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Exploring service users, families, and professionals' experiences with Open Dialogue in a Portuguese psychosocial rehabilitation unit

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Abstract: Open Dialogue is a collaborative approach that emphasizes the involvement of the person at the center of concern (PCC), their family, and professionals in network meetings to foster mutual understanding and joint decision-making. This study explores the experiences of these three groups during the implementation of Open Dialogue in a Portuguese Psychosocial Rehabilitation Unit. A descriptive qualitative study was conducted with thirteen interviews with four service users, four family members, and five professionals. The participants were selected by purposive non-probabilistic sampling. Data was collected through semi-structured interviews and analyzed through reflexive thematic analysis, using WebQDA software. Four dominant themes emerged: rethinking mental health care, implementation challenges, adherence to principles and impact on PCC, families, and professionals. Challenges included resistance to change, time constraints, and cultural adaptation. Key principles such as flexibility, immediate help, and acceptance of uncertainty were highly valued. Open Dialogue meetings enhanced communication, creating a more humanized therapeutic environment and fostering family involvement and professional collaboration. However, successful implementation requires ongoing training and organizational support.

Keywords: Open dialogue; collaborative approach; psychosocial rehabilitation; implementation; qualitative research.

Open Dialogue (OD) is a collaborative, continuous, and outpatient-oriented intervention approach in mental health that originated in Western Lapland, Finland, in the 1980s (von Peter et al., 2021), rooted in family therapy and dialogical philosophy. OD has garnered international acclaim for its effectiveness, especially in treating acute psychoses (Seikkula et al., 2006). It is now a well-defined system of care accessible to anyone seeking mental health support, in both public and private sectors (HOPEnDialogue, 2023).

In OD, the Person at the Center of Concern (PCC), along with their family and professionals, is involved in treatment planning from the beginning and throughout the therapeutic

process and the network meetings, a core therapeutic element with no pre-defined agenda, aim to foster mutual understanding of the PCC's needs and explore the resources of their social network. This approach empowers transparent, joint decisions for subsequent actions and desired changes through dialogue (Freeman et al., 2019; Seikkula et al., 2006; von Peter et al., 2021).

OD prioritizes community-based treatment over hospitalization (Freeman et al., 2019), and in such instances, the same team continues to work with the individual and their network. Additional interventions, such as individual psychotherapy, medication, nursing, and others, are provided and integrated as necessary (von Peter et al., 2021).

Seven principles were established by the Finnish team for the training, research, and implementation (Olson et al., 2014). These principles not only describe a way of engaging with others, reflecting the dialogical therapeutic style but also provide a framework for organizing mental health services to facilitate dialogue and ensure continuity of care (Bergström et al., 2018): Immediate help: Establish a meeting with the PCC and their network within 24 hours to prioritize outpatient treatment and prevent hospitalization; A social network perspective: Include the PCC, family, significant others, and other relevant individuals in network meetings, adjusting participants as needed over time; Flexibility and mobility: Adapting care to the PCC's needs, collaboratively determining meeting frequency, schedule, duration, and location; Responsibility: The care team ensures continuity and coordination of network meetings with other therapeutic processes; Psychological continuity: Maintain care across outpatient and inpatient settings for as long as necessary; Tolerance of uncertainty: Thoroughly explore care options to avoid premature decisions; Dialogue: Foster a safe, collaborative environment to enhance understanding and meaning without focusing on behavioral change or consensus. (Olson et al., 2014; Seikkula et al., 2006). In Finland, OD's application is embedded in a specific reorganization of the mental health care system (Seikkula et al., 2011). As the model has been implemented, it has been adapted to fit different mental health services and contexts (Freeman et al., 2019; Heumann et al., 2023; Kinane et al., 2022).

The evidence in the treatment of first-episode psychotic disorders is supported by several studies and includes: reduced inpatient stays, lower relapse rates, minimal use of neuroleptic medication, initially and during treatment (Bergström et al., 2018; Seikkula et al., 2006), shorter and less severe psychotic episodes (Bergström et al., 2017; Seikkula et al., 2006), decreased use of psychiatric services (Bergström et al., 2017; Seikkula et al., 2006), fewer disability allowances (Bergström et al., 2018; Seikkula et al., 2006) and stability or improvement in treatment outcomes remained fairly stable or even increased over time (Bergström et al., 2018). Also, OD successfully facilitates the reintegration of participants into work and education (Bergström et al., 2018; Seikkula et al., 2006).

