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The puzzle of therapeutic emplotment: creating a shared clinical plot through interprofessional interaction in biopsychosocial pain rehabilitation

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ABSTRACT

Interprofessional collaboration is increasingly encouraged and studied. However, there remains a need to broaden the understanding of professionals' contributions through their day-to-day interactions to minimize the impact of professional boundaries that evoke gaps in patient care. Drawing upon narrative theory emphasizing therapeutic emplotment, this ethnographic study explores how professionals contribute to interprofessional collaboration through social interactions during teamwork. Data collection was undertaken in a biopsychosocial pain rehabilitation ward in a hospital in Norway in 2016, and included participant observation of the ward-based work of two teams, and interviews with professionals from six professions (12) and patients (7). Formal and informal interprofessional interactions and patient encounters were observed. The study found that through interactions, the professionals' shared their understandings across all professions about the successfulness of their own work and of what outsider professionals were doing incorrectly when addressing patients from a biomedical approach. Imbued in these interactions were the pieces of an implicit shared clinical plot for their patients' journeys through rehabilitation and life afterwards. We argue that creating the shared clinical plot enhances conciliation across professions and interpersonal motivation to carry out the work. A struggle between perspectives in interprofessional collaboration should not be prematurely interpreted as an obstruction to collaboration, since the struggle can imbue essential narrative work. This extends the theoretical study of therapeutic emplotment as a central motivational process in interprofessional collaboration in teams.

1. Introduction

During the last decade, interprofessional collaboration in health care has been increasingly encouraged and followed by a cumulating academic interest and number of studies (Reeves and Hean, 2013; Schot et al., 2019; World Health Organization, 2010). Much focus has been placed on necessary facilitating conditions for collaboration, such as suitable information structures, time, space or clear common rules (Schot et al., 2019). Meanwhile, it has been suggested that, regardless of organizational or policy conditions, interprofessional teams have the potential to improve their collaboration (Mulvale et al., 2016). However, social scientists have argued that how the professionals themselves contribute to collaboration in their day-to-day social encounters is less understood (Croker et al., 2012; Schot et al., 2019). Accounts of the development of awareness about different professional views to overcome gaps in how to best treat patients remain insufficient (Schot et al., 2019). The limited accounts can be linked to calls to broaden the theoretical fundaments of interprofessional collaboration from studies using, for example, social psychology or organizational theories, into applying more sociological and anthropological perspectives (Reeves, 2016; Reeves and Hean, 2013).

Narrative theory has been claimed to be fertile as a lens to understand professionals' contributions to collaboration (Clark, 2014). Across branches of narrative theory, one way mentioned that professionals contribute to overcome gaps in how to best treat patients is the creation of shared narratives, which helps the professionals to understand what they have in common through framing problems and solutions (Crossby and Bryson, 2005; Del Vecchio Good et al., 1994; Kohn, 2000; Loftus and Greenhalgh, 2010; Martin et al., 2009; Schot et al., 2019). Similarly, professionals have been found to create narratives with their patients (Charon, 2010; Del Vecchio Good et al., 1994; Loftus and Greenhalgh, 2010; Mattingly, 1994). In creating shared narratives, the lens of

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therapeutic emplotment takes on a particularly vivid nature since it incorporates narratives that are not only told but also implicitly created through interactions, while enhancing the desire to move forward in the narrative together (Mattingly, 1994, 1998).

Mattingly (1991, 1994, 1998) found through studies on occupational therapists' work in rehabilitation that a therapist and patient could transform ordinary actions in their encounters into meaningful steps in a new unfolding story of the patient's life. Visions for a plot grew out of the therapists' implicit questioning about what similar stories he or she had been involved in, which is reusable in the present case to find answers to how the story should end (Mattingly, 1998, p. 72). The main reason for making therapeutic plots is to build a desire to move together in the same direction over time (Mattingly, 1998). These clinical plots, which were not generally explicitly expressed or clearly articulated in the minds of either the therapist or patient, could be read from observing the entirety of their clinical interaction (Mattingly, 1994; Tropea, 2012). Meanwhile an unsolved puzzle remains, since investigations into what mediates the therapists' preferred visions for a plot are scarce and, according to Wade (2015a), rehabilitation is often not a single therapist–patient journey, but a collaborative process involving multiple professions. This leads to the question of how is it possible for the involved actors to create a sense of being in the same story together (Mattingly, 1994), when practicing interprofessional collaboration. This ethnographic study explores how professionals contribute to interprofessional collaboration in their day-to-day interactions during teamwork using a narrative lens that emphasizes therapeutic emplotment.

1.1. The narrative lens of the study

In the narrative lens of the study, we emphasize therapeutic emplotment, while including various other perspectives to broaden the understanding of what was happening between the professionals in collaboration. When Mattingly (1994) introduced therapeutic emplotment, it was a new way of viewing the interaction between therapist and patient (Tropea, 2012). Therapeutic emplotment was based on Ricour's (1984) narrative theory that views action as a quest for narrative, interlaced with a wide range of sources, such as literary theory, hermeneutics and anthropological studies of narrative (Mattingly, 1998).

