"Open Dialogue behind locked doors" – exploring the experiences of patients, family members, and professionals with network meetings in a locked psychiatric hospital unit: A qualitative study

In our exploratory study, the Open Dialogue approach was seen as a largely positive experience for patients, family members, and professionals in a locked psychiatric unit, write Ritva Kyrrø Jacobsen and colleagues.

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The Need-Adapted (NA) approach was developed in Finland in the early 1980s in response to the care of people in psychotic crises. Resting on the idea of treatment as a continuous process that integrates various therapeutic methods, this framework incorporates rapid early intervention, flexibility in responding to changing specific needs of each case, attention to therapeutic attitude in both examination and ongoing therapy, and constant monitoring of progress and outcomes (Alanen, 1997, 2009; Seikkula, 2002).

The Open Dialogue (OD) approach has subsequently been integrated into the NA approach to accentuate the form of communication within the treatment system that involves patients and their support systems (Aaltonen, Seikkula, & Lehtinen, 2011; Seikkula, Alakare, & Aaltonen, 2011). The OD approach focuses on communication not as transmitting information between people but as a joint process of constructing meanings among involved people as the basis for the organization of both mental health services and the therapeutic process (Seikkula et al., 2006; Seikkula et al., 2011). This paper aims to explore and describe the experiences of patients, family members, and professionals with the OD approach in network meetings at a locked psychiatric hospital unit in Norway

The OD approach was also developed in Finland. Treatment according to this approach starts within 24 hours of the first point of contact. The network meetings involve the patient, the social network members (i.e., the family members), and the professional team. Together these individuals create a forum through which meanings of experience and identity are constructed, understood, and negotiated through dialogue. A group of

professionals are responsible for the entire treatment process and will work with the patients in both inpatient and outpatient settings. The aim is to develop collaboration and dialogue with the family and the network in order to gain understanding about the experiences one may have during episodes of psychotic symptoms (Seikkula & Arnkil, 2013).

The OD approach aligns well with the current emphasis on user involvement in mental health care processes. That is because there has been strong advocacy in both the international and national political guidelines emphasizing the need to develop mental health strategies that take into account service users' perspectives. The development of new strategies frequently involves challenges to procedures, therapies, and views regarding knowledge and humanity. Dialogical practice might provide a solution for these challenges, not only because of its procedures but also due to its attitudes toward service users (Seikkula & Arnkil, 2013).

During the last 20 years in Norway, there has been an increase in the development and implementation of practices related to and inspired by OD (Brottveit, 2013; Bøe, 2016; Holmesland, 2015). These studies have shown that sustainable changes can exist on individual and organizational levels when all participants engage as partners during the implementation of new mental health practices. Implementing dialogical practices requires a shared understanding of the principles associated with OD, which goes beyond the traditional notion of collaboration. Because the OD approach, with its emphasis on teamwork, challenges the traditional psychiatric approach, one is likely to encounter obstacles related to power, domain of control, or expertise, especially in involving different professions. One way, and perhaps the best way, to address these obstacles is to adopt the OD approach during the implementation and collaboration itself as a means of gaining shared understanding of the OD approach when applied in therapeutic processes.

The traditional approach to psychiatric treatment has remained within the system of psychiatric care, and there have not been many innovations introduced in the way psychiatric services are offered to patients and families in Norway. The project "Open Dialogue behind locked doors" (Jacobsen, 2016; Sørgård, 2016) was instituted as an innovation to bring about dialogue among the patients, family members, and professional providers who are involved in in-patient psychiatric services. The principal component of this project is 'network meetings,' which are aimed at developing a dialogical environment within the setting and among meeting participants.