The network meetings can have a profound effect on all participants (Bergström et al., 2018; Buus et al., 2021). Most PCC felt network meetings were different from previous experiences of care where they did not feel listened to or understood, were coerced, or experienced an unpleasant focus on medication (Tribe et al., 2019; Twamley et al., 2021). In turn, the families discovered increased capacity to support their loved ones (Gidugu et al., 2021). They valued the transparency in the process and perceived the network's involvement as a way to diminish stigma, validate concerns, gain diverse perspectives, make joint decisions, understand others, articulate conflicts and interpersonal dynamics, and observe fellow family members collaboratively working toward a shared understanding of the situation (Florence et al., 2021).

Professionals appreciated the opportunity to talk with the PCC without time pressure, fostering mutual respect, autonomy, and self-determination (Tribe et al., 2019), adopting a more democratic stance towards the PCC and their families, leading to greater openness and professional growth (Jacobsen et al., 2023; Skourteli et al., 2023). Positive experiences were reported by most family and network members (Buus et al., 2021).

However, implementing OD can pose some challenges at the organizational and/or individual level. Organizational or cultural norms may resist the principles of OD, making implementation challenging (Tribe et al., 2019). The original approach is associated with the implications for the organization of services to offer flexible and immediate help. This requires a structured organizational framework with an ample number of professionals, appropriate shifts, extended service hours, ongoing care, training, and supervision (Seikkula et al., 2011). Initial costs may be high, but OD proves cost-effective over time by preventing hospitalization and enabling community-based care (Seikkula & Olson, 2003). Other concerns are that increased workload and time constraints contribute to professional reluctance, while logistical challenges exacerbate difficulties in maintaining consistent interactions (Jacobsen et al., 2023).

At the individual level, professionals may resist OD because it challenges their positions and identities, potentially leading to a lack of genuine engagement with dialogism (Buus et al., 2017). Also, embracing uncertainty and co-creating solutions with the PCC may be particularly challenging for professionals accustomed to more structured and directive approaches

(Skourteli et al., 2023). This challenge is also felt by some families and the PCC valuing authority and expecting guidance may find the OD format confusing (Buus et al., 2017). Connecting theory to practice is a broader challenge, as translating OD principles into actionable strategies proves complex (Skourteli et al., 2023). Despite challenges, OD has demonstrated positive outcomes, although, there is limited understanding of PCC, families, and professionals' experiences of implementing the approach, particularly with the network meetings.

OD is a non-manualized, need-adapted approach where flexibility is key (Waters et al., 2021). It follows a set of principles, identified for training, research, and implementation, that are put into use or recombined in various ways depending on the needs of the context (Olson et al., 2014).

In this context, the implementation of OD, inspired by the principles of the approach, was not about restructuring all pre-existing care but facilitating better therapeutic collaboration among professionals, PCC, and the support network. It was developed alongside other existing therapeutic approaches to expand the care offered but adapted to contextual conditions (informed OD).

Although OD has proven effective in crisis services, its application in psychosocial rehabilitation contexts, especially outside of Scandinavian and Anglo-Saxon countries, is little explored. There is a lack of studies that integrate the perspectives of PCCs, families and professionals in services that are not set up as crisis intervention units.

The present study sought to explore the PCC, families, and professionals' experiences during the implementation of OD in a Portuguese Psychosocial Rehabilitation Unit named Mentemovimento.

Methodology

Design

The data was collected in a Psychosocial Rehabilitation Unit, located in S. João da Madeira, which is aimed at people who have experienced significant mental distress, currently stable, but with relational, occupational, and social difficulties remaining. The unit operates during the daytime on weekdays and is not a crisis intervention unit. The main researcher is also a member of the team of mental health professionals. At the time of data collection, mental health professionals were at different levels of training in OD (1st, 2nd or 3rd year).

All the mental health professionals took part in the OD training, and during this, they also had supervision facilitated by an external OD professional. The need to implement the approach was recognized by the institution's management. The costs associated with training have so far been covered by funding.