Emplotment is when creating a whole and giving meaning to what would otherwise be a series of events. Emplotted events become stories (Mattingly, 1998; Ricour, 1984), while the plot is a compact causal argument (Mattingly, 1998) of a story. Unique to Mattingly's (1994) use of emplotment was its direct transfer to social action, which differs from its earlier usage on texts. The stories created during therapy were based on clinical plots and the effort to create stories was known as "therapeutic emplotment". To explain how this story making enhances the desire to move forward, Mattingly (1994) brought in folklorist Propp's (1962) literary theory which shows narrative time as dramatic and organized within the gap between where we are now and the desired ending. According to Propp (1962), the indispensable drama of a narrative grows out of an insufficiency or lack in the victim, which can be caused by a villain or other events. The suffering of the victim makes the hero desire to go on a quest to fulfill the lack. A victim can also be the hero in their own quest. When this becomes a desire to move forward together, we find it to be a form of interpersonal motivation, which is relevant when exploring the contributions of professionals to their collaboration.

Few studies informed by the narrative insights of therapeutic emplotment have been conducted. However, a link was drawn early on to plot-making between collaborating professionals when Del Vecchio Good et al. (1994) found physicians treating patients with cancer to have multiple subplots for different audiences, one of which was "professional narratives" shared among colleagues. These plots were different to those developed with the patients as they were more explicit about possible time and horizons based on research and clinical experience. The process of co-creation was not, however, elaborated on. Later, Kohn (2000) found that the diverse professionals in her study emplotted their actions along a particular plot. The plot was identified by the emphasis placed on the idea during team meetings and informal communication. How the plot was developed was not further explored as she investigated the emplotment in encounters with patients. More recently, Tropea (2012) has argued that there is enough evidence to broaden the scope of studies on therapeutic emplotment to a wide range of professional groups and clinical settings.

We believe that the creation of visions for plots that collaborating professionals bring into patient encounters are not sufficiently accounted for in research based on knowledge of therapeutic emplotment. We therefore bring in Loftus and Greenhalgh's (2010) idea of professionals developing masterplots for archetypical patient cases to simplify the process of understanding problems and solutions. These plots are found in single-profession settings, carrying the culture of the distinct profession involved in their creation (Clark, 2014; Loftus and Greenhalgh, 2010). The value of this idea for the current study involves rethinking the origin of the professionals' visions for plots and pointing out how the hoped-for endings may be general across patients and common among collaborating professionals. Furthermore, when Mattingly (1998) elaborated on the process of emplotting and creating a plot through "significant experiences", she used many examples of how therapists strive to direct the meaning of interactions towards an episode of a larger story. To some degree, these examples help identify what ways of acting together this narrative work consists of. As a practical supplement, we find Gubrium and Holstein's (2009) elaboration on aspects of narrative work and contextual influences inspiring and adaptable to narrative constructing actions, in addition to the telling of stories. Such aspects include controlling a narrative through the silencing of stories, parallel to avoiding certain actions. Concurrently, it is presumable that therapeutic plots are created in interprofessional teamwork, although the process of creation remains to be explored.

1.2. Interprofessional teamwork in biopsychosocial pain rehabilitation

Interprofessional collaboration is an ongoing partnership between people from distinctive professional cultures who work together to solve problems and provide services (Morgan et al., 2015, p. 1218), when the label is used as an umbrella term for interprofessional practices. The collaboration in the field of this study can be categorized as "interprofessional teamwork", characterized by a high level of interdependence between team members, shared commitment, shared team identity, clear roles and responsibility, clear goals and integration between work practices (Xyrichis et al., 2018). Each profession has their own knowledge base for carrying out the profession, as well as for collaboration and communication (Almås and Ødeg), which can complement each other to give optimal services (World Health Organization, 2010). Negotiation and competition for professional jurisdictional boundaries, in order to achieve exclusive control over professional expertise, has been found to be central to the work and being of professions (Abbott, 1988), while the struggle and boundaries also obstruct collaboration (Powell and Davies, 2012; Schot et al., 2019). In contrast, the use of a wide range of boundary objects can potentially promote collaboration (Allen, 2009; Bishop, 2019). These objects, whether abstract or concrete, must be adaptable to all involved viewpoints, while also maintaining the different identities of the collaborating groups (Star and Griesemer, 1989; Star, 2010).

The differing worldviews of different professions can take on a more psychosocial or more biomedical perspective on health (Clark, 2014). Engel (1977) introduced the biopsychosocial model as an alternative to the traditional biomedical view in medicine. Despite this, in contemporary western societies, most people, including health care workers, use a biomedical model focused on disease that expects external treatment to cure disease. However, in rehabilitation, a biopsychosocial model is argued to be better suited to understand illness and healing, as it takes into account a wide range of factors affecting disability and

behavior, with disease being only one such factor (Wade, 2015b).

