettverksmøter sammen med deg. Der vil jeg spørre om hvordan dere synes det har vært å delta på nettverksmøter.

3. Individuelt intervju med deg, en av dine faglige hjelpere og en venn/bekjent
Jeg ønsker også å ha en samtale med deg på tomannshånd. Denne samtalen vil handle om hvordan du opplever din egen situasjon, og hva som har vært positivt og negativt med den hjelpen du har fått.

Fordi det er viktig for oss å få vite hvordan det er for andre å delta i nettverksmøter ber jeg om å få kontakte en person i fra ditt sosiale nettverk, som har deltatt i nettverksmøtene, og en av de faglige hjelperne. Jeg vil be om en samtale med hver av dem på tomannshånd. I samtalen vil jeg spørre dem om hva de synes om å delta i nettverksmøter, hvordan de opplever situasjonen ut fra sitt ståsted og deres forhold til deg og din situasjon. Dere kan selv få være med å bestemme hvilke personer jeg skal snakke med.

GENERELL INFORMASJON

Deltagelse i undersøkelsen er frivillig. Du og dine foreldre kan når som helst gi beskjed om at dere ikke lenger ønsker å delta i undersøkelsen uten å oppgi grunn. Dersom dere trekker dere, vil det ikke få noen konsekvenser for hjelpen du mottar.

Prosjektet er meldt til Personvernombudet for forskning, Norsk Samfunnsvitenskapelig datatjeneste AS. Dette medfører tillatelse til å opprette et register for å kunne behandle svarene på undersøkelsen på en raskt og effektiv måte. Alt som blir formidlet fra undersøkelsen (skriftlig og muntlig) vil bli formidlet i anonymisert form. Det vil si at når jeg skal presentere resultater fra denne undersøkelsen (i artikler eller foredrag), vil de aldri bli presentert slik at noen kan gjenkjennes. Med andre ord vil ingen kunne kjenne igjen noe som beskriver dere eller deres situasjon.

Dersom du har noen spørsmål kan dere snakke med noen av deres hjelpere eller kontakte meg på telefonnummeret eller e-post adressen nedenfor.

Med vennlig hilsen
Anne-Lise Holmesland
Forsker
Sørlandet Sykehus
Tlf. (a) 38 03 85 48/(m) 92 60 44 68
e-post adresse: anne.lise.holmesland@sshf.no

SAMTYKKEERKLÆRING FOR HOVEDBRUKER OG FORELDRENE

Jeg og mine foreldre har mottatt skriftlig og muntlig informasjon om forskningsprosjektet" Åpen dialog i Sosiale Nettverk – en evaluering av et klinisk prosjekt" og erklærer oss med dette villig til å delta i forskningsprosjektet.

Jeg og mine foreldre samtykker til at vi deltar frivillig i dette forskningsprosjektet og kan når som helst trekke oss uten å oppgi grunn. Alt som blir formidlet fra forskningsprosjektet (skriftlig og muntlig) vil bli formidlet i anonymisert form.

Jeg er informert om at innsamlede opplysninger vil bli oppbevart av Anne-Lise Holmesland inntil utgangen av 2010 da arbeidet skal være avsluttet. På dette tidspunkt vil data bli makulert. Hvis det allikevel skulle være aktuelt å oppbevare data lenger, eventuelt for å foreta en oppfølgingsundersøkelse kan dette ikke skje uten fornyet tillatelse fra meg.

Dersom vi har spørsmål om forskningsprosjektet kan disse rettes til:

Anne-Lise Holmesland
Forsker
Sørlandet Sykehus
tlf. (a) 38 03 85 48/(m) 92 60 44 68
e-post adresse: anne.lise.holmesland@sshf.no

Undertegnede har lest/blitt forklart pasientinformasjonen og fått utlevert egen kopi av denne.

A KARTLEGGING AV HJELPEBEHOV:	Brukers samtykke	Forelders samtykke	Forelders samtykke
1 Vi samtykker til å delta i kartleggingsundersøkelsen (obligatorisk)	☐	☐	☐
2 Vi samtykker til at det innhentes opplysninger fra: foreldre (oss) **Hvem?** mor____ far____ Sett kryss lærer	☐ ☐	☐ ☐	☐ ☐
3 Vi samtykker i å bli kontaktet etter 12 måneder (evt. også lærer)	☐	☐	☐
B VURDERING AV HJELPEN: Vi samtykker i å delta i intervju og observasjonsundersøkelsen **hvis** det blir aktuelt	☐	☐	☐

Sted og dato	Sted og dato	Sted og dato
Underskrift bruker Tlf. bruker_____	Underskrift forelder Adresse:	Underskrift forelder Adresse:

ORIGINAL PAPERS

I

OPEN DIALOGUES IN SOCIAL NETWORKS: PROFESSIONAL IDENTITY AND TRANSDISCIPLINARY COLLABORATION

by

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Research and Theory

Open Dialogues in social networks: professional identity and transdisciplinary collaboration

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Abstract

Aim: The aim of this article is to explore the challenges connected to the transformation and emergence of professional identity in transdisciplinary multi-agency network meetings and the use of Open Dialogue.

Introduction: The empirical findings have been taken from a clinical project in southern Norway concerning multi-agency network meetings with persons between 14 and 25 years of age. The project explores how these meetings are perceived by professionals working in various sectors.

Methodology: Data was collected through three interviews conducted with two focus groups, the first comprising health care professionals and the second professionals from the social and educational sectors. Content analysis was used to create categories through condensation and interpretation. The two main categories that emerged were 'professional role' and 'teamwork'. These were analysed and compared according to the two first meeting in the two focus groups.

Results and discussion: The results indicate different levels of motivation and understanding regarding role transformation processes. The realization of transdisciplinary collaboration is dependent upon the professionals' mutual reliance. The professionals' participation is affected by stereotypes and differences in their sense of belonging to a certain network, and thus their identity transformation seems to be strongly affected. To encourage the use of integrated solutions in mental health care, the professionals' preference for teamwork, the importance of familiarity with each other and knowledge of cultural barriers should be addressed.