A qualitative descriptive design was used to cultivate a rich understanding of how the PCC, families, and professionals experienced OD (Bradshaw et al., 2017). Data was analyzed using reflexive thematic analysis, acknowledging that knowledge is always influenced by the researcher. This approach aligns with the understanding that our assumptions, values, and choices inevitably shape the knowledge we create, rather than "discover," as emphasized by Braun et al. (2023). This perspective acknowledges the active role of the researcher in constructing meaning, rather than assuming a detached or purely objective stance. To create transparency, the authors followed the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

The authors of this study, trained in various therapeutic approaches, identified their theoretical orientation as being based on social constructionism, which generally argues that the meaning we attribute to certain aspects of the world is a product of our socio-cultural contexts, understanding that the participants provided insight into their subjective experiences through the interviews provided and in the context of the relationship developed with the study's interviewer. During data collection, a stance was adopted that encouraged the sincere and open sharing of experiences and reflections over time. The authors sought to learn from their presence and always considered the context and relational aspects unique to each story. After all, we do not endorse the notion of universally valid knowledge.

Participants and recruitment

Sampling (non-probabilistic) was guided by a purposive approach, once the research team deliberately invited participants based on specific criteria relevant to the research question.

The location of the interviews was selected by convenience based on their easy accessibility and proximity (Andrade, 2020; Renjith et al., 2021). The inclusion criteria outlined for this study were: being the PCC or a family member participating in OD meetings or being a professional with training or in training

in OD. In turn, participants who experienced language barriers or previous experience with OD were excluded from the study.

A total of thirteen participants were recruited. All the professionals in the Unit were interviewed, as well as all the families and PCCs involved in OD sessions. Each PCC chose the family members they would like to include in the OD sessions, with an average of one to two family members taking part.

Of the families participating in OD meetings and who agreed to take part in the study, at the time of the interviews, one family was no longer being monitored but was included in the data collection. The professionals interviewed had different levels of training in OD. Also, some held advanced degrees in specialized fields of psychology, while others had completed short-term training courses in specific areas.

The sample characterization is depicted in Table 1.

Sample Characterization of Participants

PCC				
Participant	Gender	Age	Time in OD service (years)	Diagnosis given (years)
1	Male	30-40	1	13
2	Male	30-40	1,5	17
3	Male	20-29	1	8
4	Female	20-29	1	6
Families				
Participant	Gender	Age	Time in OD service (years)	Degree of kinship
5	Female	60-70	1,5	Mother
6	Male	60-70	1,5	Father
7	Female	50-59	1	Mother
8	Female	60-70	1	Mother
Professionals				
Participant	Gender	Age	Training in OD (years)	-
9	Female	40-50	~1	-
10	Female	40-50	~1	-
11	Female	30-39	~1	-
12	Female	30-39	~2	-
13	Female	20-29	~1	-

Note: OD – Open Dialogue; PCC – Person at the Center of Concern.

Table 1: Sample Characterization of Participants

A review of the literature on the subject was the initial procedure carried out to understand the current state of knowledge, identify gaps, and build a basis for the study. After completing the literature review, a semi-structured interview guide with open-ended questions was created, reviewed, and approved by a panel of experts in this field and after, the main researcher conducted a pilot test to ensure clarity and completeness. Next, all participants were identified and contacted by telephone by the main researcher, explaining the characteristics of the study and inviting them to participate. Everyone agreed to voluntarily participate in the study and signed the free and informed consent form.

By email, participants received information about the purpose of the study, specific details about their involvement, and contact information for the research team. Along with this communication, a consent form was attached and was carefully reviewed with the participants at the beginning of the interviews, and it was explained that they could withdraw their consent at any time without any prejudice.

Participants were invited for face-to-face interviews, at a mutually convenient time. The environment was carefully organized to ensure a calm and confidential environment, conducive to audio recording and uninterrupted conversation.

Data collection

Semi-structured interviews were chosen as the method of data collection. To explore and understand the individual experiences of the participants, it was crucial to engage in direct conversations with them. Each interview followed the same format and used the same questions, adapted to the different participants. The semi-structured nature allowed for exploration depending on the answers given. These face-to-face interviews took place at the institution in May 2024. The main researcher informed all interviewees that participation was voluntary and obtained written informed consent before study participation. Each interview lasted approximately 60 minutes. All interviews were audio recorded and transcribed verbatim, and field notes were taken.