For the purposes of this study, the field was a hospital biopsychosocial pain rehabilitation unit, bringing in the biopsychosocial perspective on pain and rehabilitation as an issue in interprofessional collaboration. The intention of biopsychosocial pain rehabilitation is to provide an optimal service by incorporating multiple factors into an interprofessional approach to meet the complexity of persistent pain (Kamper et al., 2015; Kerns et al., 2008). This reflects the definition of pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey, 1994, p. 210). Previous studies have shown that biopsychosocial pain rehabilitation has an effect on pain and disability in patients suffering from chronic low back pain (Kamper et al., 2015; Koele et al., 2014). However, professionals may still have miscellaneous perspectives on pain as the basis for how the patient is encountered, and these have a major impact on outcomes such as function and quality of life (Boersma et al., 2014; Turk, 2014). Pain rehabilitation involves a variety of professions, components and collaborative practices, while knowledge informing the design of the service is scarce (Kamper et al., 2015). Ward-based biopsychosocial pain rehabilitation offers an abundant context from which to explore professionals' contributions through their day-to-day collaborative interactions during interprofessional teamwork.

2. Methodology

This paper is based on findings from an overall ethnographic research project that enabled the exploration of social processes characterizing interprofessional collaboration (Hammersley and Atkinson, 2007; Holstein and Gubrium, 2008; Morgan et al., 2015). Fieldwork was undertaken in a biopsychosocial pain rehabilitation in-patient ward at a hospital in Norway with a close-knit team setting (Schot et al., 2019). In this paper, the focus is on the social processes between the professionals, while an exploration of the collaborative enactment with patients will be presented in a later paper.

2.1. Research ethics

The study was approved by the hospital's data protection officials on behalf of the Norwegian Data Protection Authority, in collaboration with the Regional Committee for Medical and Health Research Ethics. Participants were informed through information sheets and signed a letter of informed consent. The first author informed the professionals in meetings and was present for dialogue with all participants.

2.2. Study setting

The setting was selected to reflect the complexity of interprofessional biopsychosocial pain rehabilitation, typically involving multiple professions providing a variety of components in a collaborative design (Kamper et al., 2015). Two teams consisting of physiotherapists, occupational therapists, registered nurses, psychologists, social workers and medical doctors were active in the ward. Some had functions across both teams. Their patients had persistent pain due to a wide range of conditions or had no physiological findings to explain the pain. Pain can be defined as persistent when lasting for more than three months (Rosenquist et al., 2016). To be included in the rehabilitation program, patients had to be evaluated as having completed the examination phase for the cause of their pain, motivated for a biopsychosocial approach, and in need of interprofessional services. One team only had patients following an individual program, while the other team carried out a group-based program, but also had some individual admissions. The program lasted for about a year, where patients would stay in the ward for approximately four periods lasting from one to four weeks. The approach was cognitive and coping-oriented, combined with physical activity and patient education.

2.3. Data collection and participants

Data were collected (2016) by the first author through participant observation over a period of 19 weeks (40 days), and interviews with professionals (12) and patients (7). Participants comprised a total of 19 professionals and 26 patients. The actions and accounts of two interprofessional intertwined teams and their encounters with patients were explored.

2.3.1. Observation

Observation was undertaken of formal and informal interprofessional meetings, activities in interprofessional offices, interprofessional written reports, and patient contact such as training, counselling, and physical and social activities. When writing field notes, the first author was mindful of interchanging attention on the content of stories, surroundings, words used, and how the social atmosphere and non-verbal interactions unfolded. The field notes had a scope of 51,010 words.

2.3.2. Interviews

After one month of observation, the first author conducted semi-structured individual interviews based on interview guides with open-ended questions. These were conducted intermittently throughout the rest of the fieldwork to ensure accounts were obtained of observed actions, thus broadening the understanding of the social processes (Rubin and Rubin, 2012). Interviews were recorded and transcribed verbatim. Two professionals from each of the six professions were interviewed to ensure varying accounts from all the professions included. Professionals were recruited based on lengthier experience or distinct perspectives needed to broaden the data. Seven patients were interviewed to ensure that accounts were obtained of their perspectives on the work of the professionals, representing perspectives from both group-based and individual admissions, and patients with various pain backgrounds. Patients who were interviewed were suggested by and recruited through one of the professionals, based on the requests of the first author.

2.4. Data analysis

The analysis was conducted abductively (Timmermans and Tavory, 2012) and all authors discussed the analysis iteratively throughout the research process. The abductive approach was combined with a reflexive thematic analysis (Braun and Clark, 2006) in order to offer a pragmatic guide with theoretical flexibility compatible to constructionism, while allowing a switch between a data and theory-driven approach.

An initial thematic analysis (Braun and Clarke, 2006) was commenced by the first author during fieldwork, where ideas relevant to exploring social processes in the teamwork were written down. An example is the idea of a shared understanding of a right and wrong way of approaching patients. Influenced by the ideas identified, the first author generated initial codes and themes across field notes and transcribed interviews using the qualitative analysis software HyperRESEARCH (ResearchWare, 2019). At this stage, the analysis was to a large extent data-driven in identifying themes, while also interpretive due to looking for latent themes based on underlying explanations (Braun and Clark, 2006; Holstein and Gubrium, 2008).