Keywords

social network intervention, open dialogue, professional identity, focus groups

Introduction

The aim of this article is to explore the challenges connected to the transformation and emergence of professional identity in transdisciplinary integrated care. The World Health Organization has recently declared that mental health is a major societal challenge. About 25% of the population will have mental health problems in its lifetime. Moreover, when suffering from mental illness, many of the afflicted may also experience social difficulties, such as unemployment, discrimination or problems within their social network [1].

Although the concept of integration is a widely used term in the health and social care discourse, the concept has no universal definition. Likewise, we have no predominant model of health system integration or integrated care [2, 3]. However, structure, process and outcome of integration represent imperative elements in integrated care [4, 5]. The structure of integration relates to the organizational and administrative structure. The process of integration relates to factors, such as the quality of the relationships developed between the actors, and the suitability of the help that is performed [4, 5]. The outcome of integration relates to patient satisfaction as well as collaborative skills among the professionals [4–6]. Moreover, to enhance integrated health and social care, the patient's total life situation should be taken into account [7]. This means the broader social context within which the person is living and the medical and psychological situation [8–10].

However, a high number of research papers focusing on integrated care in terms of multi-agency collaboration point out several difficulties associated with organizational, professional and contextual issues, such as role interpretation, communication, discipline conflicts and leadership [3, 11–15]. Hence, people suffering from complex illnesses and with multiple problems or at risk of developing severe multiple problems may especially be placed in a difficult situation. Due to fragmentation and collaborative difficulties in the helping system for those who require help from multiple agencies, we need to explore approaches that go beyond discipline-specific traditions. Service delivery may be improved through genuine involvement of the help seeker and the private network. Through negotiation and decision-making that is collectively enhanced among professionals, the person seeking help and the private network, approaches and solutions that transcend traditional boundaries may be the outcome. Hence, by integrating a great variety of voices into one working unit, there may be a greater chance of achieving success. To enhance the use of holistic approaches, however, highly interactive modes of collaboration may be needed.

Interdisciplinary teams, which are representing the most common mode of interactive team work, can be described in different ways [16]. It may be defined so as to analyze and harmonize different disciplines into a coordinated whole [16] as well as having '*shared goals*' or '*common methodologies*' [16, p. 356]. Professionals working in an interdisciplinary way may aspire to "*surrender some aspects of their own disciplinary role, but still maintain a discipline-specific base*" [16, p. 356]. An example of this is case conferences during which the members gather together to discuss their individual assessments and develop a joint service plan. Transdisciplinary teams however may be considered as an "*interdisciplinary team whose members have developed sufficient trust and mutual confidence to transcend disciplinary boundaries and adopt a more holistic approach*" [16, p. 357]. In order to stimulate the emergence of new knowledge, the transdisciplinary team strongly emphasizes a great variation in information sources involving both professionals and non-professionals [16]. Compared to traditional interdisciplinary approaches, transdisciplinarity is regarded as more "*context sensitive, eclectic, transient and inventive*" [17, p. 850]. Furthermore, in transdisciplinary teams, professional roles may be strongly affected by the requirement of role release and role expansion. The term 'role release' means "*accepting that others can do what the specialist was trained specifically to do*", while the term 'role expansion' means "*allowing that one's job can include more than what one was specifically trained to do*" [16, p. 355]. This in turn means that through their focus on flexibility, trust and mutual reliance, transdisciplinary teams underscore factors that are considered to be success factors for cooperation in general [14]. However, by focusing on the great variation in information sources and the flexibility in the professional roles, transdisciplinary teams may improve the possibility of enhancing creative and holistic solutions. On the other hand, the inclusion of the various voices may demonstrate the complexity and advancement of transdisciplinarity. Conversely, transdisciplinarity aims to highlight new and intimate processes of integration. Hence, due to its potential, the effects of transdisciplinary collaboration should be further explored to gain knowledge on the processes and outcome of integration.

Integrated care in terms of complex collaboration may have different side effects for those involved [3]. One result of intimate teamwork carried out in different communities of practice is that the professionals' identity may be challenged [18]. This could occur because the professional identity is so closely connected to knowledge and experience [19]. Moreover, in constantly shifting communities of practice, the way we carry out our work and our professional role may be valued differently

[18]. Hence, integrated care in the sense of increased intimate teamwork performed in the presence of the help seekers and the private network and adapted to their daily environment may alter the professionals' frame of reference when it comes to identity. Conversely, aiming to provide tailor-made, fully contextual and comprehensive integrated help may present great challenges to the traditional system of professions and push the tensions between professionals to the edge.

A Norwegian clinical pilot project, entitled Project Joint Development, implemented social network intervention in the form of Open Dialogue.[1] The aim was to provide tailor-made assistance for individuals from 14 to 25 years of age suffering from mental health problems. The aim of Open Dialogue is to emphasize an organisational integration structure by involving professionals from a number of agencies. The intention is that the professionals meet and carry out their work on an equal basis and in the presence of the help seeker and the private network. The process of integration is provided by a treatment approach where dialogue and interaction are key elements. By placing the help seeker and the private network in key positions, the aim is to achieve genuine changes [20]. Due to the inclusion of all these voices, successful outcome of approaches, such as Open Dialogue may require adjustments by the professionals if success is to be achieved. Thus, we want to examine how social network approaches, such as Open Dialogue can provide an approach to problems that have been refractory to integrated care in terms of multi-agency and multi-professional work. Hence, the aim of this paper is to explore challenges to professional identity in multi-agency network meetings, focusing on the way attitudes towards multi-agency practice are embedded in traditions of specialization in the sense of professional knowledge and mutual interaction.[2] More specifically, we will look into how professional identity is related to:

- the development of professional roles in multi-agency network meetings
- the development of transdisciplinarity in multi-agency network meetings.