Data analysis

Audio recordings were transcribed verbatim, and transcripts were analyzed inductively to capture participants' experiences. The main researcher read and re-read transcripts, generating initial codes, which were then organized into recurrent themes. Afterwards, the main researcher temporarily maintained a distance from the data collected, to gain a broader perspective before revisiting and analyzing the data again. This step was further supported and validated by discussing the themes with the research team.

Themes were further refined through writing short theme definitions that capture the scope and core concept of each theme based on its interpretative story. Within each main theme, subthemes were developed to capture important variations and details. This process was not purely based on data. Instead, it combined the data, the knowledge of the literature and all the professional experience of the research team. The reflexive thematic analysis was conducted using the WebQDA software.

Four researchers participated in the study throughout the whole research process, namely the main researcher (a master's student in Occupational Therapy in Mental Health,

with three years' training in OD and the person who conducted the study), a supervisor (an occupational therapist and the main supervisor of the master's thesis) and two co-supervisors, an occupational therapist and a psychologist, who contributed with their technical guidance, discussion and revision of this manuscript, both with training in OD.

Research ethics

This study adhered to the Declaration of Helsinki's ethical standards. Participants were informed of the study's aims and provided written consent, retaining the right to withdraw. Data were anonymized, coded, and stored in password-protected files accessible only to researchers, with plans for permanent destruction post-study. Interview participants were debriefed to ensure transparency and inclusion. Ethical approval was obtained from the E2S, Polytechnic of Porto Ethics Committee (n. CE0044E).

Findings

The results are displayed below (Table 2) and are organized into themes and sub-themes: Rethinking Mental Health Care; Implementation challenges; Adherence to principles; Impact on PCC, families and professionals.

Themes and subthemes
Theme 1: Rethinking Mental Health Care
Use and impact of medication
Motivations for change
Theme 2: Implementation challenges
Traditional healthcare
Lack of time and pressure for quick results
Resistance to change and lack of preparation
Family involvement
Non-hierarchical approach
Theme 3: Adherence to principles
Immediate help
Flexibility and mobility
Embracing uncertainty
Impact of reflections
Multiplicity of voices
Theme 4: Impact on PCC, families and professionals
Co-construction of change
Interactions and communications
Wellbeing and recovery

Table 2: Themes and subthemes

Theme 1: Rethinking Mental Health Care

Subtheme: Use and impact of medication

All the PCCs felt that, throughout their time in previous mental health services, the focus of care was essentially on medication: “I think that sometimes we should focus more on...personal development, we focus more on medication” (P2, PCC); “It should be more usual to pay more attention to the patient, rather than the medication itself” (P4, PCC) stating that they believe care should focus on personal development and acquiring skills, to integrate into the job market and/or study, thus promoting their autonomy:

> Care is focused on medication; it's also focused on abstracting negative thoughts. I think that part of personal development is lost. Trying to do, perhaps, some activities that help people to acquire skills that they may not have, to prepare themselves for an autonomous life, and for people to have skills to be able to find work, to keep a job or study (...) (P2, PCC).

Some PCCs also reported that taking medication can be an obstacle to achieving autonomy and independence, mentioning that the side effects can hinder a person's ability to look after themselves, find work, or study:

> (...) I think that medications are sometimes an obstacle to a person being able to lead an autonomous life. (...) they make people need more rest. Then, often... they take so many medications that they can't be... awake as they should be and be able to work, study or look after themselves (P3, PCC).

Driven by these perspectives, the principal investigator critically reflected on the traditional care model's focus on medication, prompting an examination of her training and the impact of the biomedical model on her interpretations. While initially considering medication an essential resource, the emerging reports and her own experience underscored the necessity of integrating it with strategies that encourage personal development. This realization led to an ongoing re-evaluation of conventional practices in pursuit of a more holistic approach.

Subtheme: Motivations for change

One of the main motivations identified for training was the perceived need to expand care to include greater involvement and collaboration with families and the support network:

> When I started hearing about open dialogue, it was because I was working at the association, and... since it was...a way...of working in which it was perceived that there was a great need here to work with families in addition to working with users (P12, professional).