The focus on the narrative nature of the collaboration emerged through discussion on how the professionals seemed to be striving to follow a joint story about their approach, which resembled Mattingly's (1994, 1998) work. At this stage, the analysis became more theory-driven and inspired by Gubrium and Holstein's (2009) narrative analysis, where in particular the linkage of stories to the context was fruitful when identifying a plot to explain the present themes.

3. Findings

We found the professionals contributing in a complex manner through ordinary interactions concerning 1) their own successfulness

and 2) the incorrectness of other professionals. Using a narrative lens, we identified the components of a clinical plot imbued in the interactions. We argue that creating a shared clinical plot enhances conciliation across professions and a desire to carry out the work. In the end of the findings section we bring it all together with an outline of the plot.

3.1. Their own successfulness

In day-to-day interactions, the professionals placed considerable emphasis on their own successfulness, in which we identified interactional means used in the narrative work of creating a shared plot. These interactions are illustrated and the narrative work explained below.

3.1.1. Letting eagerness endure

When team A gathered for one of the scheduled weekly meetings, they typically sat down quietly around the table in the yellow-lighted basement of the building. Time was valuable as they had many patients to talk about in this brief hour. They would proceed routinely through some patient cases, led by first one and then the other medical doctor, presenting information about each patient involving earlier and current pain, diseases, examinations, treatment and life situation. The lengthiness depended on how new the patient was to the program or whether special difficulties had appeared, whereupon other professionals would supplement with observations and views. Underway, time was managed by the team coordinator, a physiotherapist, who urged the need to proceed or prioritize. Most often, they focused much more on aspects other than the pain, and placed special emphasis on how the patient's motivation to follow their program was developing. Their patient cases would often be complex and with motivational difficulties, as clear from the dialogue during a team meeting:

> Dr. A: "The patient has radiating pain down her arms. She has had surgery several times with a strut graft in her neck. There is pressure on nerve root T5T6." (…). Physiotherapist: "Should this patient even be here, considering the fact that she travels around the world to undergo new exams?" Team coordinator: "She is not in touch with reality when she does this." Dr. A: "The patient has tried a lot of different treatments." Team coordinator: "If the patient constantly receives new treatments and does not get better, she is going in circles!" (…) They talk about the patient using methadone, which may be due to the pain condition, but without a drug addiction. (…) Nurse: "I think that she seems depressed and affected [by the methadone]." (…) The psychologist mentions how the patient may suffer from learned helplessness and that she has sleep problems. (Field notes, interprofessional meeting)

The dialogue about the patients' lives seemed unpleasant, as it dealt with e.g., loss of ability to obtain everyday activities, failing treatment and reduced employability. Then suddenly, at the trace of a positive input, the atmosphere would grow more optimistic, where eager storytelling about the successfulness of their rehabilitation program could take place. Meetings could derail into digressions about how research supported their approach, and there was agreement across the professions that dealing with the psychological and social aspects of pain carried great value.

> The team coordinator and psychologist talk together about how it is not always wise to conduct so many examinations. Psychologist: "If you scan your brain, you may discover lots of things you do not want to know." One of the physiotherapists joins in by telling them about a study in which they scanned the backs of men with and without back pain and 60% of the men without pain had pathological findings. In 80% of the men with pain, there were findings, but not a clear connection. They agree that it is obvious that the psychological and social aspects are of great importance here." (Field notes, interprofessional meeting)

Positive input could be the patients expressing views aligned with the views of most team members:

> This patient has been to a pain management course earlier and still has a lot of knowledge from that. Dr. A: "That was many years ago and the patient followed this for many years, but has not done so in recent years. Now she wants help to be able to use this approach once again." They talk about how the patient loves writing and writes a lot, but it can be painful. Team coordinator: "The OT will look at her writing technique." The patient's understanding of the situation impresses them. The atmosphere in the group seems relaxed and happy. They smile and talk in happy voices. The physiotherapist holds up a sheet of paper: "She wrote this about what she wants to learn and achieve during her stay!" (Field notes, interprofessional meeting)

Recurrently allowing eagerness about success to endure during meetings, despite being pressed for time and having a team coordinator manage progress, is a type of interaction that entails an aim of controlling to promote preferred narratives (Holstein and Gubrium, 2008). As a rhetorical act, this can, according to Mattingly (1998), be viewed as an attempt to subtly persuade those involved into experiencing an ordinary event as significant episode in the narrative about their work. In the focus on their own successfulness, there was a view that the professionals conceived as desirable, which was socially rewarding to join.