Developing a professional identity

Personal identity concerns the question of 'Who am I' and theories concerning identity have been shifting throughout history. It might be understood in terms of individual identity versus dependency of the collective or a presupposed identity versus the individual's ability for reflexivity and identity as social constructionism versus essentialism [21].

Individual characteristics, such as having extraordinary talents or firm beliefs, may have a great impact on the formation of an individual's professional identity. Thus, professional identity is always dependent upon personal identity. Etienne Wenger stresses the dependency on the collective in developing a professional identity. Because we always negotiate meaning with social experiences, identity is created from a combination of both social and individual aspects [18].

Furthermore, Wenger claims that our identity is shaped through participation within and across community memberships, a notion involving mutual engagement, accountability to an enterprise and negotiability of a repertoire. Thus, in order to maintain identity, the work of reconciliation is of great significance for professionals who move between different communities of practice [18].

Developing a professional identity involves identification and negotiability, and the work of identification may be described in terms of inclusion and exclusion, stereotypes, paradigmatic trajectories and trust. Negotiability may be described as listening to other perspectives, seeking control and sharing responsibilities. The ability to take responsibility for meanings within a particular community involves the possibility to negotiate [18].

Wenger discusses the shaping of identity as a mix of participation and non-participation in relationships and activities founded on various degrees of identification and negotiation. Modes of non-participation include peripheriality and marginality, the former term (peripheriality) meaning participation involving less intensity, for instance professionals who are only superficially involved in a case. The second term (marginality) means that certain professionals may experience ignorance concerning ideas [18].

Identities of participation or non-participation may also arise through engagement, imagination and alignment. The first term (engagement) implies joint practice, and occurs when people have their ideas adopted by others. Next, imagination goes beyond engagement in practice (i.e. trade union subjects). Imagination in minor communities may involve participating through stories about local conditions. Identities of non-participation through imagination may emerge because of prejudice through stereotypes, while identities through alignment may occur through commitment or ignorance of professional approaches [18].

[1] We use the term 'network intervention' to denote a network-centred approach and network therapy. Open Dialogue is originally a kind of network therapy [20].

[2] The authors are especially grateful to one of the reviewers for valuable suggestions witch to our opinion have improved the introduction and clarified the research questions.

Open Dialogue as transdisciplinary work

Social network intervention and network therapy originated in the US in the mid 1960s [22]. The approaches move towards an embracing of the private network (family/friends, etc.) to varying degrees, and can be used to solve problems of both a practical and emotional nature. In the Nordic countries network intervention has been used in relation to a variety of problems [20, 23]. Klefbeck and Ogden [24] have focused on network intervention regarding children in crisis. Other kinds of network intervention, such as Multisystemic Therapy, Family Counselling Meetings [24] and Anticipation Dialogues [25] have been developed.

In the Nordic countries research has been completed on social network intervention in the context of network meetings. The research concerns patients with psychosis, dual diagnosis as well as rheumatoid arthritis. The results indicate that network meetings have a significant impact on the patient's mental health [26–29]. An evaluation concerning organizational perspectives of network meetings revealed difficulties concerning professional collaboration. These difficulties were associated with professional roles, vague organizational structures and unfamiliarity with team partners in which a sense of insecurity emerged [30].

In an attempt to find new solutions for mental health care for people from 14 to 25 years of age, a pilot project entitled Project Joint Development was initiated. The project aimed to provide help for those people in an early stage of mental illness as well as provide those with more severe problems the opportunity to take a more active part in their own treatment.

Project Joint Development applied a procedural intervention model based on network meetings constructed from 'Open Dialogue' [20, 31]. The professionals were strongly encouraged to cross the borders separating professions and agencies. This was to be accomplished by creating a team for every single case consisting of a minimum of two professionals with education and positions relevant to the specific case.[3] The project's main ideas included the following:

- Organizing an immediate meeting after the contact with a professional.
- Inclusion of the social network in every case. This includes all the relevant professionals to be invited to the joint meetings together with the person seeking help.
- Flexibility in all situations, i.e. inviting various persons (from private or professional areas), varying the meeting place and integrating different methods of treatment according to the specific needs of each help seeker.
- The professionals should guarantee responsibility and continuity. The first person contacted is responsible for organizing the transdisciplinary team for the first meeting with the social network. In cases where network meetings are the primary intervention, the language and reflection should contribute to making the person seeking help more aware of his or her own resources. If the primary approach is individual treatment, network meetings will represent continuity among the persons seeking help and the private network.
- Toleration of uncertainty during the process. Instead of aiming for rapid solutions to the problem, 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 joint meetings to increase everyone's understanding of the problematic situation [20].