This need was identified within the association, where the team had already been applying the approach for around two years. Therefore, the decision to take part in the OD training was influenced by an understanding of the importance of aligning with the existing language and practices "(…) and for me to enter into this same language, I needed to start the training" (P10, professional).

Theme 2: Implementation challenges

The results show several challenges associated with implementing OD, both on a personal and/or organizational level.

Subtheme: Traditional healthcare

The change from a traditional approach to OD can be challenging, especially when professionals are conditioned to follow certain protocols and established practices

> We are formatted to do things in a certain way (...) as a social worker I'm also very attached to all the bureaucracies that I can't escape but maybe try to take them and break them down in another way or present them in another way to the beneficiary (P11, professional).

They recognize that a paradigm shift is not easy, especially when it comes to changing established practices within an institution or health system. Resistance from colleagues and the organizational structure is common

> (...) I remember this last training session, having other colleagues who said: we own the services, so we can't just take the approach and say from now on we're all going to do things this way (P11, professional).

However, the professionals emphasize that commitment to change can begin with individual change:

> (...) we do not need to force anyone to do things the same way we do. But if we can manage, individually, to put a little bit of this approach into what we do, sometimes in the simple dynamics and routine that we have as professionals (P11, professional),

incorporating elements of the approach into their daily practice, into the way they interact with people, from the way they listen to people's stories to the way they position themselves about their needs:

> The way I position myself about people's stories, how I receive what people are telling me, why people have come to the service or why they haven't, why they do not want to come to the service. I can't always do that, the way I worked, and the way I work, is very deep-rooted (P11, professional).

Subtheme: Lack of time and pressure for quick results

Lack of time is pointed out as a significant factor contributing to the automation and standardization of care

> Everything is very typified. I think we're still working too much in a very automated way (…) we do not have time to provide care calmly, to be able to listen carefully (P11, professional).

Professionals feel under pressure to complete many tasks in a limited period:

> "Sometimes we're forced to have this script, sometimes we can't even complete it because in one day we have a lot of situations to deal with and so let's prioritize, I just want to know this, this and this. (…) our professional practice is falling very much into this logic of I've done these tasks, my work is done" (P11, professional).

Subtheme: Resistance to change and lack of preparation

Many professionals are used to traditional working methods and may find it difficult to adapt to less standardized approaches "(...) I think this is also a question of changing mentalities. And we know that there is still a lot of resistance (...), especially to medical-centered models" (P9, professional).

One professional mentioned that "(…) being willing not to apply any structure of techniques" (P10, professional) is a challenge for her.

Change can generate constraints and resistance, mainly due to a lack of knowledge and/or training:

> I do not think we're all prepared to see things this way. As we are all very typified someone who challenges this can appear to put up some constraints, and resistance, a lot of it due to unfamiliarity too, because we have spent many years doing things in a very typified way (P11, professional).

The lack of knowledge about the approach on the part of professionals from other organizations can be a significant obstacle to networking:

> It would be very important for open dialogue to be worked on more widely in the network. It's much more difficult to work on open dialogue when the professionals from the other entities that involve us do not know about the approach (P9, professional).

Subtheme: Family involvement

The introduction of a differentiated approach that involves actively inviting families can be met with initial awkwardness or discomfort.

The professionals mentioned that not all families are available or willing to actively participate in the therapeutic process "Our users are, used to going to the services and having consultations that are quicker and one-to-one, where the family isn't always involved or is left on the sidelines. As working with the patient, we also end up finding out who the people of reference are and inviting them to our meetings... this gives us another dynamic that can often be received with some strangeness" (P12, professional), which can hinder adherence and participation in the therapeutic process.

In addition to this challenge, coordinating the schedules of families can make it difficult to coordinate compatible times for meetings "Families aren't always available at the times when our people are attending the association" (P12, professional).

Subtheme: Non-hierarchical approach

The difficulty professionals have in abandoning the position of authority is associated with the fact that "(...) we were taught this way" (P9, professional).

Although the intention is to adopt a horizontal relationship, professionals still tend to take control". There's a problem there that requires resolution. And so, we take on a role. I have the problem there that I must solve" (P9, professional), which creates a complex dichotomy between solving problems and sharing decisions equally.