3.1.2. Conciliated collaboration on creating patient narratives

The right view for patients was being convinced about the biopsychosocial explanation for their pain and solving the situation by taking responsibility themselves. They should use tools that the professionals believed would enhance their quality of life, such as awareness of balance in activities and social relations, mindfulness, physical training and elements from cognitive therapy. With this said, they would often live on with some pain and could struggle back and forth between the new and the old view of their situation. A divergence in views could occur between professionals and patients, as expressed by an occupational therapist in an interview about a patient requesting a wheelchair to relieve pain:

> So, I'm thinking: what is this? Is it about the need for a wheelchair to make visible that I have an illness? .. Which is completely real, because it is not visible that they are in pain, and that is a problem for many. (…) … But professionally, it is difficult to vouch for giving an aid that you know will immobilize a person so that in the long run, their function will worsen. (Occupational therapist, interview)

Among the professionals, however, there was widespread agreement about the view, as for instance seen in one meeting where the psychologist talked about a patient holding a "one-sided view on pain that was not very biopsychosocial". This meant viewing the pain as solely being a sign of direct physical damage to the body, which should be found and fixed by the health care system. Despite this, he claimed that the patient had a desire to work biopsychosocially with it, giving rise to an optimistic atmosphere where several agreed this was a proper and good start for the patient, without further elaboration. The team coordinator sat at the head of the table with her computer, which she always brought with her to write meeting minutes. She asked: "How should I better formulate that the patient is disoriented about his situation?", bringing about laughter and joking in the group. In this narrative creation, there was sudden agreement on a potential to work biopsychosocially and with such confidence that joking could occur. The interactions generated conciliation across professions to collaborate on creating the content of the narrative (Gubrium and Holstein, 2008). This narrative collaboration can be seen in how there was an opportunity to come forward with alternate possibilities following the first presentation of the patient but, instead, everyone agreed on the turn in the narrative without requiring any elaboration on the clinical reasoning.

In the development of a sense of equality across professions, the biopsychosocial model was a suitable boundary object (Star, 2010) to have in common, as the model holistically considers all components of importance to an illness. Thus, the model increases person-centered care and, consequently, the need for a collaborative and shared approach (Wade and Halligan, 2017). Alongside this, the potential of an often-observed obstruction of collaboration by, for example, defending their own professions (Schot et al., 2019), appeared to be toned down as a result of conciliation about the approach.

3.1.3. Presenting themselves as unique in the health care system

Under times of reflection, such as in interviews or informal talk with the first author, their view on successfulness could flourish into mentioning work in terms of loving it, and portraying their teams as having a special position in the health care system; as being the ones who genuinely understood their suffering group of patients.

> So, they are in such a difficult situation as patients. Therefore, it is also rewarding to work with them. Because we can somehow be representatives of a health care system that understand and recognize their problem. (Occupational therapist, interview)

Many professionals described most of the team members as skilled and holders of unique knowledge necessary to help their group of patients. This was clearly stated by a medical doctor in an interview.

> I have to tell you: I think most of them have understood how to work with those patients. It takes a while; they [the patients] are in a category of their own, in a way. (Medical doctor, interview)

Part of the unique knowledge could be seen in the way the professionals watched their step among both professionals and patients when so often facing a contradicting and tabooed view: the urge to search for a biomedical explanation and a "quick fix" biomedical treatment from the health care system. This view was considered to feed the fire when it came to patients' fear of the pain being a sign of something dangerous and leading patients away from taking responsibility for themselves. The professionals needed the patients to enter a new narrative about what being healed meant and away from what Wade (2015a) characterized as a widespread biomedical view with expectations of external treatment to cure disease. During rehabilitation, the patient may continue to live with pain and disabilities, but the rehabilitation can still be successful since the goal of the process may be to address the challenges experienced (Mattingly, 1994; Wade, 2015b). During an interview, an occupational therapist praised a patient who was able to see her own struggle among the differing views. This woman managed to follow the biopsychosocial solution to a great extent, but would suddenly not feel confident about whether her pain in a limb had been thoroughly examined. Could there be something more to find?

> And she saw that perspective; I'm backing two horses! And sometimes they're close together, other times, I'm very much behind one and then I'm completely behind the other. (Occupational therapist, interview)

Through their interactions and accounts on the successfulness of being distinctive as skilled holders of unique knowledge about their group of patients and who rescued them from continuously seeking a devastating biomedical approach, they presented themselves as heroes. In the social process of considering who is a hero (Frisk, 2019; Scheipers, 2014), these interactions disclosed the heroic role as being conciliated about their biopsychosocial approach, where becoming a hero was obtainable to all professions.

Concurrently, a struggle came to light: the biopsychosocial view was placed in opposition to the widespread biomedical view in society. This struggle on the path towards future visions positions the heroic role as a component of a plot. In terms of Propp's (1968) literary theory, the professionals were "seeking heroes" by seeking to fulfill a lack in the victims. For heroes to want to fulfill the quest of a plot, an identified lack that causes suffering is needed in order to create drama and movement in the narrative (Propp, 1968). At this clinic, the patients had mostly lived with pain for years and had tried multiple treatments. Still, they lacked biopsychosocial rehabilitation, with the hoped-for ending of living empowered lives free of the suffering caused by the eternal search for biomedical solutions.