This ongoing project started in 2010 and is conducted at a locked psychiatric unit where patients are often hospitalized against their own will (Jacobsen, 2016; Sørgård, 2016). The unit is a part of a health trust that provides mental health care to a specific geographical area. This area is diverse in socioeconomic representations ranging from relatively deprived areas to affluent areas, and it is composed of rural, suburban, and urban areas. The patients at the unit are experiencing severe mental illness, sometimes combined with substance abuse problems, and are often displaying violent and/or risky behaviors. The unit focuses on structure and security and has a hierarchical structure among the professional staff, with the psychiatrists at the top, followed by psychologists, mental health nurses, and social workers. The project's key component is the institution of 'network meetings' in which a dialogical environment is developed through the dialogical processes of the OD approach. This is in addition to the treatment meetings involving patients, family members, and professional team members that focus on understanding the experiences and meanings of patients' problems through dialogue and collaboration. The patients invite their family members and therapists to network meetings. The meetings usually take place at the unit. Two trained network leaders always lead the network meetings. In our unit, nurses and social workers, Not the psychiatrists or psychologists, are trained to be network meeting leaders. The network leaders take the role of facilitators by starting the meeting, focusing on how the conversation progresses, and ending the meeting. In general, the meetings last for 90 minutes.

In this paper, the data is based on two studies (Jacobsen, 2016; Sørgård 2016). The collection of data comes from the participation of patients, family members, and professionals. The focus of the analyses has been to see the data as a whole by exploring and describing all the participants' experiences related to differences and similarities. Our research questions are:

1. What kind of differences can be identified among patients', family members', and professionals' experiences with OD in the network meetings?
2. What kind of similarities can be identified among patients', family members', and professionals' experiences with OD in the network meetings?

Method

This study, with its descriptive, explorative design, applied the guidelines for qualitative research suggested by Kvale and Brinkmann (2015) and is based within the phenomenological-hermeneutic framework. The data used in this article was derived from two studies. In the first study, the professionals' experiences were explored in a semi-structured focus group interview. The data for the second study were written expressions of the experiences of attending the network meetings by patients and family members. The participants were asked to write down their experiences at the conclusion of network meetings. Upon completion, their written statements were immediately handed over to the author J.S.

The participants were given both written and verbal information about the studies before agreeing to participate. The participants in study 1 gave their written consent before the interviews took place. The participants in study 2 gave their written consent after finishing their written statements. The Norwegian Centre for Research Data (NSD) approved the studies (Reference numbers 43783 & 44230), and research and development approvals were obtained from the University Hospital. In consideration of confidentiality, names and identifying characteristics were changed.

Study 1

For the semi-structured focus group interview, participants (i.e., professionals) were recruited strategically. Each participant had been employed for more than six months and had attended at least four network meetings. Five professionals (four psychiatrists and one psychologist) participated in this study. Both men and women were present. Three of them had more than three years of experience with OD, while the remaining two had less experience. A semi-structured interview guide was developed and used in the focus group interview. The questions focused on the participants' experiences regarding participation in network meetings. One of the authors (R.J.) conducted the focus group interview. Following permission from the participants, the interview was recorded, anonymized, and transcribed by R.J. The recording was erased following the completion of transcription. Data was analyzed using systematic text condensation in four steps: (a) first impression, (b) identifying and sorting meaningful units, (c) condensation, and (d) synthesizing (Malterud, 2012).

Study 2

Data were obtained from five patients and six family members. The patients consisted of three men and two women. Family members were either parents or siblings of the patients and everyone had participated in network meetings. In the last network meetings before discharge,

participants were asked to write down their experiences regarding participation in network meetings. The eleven notes varied in length from four lines to three pages. In our data, there is a variation in the number of network meetings from one to six (Sørgård, 2016). The data were analyzed using systematic text condensation. The procedure used was a step-by-step deductive-inductive method (SDI) following six steps: (a) generating empirical data, (b) processing data, (c) coding data, (d) categorizing, (e) theoretical focusing, and (f) discussing concepts using theory (Tjora, 2012).