One participant illustrates the complexity of this dichotomy by recognizing that professionals, because of their training, tend to believe that they are more right in certain aspects:

> You have been taught that this way is the right way and that the other ways are not so right. Maybe, because of that, you think that maybe you're more right about this or that (P2, PCC).

The idea is to value the PCC's narrative, recognizing the person as the expert in their own story

> (...) health professionals do not place themselves as decision-makers. I do not have the right to decide for the other person. The person who brings the narrative is an expert, in their narrative (P12, professional).

However, one participant mentioned the need for a more assertive and occasionally "manipulative" approach to "(...) coerce people more. You must be more manipulative, in the sense of getting people, sometimes, along a not so docile path, to do what they're supposed to do" (P3, PCC) contrasting with other experiences of care:

> (...) sometimes when I go to a psychiatrist, the psychiatrist is cold to me. (...) And he has to be. The profession demands it. Sometimes, when I go to a doctor, he says: 'You have this, and you have to do this' and he doesn't nurture much sympathy (P3, PCC).

On examining this data, the principal investigator realized that the inertia of traditional practices is not merely an organizational obstacle but also reflects the internalization of care models that have become consolidated over time. Reflecting on her journey through training and her own challenges, she understands that it has been, and continues to be, a process of constant questioning. Embracing the principles of the approach has consistently been met with a sense of lightness and the unfamiliar comfort of a safe space. This signifies, above all, recognizing the limitations of traditional models and demonstrating a willingness to rethink practices often internalized as almost immutable truths.

Theme 3: Adherence to principles

Subtheme: Immediate help

Meetings were "scheduled according to the requests that come to us and are scheduled as quickly as possible, depending on our availability" (P11, professional).

One family member mentioned that, for her, mental health care could ideally take on a more dialogical approach and be less focused on drug interventions:

> As my son, in particular, calms down, restructures himself with conversation, ideally and instead of calling the doctor to say that we are here with a crisis (...). For me, the contact wouldn't be with the doctor, but it could be with...a psychologist, a therapist, it could be more along these lines, not medication (P7, family).

Suggesting that this type of care should be more widely available, “being accessible at a time of crisis would be ideal” (P7, family).

This perspective highlights the importance of adapting mental health services to meet people's specific needs, offering flexible and accessible support that is aligned with their preferences.

Subtheme: Flexibility and mobility

The frequency, time, duration, and location of the sessions are discussed among participants

> It's something that's asked and in the logic of what makes the most sense for you, when you feel you should come back here, within what our availability is and the hours we have to provide care and to be at the service (P12, professional)

based on individual awareness of their own needs “We are also the ones who have to be aware of when we need to seek help” (P2, PCC).

On the other hand, one family member expresses her preference for receiving guidance, emphasizing that the personal decision makes no significant difference to her “It makes no difference. I like being told, look, on this day..." (P5, family).

One participant reflects on the freedom and comfort provided by the possibility of deciding when to seek help, in contrast to a more imposing approach:

> It seems to me to be an attempt to give people a certain amount of freedom (...) if this were something, perhaps, imposing, that could lead people to think differently: I have to go, they're there to boss me around (P3, PCC).

The possibility of holding meetings in a home context is mentioned as important since it is recognized that offers valuable insights into the life of the person and the family “And often we are talking to someone without understanding where that person comes from. The home context allows us to observe other things beyond that dialogue” (P9, professional).

This data challenged the principal investigator to recognize the complexity of offering flexibility without falling into the trap of absolute freedom, which, for some, can be perceived as disorienting.

Subtheme: Embracing uncertainty

The OD recognizes that uncertainty is part of the human and therapeutic experience, and that sufficient time is needed for everyone to be heard and for a dialogue to emerge in which the most important issues/experiences for the PCC/network can be addressed, avoiding premature decisions:

> Having to deal with the unpredictable is also something very difficult to do. But I think that if it's done together, it has a different impact. As professionals, we also have a lot of... ambition that what we're working on will have an immediate result. There's that tolerance of uncertainty, that something that might not happen exactly like that is something that has to be built up (P11, professional).