3.1.4. Evasive maneuvers from certain interventions and conclusions

To achieve a successful turn away from the biomedical search, most of the professionals considered it crucial to put many of the biomedical examinations and treatments in the background or exclude them from further plans, e.g., not conduct further MRI examinations or focus on adjusting pain medication. The exclusion was not to the full extent and was not an official rule nor clearly articulated among the professionals. In a balancing act, such interventions could be considered and were sometimes implemented. In interprofessional meetings, instead of fronting that this kind of intervention should not be used, they would often argue that there was no need for such biomedical interventions because their approach was successful in solving the patient's problems. This was exemplified at a team B meeting where a medical doctor talked about a patient who consistently scored 8 on a pain scale from 0 to 10. The doctor was worried because he thought this was too high, leading him to consider a new MRI. This reflection was countered by a physiotherapist being very clear that the patient did not need further examinations because even though 8 was high, they saw such numbers in many patients, and she said "he is very afraid and tense but has such positive changes during exercise! There was a time when he said he was not in pain. There is a lot that can be worked on and changed." After this, nothing more was said about further examinations.

Success was not measured on pain scales or the like, but was rather an assessment of what the individual patient needed to experience a better life. Stories of what counted as success thereby varied a great deal, as illustrated in a success story about a patient told by a nurse during an interview:

> She had a much better life, so she said: I'm in exactly the same pain as when I first came here, but I have a much better life. (…) and she said: before, I could raise my arm up to shoulder height, now I can lift my arm high above my head! And she had done things with her family and travelled and … And it went well. She was not in more pain, nor in less pain, but she had a better life and was very happy and content and said: I don't need you anymore. (Registered nurse, interview)

By combining different stories about a healed future and not drawing conclusions about expected outcomes, the possibilities for healing remained open, despite the potential insolvability of the pain. To understand the rhetorical power and narrative significance of these evasive maneuvers, we found inspiration in the similar tactics of telling varying and inconclusive stories found by Good and Del Vecchio Good (1994) in illness narratives when preserving one's own hope for a healed future. Our findings show a professional use of such tactics through social evasive actions. This allowed for interpretive gaps to be filled by the patient's visions about a good quality of life and whether the pain might dissolve in the future. According to Loftus and Greenhalgh (2010), interpretive gaps are always present in narratives, as such gaps are the information left out of a story. However, some narratives farther help to control which information should be considered, such as in the control of future visions created when promoting a biopsychosocial view combined with the avoidance of certain biomedical treatment and conclusions in order to promote hope for a healed future. Earlier research has found that establishing narratives of hope in patients is central to their participation in rehabilitation (Mattingly, 1998; Warren and Manderson, 2008).

The professionals in the pain rehabilitation unit created shared

future visions for their patients, by which possibilities for healing were kept open to a certain degree, although narrowed down by characterizing the right kind of healing for which to hope. To gain access to these details, it was crucial to be exposed to many of the teams' interactions, such as sharing stories in meetings about praising patients' use of the learned tools to handle a life with pain, while referring to patients still in search of biomedical remedy as disoriented. This made it clear that success was characterized by, for example, independence and empowerment, while biomedical solutions should not characterize their future visions. The controlled future vision can be placed within the structure of a therapeutic plot by promoting hope for the patients' healing, which motivated interactions among the professionals in a specific shared direction.

Divergence between the future visions among professionals and between professionals and patients could occur in the rehabilitation unit. In the encounter between therapist and patient, Mattingly (1998) also found that therapeutic emplotment based on the therapist's visions could end in an unfruitful struggle between the patient and therapist, which raises an ethical issue, as the individual personal stories and future visions of patients must be taken into consideration in order to avoid obscuring or losing the specifics of the case (Clark, 2014; Loftus and Greenhalgh, 2010; Mattingly, 1998). Otherwise, patient autonomy and shared decision-making may be lost in the process (Charon, 2014). However, among the professionals themselves, the controlled future visions in which certain interventions should be avoided, imposes a risk of not equally taking into consideration the various knowledge bases and not preserving the individual identity of the collaborating professions.

3.2. The incorrectness of other professionals

Interactions concerning the successfulness of the professionals' own work were found to be closely linked to interactions concerning the incorrectness of other professionals as two sides of the same story.

3.2.1. Controlling the attention away from outsider perspectives

One sunny morning, team B crowded together in a meeting room for their scheduled team meeting. Along came two medical doctors from outside the team who had received a few of their patients during the weekend. The meeting started by the visitors sharing their observations and views, which turned out to be an overly biomedical report for the likings of the team, with much advice about medication. The atmosphere grew tense. Attempts from some team members to change the course of the dialogue by asking about the patients' motivation, were not successful. The team coordinator said: "Our focus is on a cognitive approach, but still, medication is important". All professionals in this normally very talkative team fell silent as the unwanted focus took its grip on the meeting, and was not resolved until the visitors left the room. When the outsiders closed the door behind them, the silence remained for a moment. The two medical doctors from the rehabilitation program sat beside each other. One leaned slightly towards the other saying "cognitive approach" in a low voice, whereupon the other said out loud "I will focus on a cognitive approach", followed by eager agreement from a physiotherapist saying "I support that one hundred percent!" The team coordinator backed this up by stating that the visitors are good at what they do, but did not understand how they worked here. This resonated well in the team as laughter and relief arose and the meeting proceeded as usual. The team coordinator's statement was one that characterized their view about the incorrectness of other professionals.