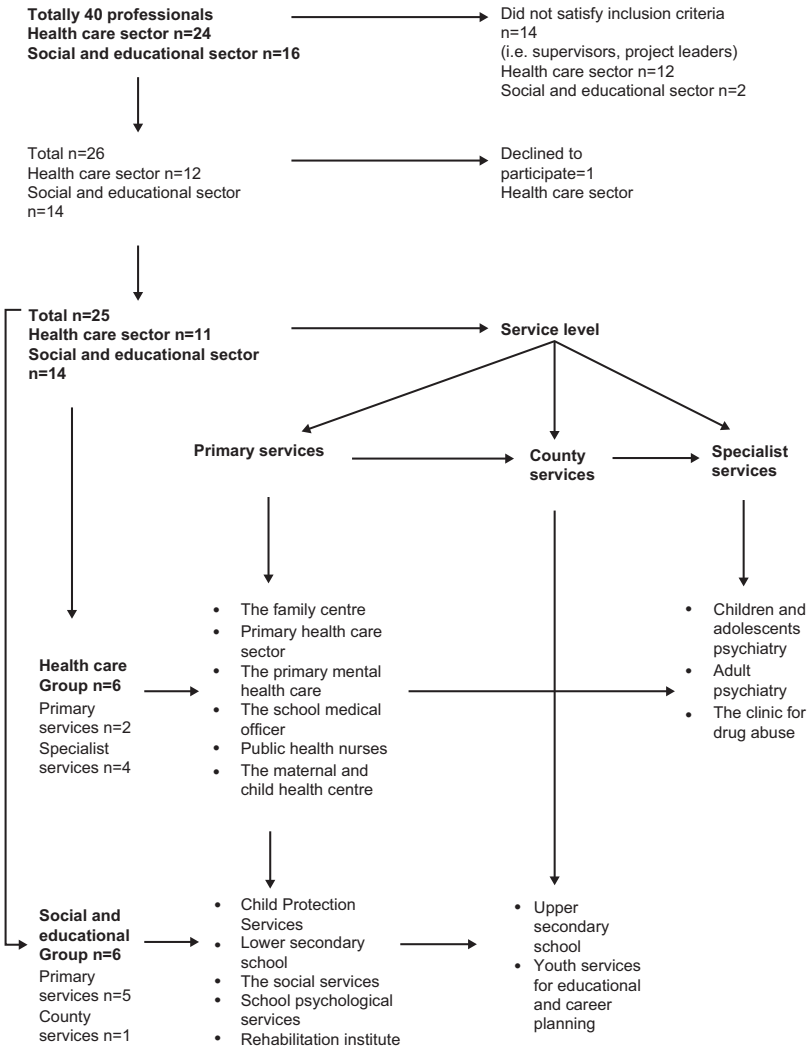
In the Open Dialogue approach, a slowly developing dialogue within the network meetings should be attained to create joint understandings and joint solutions among all persons present [20]. This means listening very carefully to the help seeker as opposed to providing prepared plans and ready-made answers. Due to the evolving dialogues in the network meetings, the professionals' positions may change. By focusing on the voices of the help seekers, the professionals can move toward a more and more personal participation, in the sense that they may increasingly "*adapt themselves to the present moment*" [32, p. 485], and to the particular context. Thus, rather than being a technique, Open Dialogue represents a basic attitude involving increased transparency and disclosure of the professionals [9, 10, 32]. Due to this more personalized relationship among the network members, emotions and dialogues may be increasingly shared [32]. Therefore, through the focus on the help seekers' voices and the dialogue founded on their statements, the private network may be sufficiently inspired to create and maintain its own dialogues and solutions [20].

Project Joint Development was initiated and anchored in the department for drug abuse and psychiatry at the local medical hospital. Two municipalities in the hospital's catchment area were invited to participate. All agencies related to mental health care for people 14–25 years of age within the two municipalities, the county services and the relevant departments at the local hospital were included (Table 1). Professionals representing the psychiatric services were allowed to

[3] For practical reasons, it was not always possible to have tailor-made.

join three network meetings in relevant cases without referrals (founded on their supervision duties). Help seekers who were regarded as suited for network intervention by the professionals were invited to network meetings when they themselves approached agencies involved in the project. Professionals were also encouraged to propose network meetings to persons if this could possibly improve their lives (i.e. teachers who were concerned about particular pupils). The situation was defined as a crisis situation when the help seeker approached the helpers, where the first meeting should be arranged within 24 hours if necessary.[4]

Table 1. Overview over agencies and professionals in Project Joint Development and informants in the focus groups



[4] This was impossible at the outset of the project.

During the clinical Project Joint Development, a research study was also conducted to evaluate it. The research study focused primarily on the help seekers' experiences. Forty-two help seekers were included in the research study. Overall, however, 81 help seekers were involved in Project Joint Development from August 2003 to June 2005. Out of these 81 individuals, adolescents under 18 years of age represented the majority. Eighteen help seekers were referred to Project Joint Development by the educational system (including the school medical officer) while 20 persons were referred from the child and adolescent clinic and the adult psychiatric out-patient clinic. The remainders were referred by other agencies. Most of the subjects included in the Project Joint Development were suffering from difficulties relating to their social network, such as family or friends/colleagues. Many of them were in need of psychiatric treatment due to various levels of depression and anxiety.[5] At least 20 were suffering from multiple problems. Thirty-one were known to the specialist services prior to the first network meetings. Twenty-one persons were in such shape that no referral to the specialist services was intended when the first network meeting was arranged whilst referral for eight persons were sent to the specialist services.

In order to develop the new practice, a two-year training programme was conducted in which 40 professionals participated (Table 1). This programme consisted of 75 hours of lectures and 73 hours of supervision. The lectures focused on ethics, dialogues, common understanding and processes.

Methodological approach

Participants

During Project Joint Development, 42 help seekers accepted to be screened for mental health problems, five of these did not arrive at the first screening interview. Thus, 37 were screened within a few weeks after the first network meetings and 17 of these participated in the follow-up screening after one year. In-depth interviews were conducted with 14 help seekers. Furthermore, ALH observed 151 network meetings in 16 cases. JS participated in 18 network meetings in addition to acting as the lead clinical supervisor in Project Joint Development. Both participated in the training and supervisory groups. During the observation of the network meetings, interesting differences appeared between the ways the professionals understood the concept of Open Dialogue. This was mainly due to different interpretations of communication, role and teamwork. Bearing this in mind, two different focus groups were created based on the total of 40 professionals working in the various agencies participating in Project Joint Development[6] (Table 1).