Finally, the data from both studies were analyzed using thematic analysis (Braun & Clarke, 2006). Both inductive and deductive approaches were used to develop themes. First, each author read the findings from both studies and looked for thematic differences and similarities. Afterwards, the authors met and discussed their preliminary themes and related them to each other based on the research questions. Finally, the three authors reviewed the preliminary themes and focused on overlapping and combination to allow the final themes to be defined. We defined three main themes and named them, grounded in data.

Findings

The following three themes summarize and combine the findings from both studies: (a) *Experiencing otherness and equality;* (b) *The content and possibilities of Open Dialogue in network meetings*; and (c) *Tone, time, and openness in Open Dialogue*.

1. Experiencing otherness and equality
All the participants described the network meetings as something different from traditional meetings like collaboration meetings or family meetings. Here the agenda is set by the professionals and characterized by linearity in questions and answers. The patients and their families stated that they felt seen and heard in the meetings: "As a relative meeting the healthcare services, you are vulnerable and you feel disqualified or that you are the weaker part (of the equation). In the network meetings, we were met with respect and experienced equality."

The professionals experienced that families were given an opportunity to voice their concerns and raise issues that mattered to them, just like everyone else: "It is very important that relatives can speak freely. In the network meetings, they have a more active role and make decisions, unlike [in] traditional meetings, where they normally have a submissive role." The professionals also mentioned how their role had changed. In

network meetings, they were not responsible for facilitating the meetings. Therefore, they could participate in the meetings, just like the others. Other professionals were responsible for leading the meetings. Thus, they felt they could focus on the dialogue and participate more actively in the meetings. On the other hand, the professionals stated that all participants were held responsible for the dialogue but in a different and more positive way. One professional said: "In the meetings, everyone has to interact with each other, speak freely, and take responsibility for the dialogue." A patient wrote: "It was a positive experience, having the therapist speak directly to my family and me." One relative wrote: "Everyone is free to say what they want. Free to talk about what is important for them." Another family member wrote: "We were included and informed about our son's hospitalization and treatment. We felt reassured and the staff made us feel secure and safe. There were no such things as stupid questions."

All the participants experienced the network meetings as the patient's meeting. The patient decided whom to invite and what should be on the agenda based on his or her needs. "It is really important that I can invite the people I want to the meetings," stated one patient. Another patient wrote about the importance of being a decision maker: "I invited the doctor to the second meeting. I wanted my family to ask him, being the expert in the field, questions about my diagnosis." The professionals experienced that the majority of the patients were more engaged and active when participating in the network meetings. This tendency gave the professionals a nuanced impression of the patients and their resources. One patient described the importance of the meetings in regard to experiencing a major psychological crisis. Humor, normal conversations, and a focus on his resources gave him hope for the future. The family members' notes offered further support to this incident. The professionals also experienced that the network meetings could have a significant impact on patients who were experiencing a major psychotic crisis. That is because the patients and their social network were strongly affected by the circumstances of the crisis.

2. The content and possibilities of Open Dialogue in network meetings

Several professionals described the first network meetings as exhausting and filled with emotions. One of the professionals experienced the meetings as providing an opportunity to express and share difficulties. The network meetings helped the participants by teaching them to talk with each other. It also provided them with the opportunity to learn how to handle emotions, without having to leave the room or end the meeting.

Several professionals experienced the meetings as arenas and a means for the families to communicate with each other. One of the professionals said, "Network meetings have the potential to bring forth change and teach the patients and their networks to have similar conversations in the future." One patient emphasized that it was important for the dialogue to continue: "The dialogue makes it possible to look at things in a different way and from different angles. Different views appeared during these dialogues." The relatives and the patients wrote about what the open dialogues in the meetings had accomplished. They were able to sit around the same table and listen to the same conversation at the same time. One patient wrote, "No one has to wonder about anything."