The meeting illustrates the struggle between the insider biopsychosocial view, which emphasizes a cognitive approach, and the widespread biomedical view in society, while adding a central piece to the implicit plot by bringing in the individual professionals in the vanguard of the biomedical view as a day-to-day challenge. One way the teams countered this was through collective silence, as seen in this meeting with two external medical doctors, which can be viewed as what Gubrium and Holstein (2009) refer to as passively controlling a narrative by refraining from participating in its creation. The team appeared to have had a shared experience that they cared about, where emotional expressions and behavior were aligned among them, pursuing meaning within a larger context. That meaning was made explicit by underscoring a dramatic insider/outsider situation in which the outsiders took an incorrect approach. In narrative terms, the outsiders were the "villains". This event seems to have become a "significant experience", as the actions taken created an experience to care about for the parties involved due to being a component in the drama of a plot (Mattingly, 1998).

To understand the need to create the particular insider/outsider situation in order to motivate the actors in this clinic forward, we emphasize that the possible insolvability of the persistent pain was a challenge to the patients' need to become involved as active contributors in their own healing. The biomedical expectations of health care services to cure disease required them to defend their professional point of view, since patients were given no guarantees of reduced pain. Using the narrative lens of this study, we can see how creating outsider "villains" who caused a lack of correct treatment helps enhance the desire among professionals, and possibly patients, to initiate a new quest. In this new quest, the expectations for a healed future were modeled into a more realistic scenario than the desire for a pain-free life, as experienced before the pain occurred. This was of importance since, according to Wade (2015a), in rehabilitation, therapists must influence patients to have realistic expectations in order to avoid impossible hopes of success that might end in self-fulfilling prophecies of failure.

3.2.2. Referring to uninitiated professionals as a challenge

The professionals told many stories about the incorrect actions performed by other professionals during interviews and in informal conversation. The incorrect actions would typically be to continue to perform examinations to find physiological reasons for the pain after extensive examinations had already been executed. It could also concern only offering patients' biomedical treatment such as pain medication. Very often, as a psychologist pointed out, it concerned addressing the patient with a dualistic view on pain:

> But there are many [health care professionals] out there who maybe have a bit of a dualistic view on it, either the pain is in the body or it is psychological. And much of our job then becomes to maybe clue up a bit in what previous experiences they [the patients] have had, and hopefully contribute to them having new experiences with a more, yes, biopsychosocial thinking. (Psychologist, interview)

The stories were most commonly about health care provided to patients elsewhere, but on a few occasions, they were about professionals from within the teams. In one of the two interprofessional offices, which was packed with desks and computers, the professionals often sat concentrating on writing and reading their documentation. However, the desks never seemed to all be occupied at once, since the professionals went back and forth between meetings and patient encounters. Besides one display device, there were hearing protection earmuffs, which bore witness to how this room could be prone to somewhat interruptive, and more or less work-oriented chit-chat. Here, stories about other professionals' incorrectness could come about, as was the case one morning when a team member talked about one professional who thought differently to the other staff there, and she said: "Just one sentence from a different viewpoint can make the patient insecure! It can break down trust!" When such stories were about colleagues, they were characterized as being short and secretive by for instance, not using names but rather talking in general terms, even though everyone knew who was being referred to.

> Psychologist: "She [a patient] seemed worried about activity. During pain physiology [patient education session], she talked about receiving different messages from different health professionals. (…)

> Physiotherapist: "I felt we [herself and the patient] were a team during strength training … I find it frustrating when I say something else than what the doctor has told her. For example, when I say that a patient should exercise and practice, while the doctor tells her not to strain herself, almost to the point of suggesting the use of a wheelchair! I wish we talked more together." Occupational therapist: "It is often doctors who do not know the patient who give advice that is on the safe side." They continue to talk about this for a little while until the occupational therapist says, "Well, that was "Sophie's" blowout!" They laugh a little and move on to talk about another patient. (Field notes, interprofessional office)

Stories about other professionals' incorrectness were told by all six involved professions in settings such as interviews and informal office conversation. They told stories about members of their own profession, but most often not about the team members. This demonstrated who was an insider or outsider of their heroic teams. Previous literature has shown that professionals in health care tell stories about the incorrect actions of other professionals, called atrocity stories, to demonstrate the boundaries between their profession and other professions (Allen, 2001; Dingwall, 2008; Morriss, 2015), and between the proper and improper members of their own profession (Morriss, 2015). Concurrently, the heroism of professions portrayed through atrocity stories has previously been found to portray members of one's own profession as heroes (Morriss, 2015; Dingwall, 2008), while we also find this to apply to casting an interprofessional team as heroes.