Given that the project required collaboration from a whole range of professions and agencies, the composition of the groups should reflect the breadth of Project Joint Development [33]. Thus, as the point of departure was to ensure that professionals working in such important agencies as the educational sector and psychiatric services were included in the focus groups, the professionals were selected according to their agency affiliation.[7,8] Furthermore, the groups should have an equal number of participants from the two municipalities as well as the four supervision groups linked to the educational programme. Moreover, the professionals in the groups should be ordinary participants in Project Joint Development (i.e. not supervisors, project leaders etc.) and have participated from the project's outset.[9,10]

Twenty-six persons fulfilled the inclusion criteria of the focus groups (Table 1). Based on a purposive sample [33, 34] guided by the criteria for the group composition, 12 persons were invited to join the focus groups. One focus group included six professionals working in the health care sector (Health Care Group), whilst the other six professionals were employed in the social and educational sector (Social and Educational Group).

The 12 participants were invited to participate by ALH. One person rejected the invitation due to a lack of time. Six persons from the Health Care Group were

[5] Information about mental health problems is mainly given by the professionals who had met the help seekers and is a result of information assigned to very rough categories. Since the outset of the research project was in February 2004, some help seekers were included in the Project Joint Development prior to the outset of the research study. There is limited knowledge concerning the problems of those who were included prior to the outset of the research study (n=16) and for those who declined to participate in the research study (n=23). For those who were included in the observational part of the research study (n=16) we know much about their problems. For those who were included in the research study, but only participated in the screening for mental health problems (n=21), we also have limited knowledge about their reason for seeking help in the Project Joint Development, since the questionnaires concerning their mental health problems not yet have been analysed. However, concerning those who were included in the research study in general, there were more help seekers who already had a record in the specialist services, compared to those who declined to participate in the research study.

[6] The focus groups were carried out instead of group interviews with whole networks.

[7] Some professionals had more than one kind of education and/or work experience related to the other group of which they were members.

[8] Very few MDs participated in the project and few patients were referred by MDs.

[9] 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 with regard to the particular supervisory group.

[10] One member in the focus groups did not participate in Project Joint Development from the beginning.

present at the first two meetings.[11] At the third meeting four persons were present, including one by telephone conference call. Out of the six persons in the Social and Educational Group, five were present in the first focus groups, whereas four persons were present[12] at the second meeting. Only two professionals in the Social and Educational Group participated in the final meeting.

When the first focus groups were first established, three members had no practical experience, whilst the others had participated in from three to more than 25 network meetings. The professionals in the Health Care Group had more experience from network meetings compared to the Social and Educational Group. In both groups, there were two or more members with experience from more than 25 network meetings when the second meeting was held.

The age range (2004) was 33–58 (mean=46), including four men. The number of years employed in the current position ranged from 3 to 25 (mean=8) (2 missing). Five persons (2 missing) had previously worked in agencies with relevant tasks concerning individuals with mental health problems.

Procedure

The two focus groups met three times, the first encounters taking place in 2004 and 2005. They met once again in 2007 in order to validate the former findings through discussing central topics more closely. ALH was the leader of the first two meetings in each group, whilst the final meetings were led by ALH and MH. Each focus group lasted for 2–2.5 hours, taking place in the child and adolescent clinic, and these were all audiotaped. The first and second meetings in both focus groups have been transcribed verbatim by ALH. The transcriptions include breaks, expressions, such as laughter and sighing and the informants' interruption of each other [35]. During the interviews, ALH wrote notes and made short verbal summaries of how their expressions were understood. During the last meetings, ALH and MH undertook some open reflection [36] with the aim of encouraging the professionals to confirm or correct their understandings. Immediately after the focus group, ALH made audiotaped summaries of how the focus groups had functioned, focusing on the conversation and group dynamics [34].

In order to grasp the professionals' reflections concerning their professional identity in network meetings, they were encouraged to discuss the skills and knowledge they found to be relevant for network meetings. They were encouraged to refer to actual situations and examples [35]. The first focus groups started with a vignette illustrating a typical case for network meetings. The case was followed by questions on how they could act to facilitate a successful network meeting as opposed to a network meeting with poor outcome.

Before the second meeting ALH wrote a summary based on the key findings for each group. The summary also included questions for the professionals to discuss. The summaries generated reflections on the changes in understanding the professionals had undergone since the first meeting. Before the third meeting, each group received a summary including their own quotes and ALH's preliminary interpretations. The possibility the informants had to recognize their former quotes in the focus groups and read the summaries served as a credibility check [34, 37]. During the last meeting, the professionals were encouraged to reflect on how the findings could be applied outside Project Joint Development.

To enhance credibility, the transcripts from the first two meetings in each group have been closely examined by ALH, whilst MH and JS made comments on these initial analyses. The analysis mainly evaluated the group process to increase awareness of biases [34]. The analysis revealed that some expressions in the Social and Educational Group should have been more closely followed-up. Moreover, during the first meeting in the Health Care Group, the group may have been led too strictly, where the professionals may have experienced difficulties in expressing their thoughts and opinions.

Approval for the study was given by the Norwegian Data Inspectorate and the Regional Research Medical Ethical Committee. The participants were informed about the studies both orally and in writing, and they also submitted their written consent with regard to their own participation.

Analysis

The focus group interviews consist of 198 pages of transcripts (first and second meeting). The subsequent analysis is based on content analysis, focusing on explicit and latent underlying content [37, 38]. Content analysis places important categories for the material in the centre of the analysis by using a step-by-step approach [39]. Moreover, as we were aiming for an explorative study, content analysis could provide us with the overview we needed. Multistage focus groups make it possible to observe more in depth the emergence of a developing professional identity. However, multistage focus groups also rep-

[11] A student was present in the second meeting in the Health Care group. The student was only observing and did not participate in the discussions.

[12] Two persons had moved, whilst another one who had been absent during the first meeting was now present.

Table 2. Main theme, categories and codes related to the first and second meetings in each focus group

Main Theme		**Professional Identity, Professional Role and Transdisciplinary Collaboration in Network Meetings**			
Group		**Health Care Group**		**Social and Educational Group**	
Categories		**Professional role**	**Teamwork**	**Professional role**	**Teamwork**
Codes	First meeting	*Role release across stereotypes*	*The impact of mutual reliance*	*Role expansion across stereotypes*	*Towards peripheriality*
	Second meeting	*Role release across stereotypes*	*Mutual reliance as a condition for teamwork*	*Performing role expansion and calling for role clarity*	*Engagement and alignment*

resent the risk of losing the continuity of the core representatives due to the number of meetings that were held [34].