The OD brought forth several perspectives that increased the participants' possibilities to see things from different angles. Several participants described how the OD had made it possible for their families to express feelings they were not able to express on their own. The professionals experienced how the meeting dynamics made it possible to change focus. Participants could now talk about the future and life outside the hospital. One relative who was part of a couple wrote that the network meetings had made it possible for them, as parents, to speak freely about their son. Furthermore, they were able to focus on other issues besides the problems and their concerns only. One relative spoke about how it felt to have other people share her or his difficulties. The family was no longer alone in the situation: "The meetings gave our family the opportunity to talk about issues we never had talked about before." The professionals said that even though the meetings were emotionally challenging, participants were able to cherish the moments and the time they had spent together.

Both patients and their relatives stated that the OD had given them hope for the future. One relative was very skeptical about the network meetings. Her daughter had been struggling with severe mental illness for years. The mother was worried about her daughter participating in the meetings. She was afraid it could affect her negatively. After taking part in several meetings, the mother wrote, "Our daughter is building a new platform in her life. The meetings have given us hope and security for our daughter's future. We have gained useful and valuable tools, which we can use to help our daughter on her road to recovery and well-being." Another relative suggested that the network meetings should become a part of the standard treatment at the unit: "This has prepared us and our daughter to meet the future in a better way." A third relative said, "We will strongly recommend this form of meeting. It has given us a lot, and we have gained another perspective of our son's illness and how we can handle his

demons in different situations." Several patients stated that the network meetings could bring forth solutions to their problems and challenges. One said, "The network meetings gave me the opportunity to experience the normal things in life. They started to open up possibilities for me." When the professionals experienced difficulties in the meetings, some of them thought about ending the meetings because they did not see any progress: "If the parents' lives are being threatened, should we end the meeting? Or has the meeting shown us the dynamic in the family?" Another professional said, "The dynamic in the family is what it is. If we can help them communicate differently or in a better way, it's a good thing." They all agreed that making a decision regarding whether or not to end a network meeting would be difficult.

3. Tone, time, and openness in Open Dialogue

The patients and their relatives described the meetings as informal and filled with openness. One relative wrote, "The network meetings had an informal, open tone. There was no agenda. The goal was openness, which was perceived as a good thing." A patient said, "The meetings had an informal style, with great openness." Another patient wrote, "The network meetings functioned really well. I enjoyed that the topics discussed were broad and open and did not always have to be narrowed. This nice, comfortable, and normal atmosphere in the meetings is just as important here as it is for the difficult ones." The professionals mentioned that the meetings had made it possible to focus on other issues and not only the difficult ones. Participants could talk about the future and life outside the unit. This helped create a calm environment and made it possible for the dialogue to continue.

The relatives and patients alike were surprised by the amount of time the professionals had been allocated to attend meetings. They referred to the time spent in each session and the possibility to meet more often. On patient wrote, "It is positive that there is enough time in the network meeting to talk about things." Another patient was impressed that the meetings were scheduled every week: "I am grateful that we have enough time in these meetings. We discuss many topics, difficult ones, hard ones, funny ones, and nice ones."

On the other hand, some professionals had concerns relating to the amount of time they spent in meetings. One professional was concerned about the use of time and resources in establishing open dialogue in network meetings. However, after participating in a couple of meetings, this individual came to value the importance of time spent in them. After

participating in some meetings, all the professionals highlighted positive outcomes and related them to the amount of time spent in the meetings. During the meetings, they could gather and provide information. They had the proper time to see, to listen, and to get to know the patients and their families. In the meetings, the patients' resources became more apparent. Several patients said that the meetings provided their families with the opportunity to gather more information. The meetings gathered the family together so they could talk about what had happened in relation to treatment as well as discuss plans for the future. A patient wrote, "Network meetings have made it possible for my relatives to gain information from the therapists. Extremely positive."