A few of the team members were to a lesser extent aware of or embraced the commonly shared views, putting more focus on biomedical aspects. One norm among most of the professionals was to assure patients that the persistent pain was not a sign of anything dangerous. A team member said in an interview that she struggled, especially when she was new in the job, with telling the patients and doing with the patients what she knew the team wanted her to do, because it did not seem right to her.

> I think maybe one thing that I thought was very difficult at first was to go in and assure them, so they feel safe. All these different pains and this fear of … Some have had a prolapse and are afraid that they will have a permanent injury, and then it is very difficult to say "No, no, it will not happen" when I know it can happen and have had many patients who have been paralyzed after a prolapse. (Member of an interprofessional team, interview)

A professional also explained that she initially had trouble getting fully to grips with what they were doing in the rehabilitation program.

> So, when I came here, it felt like I had been flown to another planet … Because I didn't understand anything. I hardly understood their language. (…) What should I examine? What should I do about it, and what kind of goals do we have? When do we feel it has been a good rehabilitation? Very difficult. (Member of an interprofessional team, interview)

When not familiar with or not embracing the commonly shared views, the professionals sometimes showed less conciliatory behavior and were referred to as a challenge. The conciliated heroes were on a voyage towards the future visions of a plot, despite the outsiders' incorrect biomedical approach, while also depending on the challenge to perform their heroic role and enhance a desire for their work. This dependence was articulated through Propp's (1962) "villains" as those causing an insufficiency or lack in the victim. In creating such villains, interactions on the incorrectness of other professionals were decisive for conciliating the professionals' understanding of their common enemy and the lack and suffering they caused in the patients. The patients' suffering was part of the indispensable drama of the plot, as was the suffering of the professionals from being challenged. By causing a lack of correct treatment in addition to the other deficiencies caused by the pain, the villains enhanced the professionals' desire for a quest that could realistically be solved with their help.

3.3. The plot in the clinic

The clinical plot was intended for their patients' rehabilitation process with the team members in a crucial role: the patients had conducted a prolonged search for the cause of and remedy for persistent pain in the health care system, exposing them to an incorrect biomedical approach from other professionals. The solution was learning tools from each profession in a conciliated team in the biopsychosocial pain rehabilitation program that enable them to handle a life with persistent pain on their own, resulting in them quitting their biomedical search and living with some degree of pain and a better quality of life.

This plot was not outspoken and cannot be illustrated by a single interactional situation in the field. It had to be inferred from the entirety of interactions between the professionals, by which the most ordinary interactions could become significant experiences. In this implicit process, the professionals conducted a threefold act of subtly shaping the social interactions among themselves along a plotline, while creating the plot in the interactional moment and facilitating the continuation of a collaborative process through enhancing a desire for the future.

Kohn (2000) also found a shared plot among the professionals in her study that was meaningful to patients, by which the lens of therapeutic emplotment addressed the shaping of social interaction between the professionals and patients along the plotline. The plot resembled what Loftus and Greenhalgh (2010) called a "masterplot". These findings inspired our identification of a plot in the pain rehabilitation unit. However, we depart from these by finding the plot not only meaningful to the patients, but also to the professionals and created across professions.

4. Conclusion

This paper demonstrates how therapeutic emplotment is not only a process between a therapist and patient in rehabilitation, but also a process that takes place among professionals in collaboration. The professionals had backgrounds from six professions with distinct views on the possibilities for action involving patients. They needed to find a way to achieve a shared understanding of the possibilities and, equally as important, a desire for their work, so that they would be motivated to move forward despite the challenges of their patients' complex conditions and differing professional views. When interacting on their own successfulness and the incorrectness of others, they created a major opportunity for themselves to gain a shared understanding of the possibilities for their work and a desire to continue to perform that work. We identified a narrative structure in how the professionals created a role for themselves as conciliated heroes on a voyage towards a controlled future vision, while the creation of villains who caused a lack was indispensable to the desire for the quest. A struggle between perspectives in interprofessional collaboration should not be prematurely interpreted as an obstruction to collaboration, as the struggle can imbue essential narrative work.

What differentiates this study from the outcomes that could be obtained using other perspectives on co-constructed narratives or shared identity is the identification of a narrative structure in the professionals' shared experiences, which gives rise to an interpersonal future-oriented motivation among them. They became motivated to subtly work to create significant experiences in the ordinary interactions among themselves in order to persuade professionals to view healing and disability in a particular way, enabling progress in the plot of their work together. Adopting this narrative view on interprofessional collaboration can open thinking about how the ordinary interactions matter in day-to-day interpersonal motivation in a complex practice.

Credit author statement

Gudrun Songøygard Battin: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Project administration. Grace Inga Romsland: Conceptualization, Methodology, Formal analysis, Writing – review & editing, Project administration. Bjørg Christiansen: Conceptualization, Methodology, Formal analysis, Writing – review & editing, Project administration.

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