The first step of the analysis was to read through the focus groups' discussions to obtain an overall understanding. From this first reading, about 45 topics were identified. During the subsequent analysis, we identified the most important themes that emerged from the discussions. After having identified the main theme, "Professional Identity, Professional Role and Transdisciplinary Collaboration in Network Meetings", we created two categories; 'Professional Role' and 'Teamwork' (Table 2). Nineteen subcategories and 19 codes were linked to these categories before the subcategories and codes were merged into eight codes during the final analysis.

However, the discussions in the groups developed rather differently, e.g. professionals in the Health Care Group focused on their sense of insecurity. To highlight these differences and thus identify differences between the groups from one meeting to the next, we identified sequences of discussion linked to each category during the final analysis. This identification was based on both the interview guide (e.g., asking about professional roles), and what the participants themselves brought up [33] (e.g., the impact of mutual reliance). We analysed each sequence closely in order to identify the core message, creating one code for each group and meeting consisting of a minimum of four transcript sequences reflecting each category, i.e. 'Role release across stereotypes' and 'The impact of mutual reliance' [37].

The codes reflect the core messages in each category. As there were great variations in each group concerning the density of quotas in each sequence, the codes may represent various numbers of quotas, which in turn may represent answers to actual questions from the researcher or other informants, be a minor part of a discussion, or concern the first meeting being a part of the case discussion.

To some extent the categories overlap one another, and hence the results could be analysed in connection to both categories.[13] Quotas concerning professional role include their present understanding of their professional role, including difficulties that emerged. Quotas related to teamwork concern their understanding of collaboration in network meetings in which mutual interaction is highlighted.

The categories and codes were created by ALH. JS and MH read the preliminary analysis. During the development of the final analysis, they also read reports in which the category system was presented and which the meaning units were assigned to categories. MH's and JS's feedback were used to modify the category system and the assigned meaning units, where the aim was to identify the most suitable meaning units, categories and codes [37]. When the categories and codes were finally clarified, MH read and confirmed the analytical themes. To further ensure credibility, MH examined the data to explore if any items had been systematically or randomly excluded or if irrelevant items had been included [37].

Each focus group's quotas are referred to as either HCG (Health Care Group) or SEG (Social and Educational Group). The particular meeting is referred to as first, second (or third) meeting (m) and the given informant by a number (SEG/1m/1). Results from the third meeting are included if they are of great significance with regard to the first and second meetings.

Results

The findings reported here (see also Table 2) emphasize the group discussions concerning professional roles and teamwork in network meetings. In order to illustrate the professionals' opinions, some quotas are included. The supplementary text represents a summary of the discussion connected to each category.

[13] Some quotes have been analysed according to both professional role and modes of communication and will therefore appear in other articles as well [40].

Professional role

First meeting in the focus groups

The professionals in the Health Care Group highlight the difference between therapy and network meetings, stating that: "*It is [a] conversation with therapeutic effect, but we're not doing therapy*" (HCG/1m/2) and "*I'm not going to be an expert, and people should never experience me as one*" (HCG/1m/1). They discussed professional terms to be used in network meetings like '*collaborative partner*' as opposed to '*therapist*'.

The members of the Social and Educational Group argued more about their roles. Some of them were eager to facilitate a non-prescriptive behaviour by focusing on the help seeker's personal opinion concerning his or her life situation. They encouraged the individual to make his/her own choices: "*You've got this food platter, and here are the different dishes you can choose*" (SEG/1m/4). They also denoted behavioural difficulties: "*It's easier to go into the role of helper rather than being passive*" (SEG/1m/1). Others emphasized their ability to provide supervision and advice.

They all reported difficulties throughout the role development process. This was mainly due to the stereotypical approach to professional roles introduced by professionals unfamiliar with transdisciplinary network meetings, the individual seeking help and the private network. Additionally, professionals in the Health Care Group claimed that practical issues were often brought up by these same professionals: "*They can be prescriptive and much focused on implementing solutions*" (HCG/1m/5). The Social and Educational Group confirmed this by referring to the pressure they felt when either the individual seeking help or their family called for immediate help: "*Now it was a question of what we had to offer. They really demanded that I come through on this*" (SEG/1m/1).

Our interpretation:
Professionals in the Health Care Group search for role release by reducing the impact of therapeutic skills and altering terms denoting their position. Also for those without any previous experience in social network interventions this was possible. On the contrary, members of the Social and Educational Group emphasized communication guided by the help seeker and role expansion. The stereotypes that become apparent represent difficulties transforming their professional roles according to transdisciplinarity. Nonetheless, participating in network meetings created new possibilities for these participants to relax their professional borders.

Second meeting in the focus groups

Since taking part in the first meeting, professionals in the Health Care Group had gained conflicting understandings with respect to the possibility of adjusting their professional role according to holistic approaches. One claimed: "*We talk a lot more about what the families are concerned with. Then it becomes a more humane meeting where everyone participates with their experiences, but without compartmentalization based on role knowledge*" (HCG/2m/2). Another participant emphasized the difficulties that emerged, e.g., the help seeker's expectations with respect to long-established therapy: "*Persons who are familiar with welfare services sit down and wait for one of us in the professional support system to take the lead and have an agenda*" (HCG/2m/6).

Professionals in the Social and Educational Group defined their role as being to "*reflect such that the help seeker makes the right choices*" (SEG/2m/1). They were encouraged to discuss network meetings as opposed to case conferences. According to this, a manifestation of role transformation involves a change from prescriptive actions to collaboration: "*Network meetings are an offer that exist over time and moving in the direction of something like therapy*" (SEG/2m/6). Others claimed that numerous problems arose when several agencies were involved but in which vague role and responsibility structures occurred.