The professionals underlined the importance of time when it came to the reflection processes. They experienced the participants' reflections as encouraging changes and providing everyone with the opportunity to find new solutions and gain new perspectives. The participants pointed out the importance of the leaders' role during meetings. One patient wrote, "Openness was secured through the meeting leaders. They created a good atmosphere by being good listeners and by listening to the participants' wishes and questions." The professionals emphasized the need for secure and experienced leaders. They felt uncertainty in their own role when the leaders were vague or unclear: "I become uncertain in my role when inexperienced network leaders led the meetings. I sat and wondered all the time. Is it okay for me to say this, or is it the responsibility of the leader?" Another professional said, "I appreciate an experienced network leader who takes the leading role in the meetings." A third one said, "There is a big difference among the leaders, and it is not necessarily related to their formal education. It is about personal skills. There is no need to show off. You should stay in the background, not due to shyness but because you know that you are not the most important person in the meeting." Some of the professionals mentioned that they were more likely to intervene and take control of the meetings when they did not trust the network leaders' skills and abilities. They explained that their own uncertainty of the structure and content of the network meeting should not disturb the leaders' role in the meetings.

Discussion

We extracted three different themes that represent the experiences of the patients, family members, and therapists involved with OD in the network meetings. These themes are reflected in the following two topics: (a) *Our context of Open Dialogue behind locked doors* and (b) *The potential of Open Dialogue in network meetings.*

1. Our context of Open Dialogue behind locked doors

In Finland, the development of OD emerged from an effort to reorganize the psychiatric services. Furthermore, it was an attempt to guarantee a continuity in treatment for patients moving from locked to open mental health services (Seikkula, 2002, 2011; Seikkula et al., 1995; Seikkula, Alakare, & Aaltonen, 2001). In our context, the patients are involuntarily hospitalized. Our development of OD did not relate to the idea of changing the existing psychiatric services. Instead, we wanted to facilitate a better therapeutic collaboration among the professionals, the patients, and the patients' social networks. In our unit, working with OD in networking meetings was a new practice, one that was developed alongside other and existing treatment approaches. Our aim was not to change or reorganize the services at the unit. Rather, it was to expand the treatment offered to the patients. This expansion included the idea of user involvement and the involvement of the patients' social networks.

In the network meetings, patients, relatives, and professionals are brought together in an open dialogue where the goal is to create reciprocity and a responsive environment (Seikkula & Arnkil, 2007). The dialogues among all meeting participants brought forth a form of expertise that differs from the traditional perception of expertise. This is where one wants to control phenomena through professional, specialized knowledge. "The new challenge lies in exploiting the professional knowledge and experience for the purpose of creating common understanding and collaborative solutions" (Seikkula & Arnkil, 2007, p. 165). Introducing OD in network meetings was based on the idea that this approach can contribute to a new and different perspective on how treatment can be offered in a locked psychiatric unit. Still, the ideas and practices in our context are characterized by the psychiatric literacy and terminology as well as by the traditional psychiatric approaches to treatment. At the same time, OD in network meetings is now a well-established part of the practices and services at the research site.

The way we arrange the network meetings created a different arena for conversations around the problems patients and their social networks faced. The participants in our study experienced the network meetings as good arenas for creating and maintaining an open dialogue. The professionals underlined the importance of having network meetings with patients they felt had severe challenges with their mental health since these patients' networks are also heavily affected by the situation. The professionals also deemed it important that the patient and his or her network to be brought together in the midst of a crisis, because they felt

that this was when the patient and his or her network needed the meeting the most. The patients and their relatives echoed this sentiment. The patients described the importance of having network meetings when they were experiencing severe difficulties with their mental health. According to the patients and their relatives, being together in a network meeting provided them with hope and opportunities. In these meetings, the dialogues are mainly about the future. The purpose of such dialogues is to build credible hope (Seikkula & Arnkil, 2013). "When everything is hopeless, concrete and realistic inputs are needed in order to see the potential for change in a positive direction" (Seikkula & Arnkil, 2013, p. 70). Consistently focusing on hope can help create and unearth resources in ourselves, alone or with others. The goals revolve around developing and sharing hope and faith, finding an environment that nurtures and strengthens mental health, and providing a forum that makes us believe in a meaningful future (Karlsson & Borg, 2013).

Sælør (2016) focuses on people who are experiencing concurrent mental health and substance abuse problems. He writes that hope appears to be a prerequisite for experiencing recovery. The author summarizes how hope is linked to different forms of change. Being able to believe in something better is the key. Improvement connects to both personal processes as well as social processes. Experiencing daily life gives the feeling of being human. The individual can take control of his or her own life by interacting with fellow human beings. Patients admitted to our unit may, at times, experience being far from their "normal life." Our studies indicate that patients can experience some parts of a "normal life" through dialogue with their social network during the meetings. The network meetings can create an arena where opportunities to believe in something better arise and the experiences of stigmatization can be expressed. The persons who are participating are the ones in whom the patient trusts and who therefore may be helpful in the process of recovery. Combining professional resources with everyday life resources multiplies the potential for solutions, according to Seikkula and Arnkil (2013). They point out that "Moving out of the convenience of discussing patients' cases behind the patients' back is not only ethically correct, but also effective" (Seikkula & Arnkil, 2013, p. 151). Being in dialogue with the patient is an important principle in OD in general. As evidenced in our data, participants experience such dialogues as useful, enriching, and helpful.

2. The potential of Open Dialogue in network meetings

Practicing the OD approach is central to our network meetings and appears to be very useful in our context. The patients, their relatives, and

the professionals all described how the open dialogue in network meetings created opportunities—opportunities for the participants to talk, to share, and to be together. Such an environment provides the professionals with opportunities to play a different role, one in which they can "relax," relinquish control, and be a part of the meeting's processes. The fact that the open dialogue appears to be useful and helpful in our context can be understood in relation to Seikkula and Arnkil's (2007) descriptions of how OD has healing power. All the participants developed this power because of the feelings seen and heard in the meetings. Seikkula and Arnkil (2013) argue that dialogical conversations allow everyone to feel difficult emotions and express them while at the same time experiencing emotional reciprocity and belonging with other participants. Telling one's story and being listened to gives an experience of mutual respect and appreciation.

Brottveit (2013) finds that the hope for better communication with one's relatives is an important aspect of the patient wanting to participate in network meetings. This tendency may derive from a desire to be understood and respected, especially if the mental health issues involve symptoms and behaviors that can seem threatening and/or incomprehensible to others. Network meetings provide opportunities for reflecting on what patients and their support systems had emotionally expressed earlier and how these expressions could be interpreted in the actual meeting. Our study indicates that the patients and their relatives have previously had difficulties with talking about their problems and concerns. There may have been concerns about substance abuse, mental health problems, and/or threatening behavior. The emotional stress and level of conflict in the social network may have been ongoing for a long time. Seikkula and Arnkil (2007) state that when family members find it difficult to talk about the crisis or their concerns regarding the situation, the dialogue can increase the feeling of hopelessness. At the same time, the dialogue can bring forth a mutual feeling of unity and belonging among the participants.

The professionals described the network meetings as helpful and useful in enlarging the participants' capacity to talk to each other and cope with present emotions without leaving the room or ending the meeting. When people are invited to participate in a network meeting, and everyone has a voice and is being heard, a mutual understanding and connectedness can be developed without participants being able to define their exact contributions or knowing the dynamics of the process itself (Seikkula & Arnkil, 2007). A shared experience is difficult to describe in a precise and rational way. It is difficult to state what led to what and why. Seikkula and

Arnkil ([2013](#)) claim that a dialogical relationship occurs through communication among participants and not as linear processes in each participant. Being able to express one's frustrations and be heard makes changes happen. Listening to others and being curious about their experiences is important. Seikkula and Arnkil (2013) describe this as "respect of the otherness in the present moment." Unreservedly recognizing others by listening to them and letting them claim the emotional space they need is the foundation of the dialogical practice. The prerequisite is that the professionals relinquish control in network meetings and adopt a new role in which they become equal participants in a mutual process. In a dialogical network meeting, participants are seeking to find solutions through a relational collaboration ([Bøe, 2016](#)).