Stereotypical positions and workplaces were still associated with obstacles, e.g., when teachers were met with traditional expectations: "*When I'm together with teachers it's completely different. Then there's usually a lot of talk about school*" (HCG/2m/1). The other group confirmed these observations: "*If the meeting is with Child Mental Health Services or the Family Center, they talk about feelings, about being in a process. If they come to Child Welfare Services, schools, or drug addiction services, they expect us to do something. Not just talk, talk, talk*" (SEG/2m/1).

Our interpretation:
Members of both groups seek role expansion, aiming to increase the help seeker's activity. Some members of the Social and Educational Group have conflicting interests, searching for clarity about organizational issues and hence interdisciplinarity. They are all still fighting against stereotypes.

The development between the meetings

Their motivation about identity alteration moving towards transdisciplinarity is illustrated through role release and role expansion at the first meeting. The second meeting indicates a change as the professionals within each group had rather different experiences. Thus, as discrepancies about role transformation

become stronger, the difficulties with respect to identity transformation become apparent.

Teamwork

First meeting in the focus groups

Professionals in the Health Care Group experienced an increased sense of professional insecurity through their practice. Professionals working at the primary care level supposed that individuals were referred to the specialist service because of a need for more sophisticated treatment, hence the statement: "*I start feeling insecure about my role as contact person and as the person they (help seeker) trust*" (HCG/1m/1). Their feelings of insecurity were also related to the mutual reliance between themselves and those who were working in the specialist service: "*Does that mean that when you and I sit in a network meeting, you see me as the expert and yourself as the follower?*" (HCG/1m/2).

They noticed in a broader sense the challenges of negotiation brought on by the multi-agency perspective: "*When composition is multi-disciplinary and there are participants from the school system, I think they're more aware of the distance. At the same time, they're more on the sidelines, because here they talk to the person who's sick. The concepts of health in a way*" (HCG/1m/6).

In response to a direct question about the educational programme, the professionals in the Social and Educational group[14] noticed challenges related to differences in agencies as well: "*The health care sector in a way only sees its own clan*" (SEG/1m/4). They emphasized the difference in the knowledge base between themselves and the Health Care Group: "*We're like supposed to have respect for the job we do. That we actually meet with most of the kids*" (SEG/1m/1). Contrasting collaboration prior to the onset of the project, one claimed: "*It's the traditions we're a part of that determine how things happen. I don't feel like there's been very much change*" (SEG/1m/3).

Our interpretation:

Professionals in the Health Care Group demonstrate an increased sense of insecurity linked to mistrust in others. They place professionals in the other group in a marginalized position, pointing to their unfamiliarity with medical terms in which a decrease in eclectiveness emerges. However, the Social and Educational Group place themselves in the periphery, pointing to the health care sector as representing the principal paradigm. These factors may be of major importance concerning their mutual identification and negotiability. Hence, their motivation and potential for altering their professional identity according to transdisciplinary collaboration may be strongly affected.

Second meeting in the focus groups

The professionals in the Health Care Group discussed the impact of familiarity with each other as being important according to team formations. During the project, mutual reliance had emerged among the professionals included in the project: "*Before it was like the teachers and child protection workers and school psychologists sat together, but now we're much more persons sitting together and I feel in a way this is my group, or our group*" (HCG/2m/2). But still, difficulties emerged due to the multi-agency approach: "*Maybe some aren't that comfortable with that role, allowing oneself to be vulnerable with your own thoughts and feelings*" (HCG/2m/6). In the third meeting some professionals claimed that the most important factor concerning mutual confidence was depending on their partners' *belief* in Open Dialogue.

The professionals in the Social and Educational Group pointed to difficulties caused by different interpretations of the situation: "*If someone from the social sector says it happens, then maybe there's someone who has more psychiatry that says, No, we have to wait with this, this is the past, present or future*" (SEG/2m/6). They also discussed how exercise of authority affected the collaboration: "*If network meetings don't manage to keep the kids within acceptable boundaries, then it's easier to initiate other measures*" (SEG/2m/1). These expressions were replicated during the third meeting, when the Social and Educational Group discussed mental health care in terms of the law: "*Everyone knows where government has placed the responsibility*" (SEG/3m/6).

The professionals in the Social and Educational Group, when asked directly, denied that a sense of insecurity had emerged during practice. However, they said: "*It's kind of good to know what one can expect from the others. And then there's the personal. What attitudes does he have?*" (SEG/2m/1) and "*It's really important who. It's very personal"* (SEG/2m/5).

Our interpretation:

The Health Care Group's example regarding mutual confidence and trust illustrates the importance of becoming familiar with partners in order to achieve transdisciplinary engagement. Nevertheless, some professionals are still being marginalized through questioning their competence. Professionals in the Social and Educational Group demonstrate practical implications because of diverse understandings and thus, the

[14] During the first meeting, collaborative aspects were given less focus in the Social and Educational Group than in the Health Care Group.

need of respect for eclecticism in order to achieve collaborative processes which will lead towards transdisciplinarity.

The development between the meetings
Mutual confidence was the main topic for the professionals in the Health Care Group at the first meeting, whilst this idea became important to the professionals in the Social and Educational Group during the second meeting. Professionals in the Health Care Group pointed to difficulties in arriving at a common understanding during the first meeting, whilst this is illustrated by the Social and Educational Group during the second meeting. As problems of identification and negotiation existed, identity changes were affected by this factor.