In our study, the patients and their relatives described the professionals as equal partners. This perspective is encouraging in a context where patients are often admitted against their will. Many patients disagree with the admission and can refuse all treatment. However, treatment can be provided by force or through compulsory measures. Compulsory treatment actualizes concepts such as power and the use of power. Patients can experience lack of influence, absence of choice, and unnecessary and brutal compulsion. Such experiences of control contrast with the level of equality the patients described in the network meetings. In network meetings, patients are the main agents, defining their own agenda and the topics of conversation. Patients are located in a setting where they are more likely to participate in their own treatment, based on their own prerequisites and with the opportunity to make their own choices. In network meetings, patients are their own experts, expressing their experiences on their own terms, which may challenge the professionals' power. Patients' experiences of empowerment could contribute to equalizing power among all participants in network meetings ([Seikkula & Arnkil, 2007](#)).

All participants in our study described the critical contribution of the network leaders in ensuring that everyone was heard and in organizing reflections on central issues. The most important functions of the network leaders are to create and promote dialogue among the participants and to invite and bring forward all the different voices in the meeting ([Seikkula & Arnkil, 2013](#)). Time for reflective dialogues and processes was highly appreciated by the participants in our study. The professionals indicated that the reflections that arose created new opportunities. Through the reflective dialogues, the leaders focused on different perspectives and aspects in a new way. This environment gave participants the opportunity

to think through their own thoughts and statements and to make choices from a greater variety of perspectives than before.

Strengths and limitations

As in all qualitative studies, we cannot determine the representativeness of our sample. A strength with our sample was that the data were from those with participation in the practices. Validity could have been compromised if the participants did not respond honestly, especially when the dishonesty came from the patients and their family members. The ones who responded could have been those with positive experiences. The ones with negative experiences or attitudes could have chosen not to respond. Three researchers analyzed the data together. All five authors collaborated in the interpretation and contextualization of data, which strengthens the validity. The material is small and limited. The study was carried out in a very different context compared to previous studies done on OD. Therefore, any representation or general conclusions cannot be made. However, the study provides interesting local knowledge that can contribute to our context in relation to treatment in general and to OD in network meetings in particular.

Conclusion

The Open Dialogue (OD) approach was initially developed as an intervention for first-episode psychotic crises applied at the beginning of the community's first treatment meeting. The focus in such applications is treatment meetings that are initiated by professional providers. The findings in our study from the application of "*Open Dialogue behind locked doors*" suggest the merits of the OD approach with inpatients in a locked hospital unit. Network meetings with patients as their initiators make this application different from the community's usual practice.

The findings show that the approach can develop confidence in patients, relatives, and professionals regarding the power of dialogue, it can engage them in mutual, therapeutic collaboration and conversation, and it can enable them to experience sharing, hope, and new ways of seeing and listening to each other. The practice of the OD approach through network meetings in which the patient assumes the role of the initiator and inviter is an application in a new context of mental health care that integrates traditional psychiatric discourses with network meetings. A more systematic examination of the effects of such application will benefit the approach's further integration into various forms of psychiatric and mental health care.

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Citation

Abstract

"Open Dialogue behind locked doors" – exploring patients', family members', and professionals' experiences with network meetings in a locked psychiatric hospital unit: A qualitative study

This paper explores and describes the experiences of patients, family members, and professionals with the Open Dialogue approach to network meetings at a locked psychiatric hospital unit in Norway. Previous research on Open Dialogue has mostly focused on acute crises in community care contexts. In this article, we discuss the participants' experiences with Open Dialogue in a new context; that is in an inpatient locked unit. The inpatients are suffering from severe mental illness and might have been admitted to the unit against their will. The study has a qualitative design. Data were collected through a focus group interview with professionals and from written evaluations by patients and their families. Data were analyzed using systematic text condensation. The findings suggest that the Open Dialogue approach is largely a positive experience for patients, family members, and professionals in a locked psychiatric unit.

Keywords: inpatient treatment, network meetings, Open Dialogue,

qualitative study.

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