Discussion

Our aim in this paper was to explore the challenges to professional identity in multi-agency network meetings, focusing on the way attitudes towards multi-agency practice are embedded in traditions of specialization in the sense of professional knowledge and mutual interaction and more specifically, how professional identity is related to:

- the development of professional roles in multi-agency network meetings
- the development of transdisciplinarity in multi-agency network meetings

To conclude the findings:

Professional role: Reconciliation to transdisciplinary roles emerged for some members of both groups. Other members found role release unfeasible and called for traditional and therefore interdisciplinary roles. The role-developing processes were during both meetings strongly affected by the anticipation of stereotypical roles by those who were unfamiliar with network meetings.

Teamwork: Professionals in the Health Care Group were affected by a sense of insecurity towards other members in the network. They underlined the importance of having familiarity with each other in order to increase mutual reliance and thus increase possibilities of transdisciplinarity. Professionals in the Social and Educational Group discussed their position by pointing to lack of complete acceptance by professionals in the Health Care Group. They also argued about the impact of the exercise of authority and responsibilities in terms of laws for transdisciplinary collaboration.

In this study, the findings reveal a reconciliation of professional roles during the project in which an emerging identity change is demonstrated. However, even if the professionals change their roles and attitude, the tradition and discipline-specific dimensions may create difficulties in situations where other professionals and non-professionals maintain their actions according to stereotypes [18]. Moreover, the findings indicate that professionals in primary services place themselves somewhat in a non-participative position through claiming to have different areas of competence and insufficient legitimacy. Professionals in the social and educational sectors seem to be placed in a marginalized position due to their lack of medical terminology. However, they also place themselves in the periphery through their complaining about the lack of attention paid to their perspectives. Likewise, professionals in primary health care services question their position through making a distinction between primary and specialist services. These results correspond to a study [11] finding that 21% of professionals in primary care asserted that professionals in the specialized mental health care sector showed a lack of respect with regard to their level of skills and expertise. Moreover, close collaboration calls for social intimacy and social competence [41, 42]. Since the emergence of new solutions and creative ideas at first glance may be considered strange and unprofessional, mutual reliance may affect the processes generated in teamwork in the sense that vulnerable professionals may be less creative [42]. The findings from our study point out the importance of the professionals' sense of security, as well as the impact of mutual reliance. Although their mutual reliance increased during the project, their focus on their collaborative partners and their attitudes was maintained. Bearing this in mind, the processes generated in teamwork find the importance of the professionals' personalities when taking part in close collaboration to be a critical factor. Moreover, working in a transdisciplinary way increases the professionals' knowledge about each other, both professionally (how they understand collaboration in terms of their position) and individually (their personal values and beliefs). Consequently, transdisciplinary collaboration may potentially contribute to a stronger culture of transformation, compared to interdisciplinary collaboration.

Conclusion

Through synergetic effects, it follows that transdisciplinary social network intervention may also improve results in other cases involving the same professionals. This may occur through the generation of more flexible solutions for the help seekers based on increased levels of reciprocal confidence among the professionals. Moreover, the focus on person centredness followed by a change in the helpers' position may in turn affect the stereotypes associated with professionals.

Bearing this in mind, the increased familiarity between the professionals developed in transdisciplinary multi-agency teamwork may improve the health care system in general [3]. However, the results also illustrate several challenging aspects with respect to the achievement of successful transdisciplinary collaboration. Thus, according to the findings in Project Joint Development, we need to address the following:

- Emphasize motivation and personal commitment [14]. Even though role reconciliation seems to be more challenging for professionals representing peripheral agencies, the inclusion of these professionals is equally important as professionals representing the leading paradigm.
- Increase the professionals' ability to become familiar with each other [30, 42]. This means being aware of the importance of creating meeting places (such as training and supervision groups) for the professionals in order to increase confidence and trust. Lack of familiarity between the professionals can hamper flexibility and creativity in transdisciplinary teams and should be addressed adequately in the development of integrated care solutions.
- Nurture professionals who have a preference for teamwork. Through their assessment of teamwork as being especially important, these people may contribute greatly to the genuine integration and expansion of integrated care.
- Be aware that cultural barriers contribute to delaying in the process of integration among professionals and non-professionals in multi-agency work. Nonetheless, reinforce the efforts in order to develop knowledge and practice concerning collaboration involving a variety of different voices.

Methodological considerations

The sample in this study represents a great variation in professionals and agencies and hence it 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 [33]. These differences may have been even more reinforced as the project was initiated by the local hospital and was also managed by the agencies involved. The fact that the focus groups were arranged in the child and adolescent clinic underlined the fact that ALH was working for the hospital. However, when combined with the fact that ALH had also observed much of the previous activity linked to Project Joint Development and therefore was a well-known person to the informants, this may have affected the information, in negative as well as positive directions. Moreover, the term 'interdisciplinary' was used in Project Joint Development instead of the term 'transdisciplinarity'. Although the substantial messages concerning collaboration given to the professionals was in terms like holism, transcending, creativity and flexibility, the fact that the professional were not familiar with transdisciplinarity as a key concept may have influenced on the analysis and interpretation.

Moreover, most of the help seekers in this study were suffering from frequent mental health problems and consequently, the professionals have mainly been dealing with difficulties that are fairly common in their daily work. We consider this to be a benefit in terms of credibility. Bearing this in mind, we believe that the findings from Project Joint Development may have relevance in other settings where the aim is to implement and work in a transdisciplinary way involving both professionals and non-professionals in the health, social and educational sector. This is due to the fact that challenges to transdisciplinary collaboration are so general in the sense that intimate teamwork is related to such factors as communication, motivation and enthusiasm [14]. Conversely, projects that aim to implement transdisciplinary collaboration in the sense of social network intervention will to a certain extent gain the benefit and meet the challenges reported in this paper.

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II

INTER-AGENCY WORK IN OPEN DIALOGUE: THE SIGNIFICANCE OF LISTENING AND AUTHENTICITY

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III

TRANSDISCIPLINARY COLLABORATION AND ROLE RELEASE IN OPEN DIALOGUE WITH ADOLESCENTS' SOCIAL NETWORKS

by

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