Tolerance of uncertainty is reinforced by creating a space in which everyone involved can feel secure in a joint process “We are effectively building a path together, it makes all the difference for everyone to feel an integral and collaborative part of the process” (P9, professional).

Tolerating uncertainty also implies that professionals do not bring an agenda to meetings “There's no need for external planning” (P12, professional), but rather a willingness and openness to listen and respond to the needs and concerns that arise at that moment. By starting the sessions with questions such as “What brings you here today?” (P12, professional), the professionals create a space where the participants set their agenda and topics of conversation, which increases the feeling of security, but also reinforces the perception that their questions are important and valid “It gives the other person security, capacity and the feeling that they are being seen, that their questions are being considered” (P12, professional).

Subtheme: Impact of reflections

Reflections should be based on what has been said or expressed during the conversation. It is important that the reflections shared are not declarations, opinions, or statements of meaning, but are formulated as ideas or suggestions (van Dieren & Clavero, 2022) “(...) we can disagree here or there. There's nothing wrong with that. (...) This openness is fantastic because... we talk and then in the end no one is judging anyone but they're reflecting on what we've been talking about” (P6, family).

In addition, there is a perception that this moment of sharing promotes trust and transparency among the participants, creating a safe environment “This sharing I think also promotes some trust here and shows that it is a safe place” (P9, professional).

The participants express appreciation for the opportunity for reflection provided by the interaction with the professionals.

They see it as an opportunity to look at and broaden their perspectives "(...) it draws my attention to aspects that I might also have to look at a second time. (...). And it also shows us our image in the mirror. When we're interacting, we do not see it" (P7, family) and to consider different points of view:

> Maybe it also helps us to reflect on our own opinion, that by listening to the opinion of others, maybe we can see a point of view that we hadn't seen before you shared it, maybe we can have a more comprehensive view of things, more differentiated (P2, PCC).

According to the literature, the reflection teams do not give much concrete guidance, but one family member says:

> The fact that they give feedback on the paths and the choices that are being made, what is happening, is also positive because I feel that my son needs constant external confirmation. This is the moment when that happens (P7, family).

The sharing of reflections by professionals is an important contribution to promoting a polyphonic environment, and it is also important to engage in dialogue with the body and sensations. When this happens, professionals can also be transparent about the fact that they feel touched by the participants´ feelings.

> We are very motivated in training, to bring our sensations that are physical, that are bodily, and I feel that this is received as a surprise for those who listen to us and makes us all closer to what the human experience is. It's almost as if some walls have been broken down between therapists and people (P12, professional).

The professionals recognize that this sharing "(...) is important because we are also human and we bring this humanity to the dialogues" (P9, professional).

Subtheme: Multiplicity of voices

OD recognizes the need for a network approach, considering the person as "(...) a multifactorial, multidimensional system (...)" (P12, professional).

From this principle, "(...) it makes perfect sense that the premise is to involve the people who are somehow involved in the therapeutic process of the person asking for help" (P12, professional), believing that "the dynamic influences the patient and vice versa" (P11, professional) and that "despite being a unique and original person, they have different areas of their life, which only when combined form what they truly are" (P13, professional).

All participants had at least one family member present, and whenever possible, other network professionals such as psychologists, psychiatrists, nurses, and social workers were included.

The PCC valued the participation of the network in the meetings: "It helps to seek new goals" (P1, PCC); "It felt good to have the opportunity to connect with my mother" (P3, PCC).

However, two PCCs mentioned that they felt family involvement was seen as a form of intrusion: "She ends up knowing everything about my life, and I do not want that" (P4, PCC).

This highlights potential tensions in the process of identifying who should be included in the network and to what extent their involvement is beneficial or appropriate, although the PCCs chose all the participants in the sessions.

Professionals believe that the network's participation offers the PCC "a greater sense of trust in the services, (...) seeing that everyone is coordinated and almost nothing is hidden (...). This greatly increases the user's security" (P13, professional), besides demonstrating "(…) transparency about the situation" (P7, family) and being considered "highly essential, (...) enriching any work with the user and the family, since each situation is unique and requires a different approach" (P11, professional).

They also felt that "The family is very grateful to be able to participate, to contribute, and to be heard, because many times the family's difficulties do not have a space to be re-signified" (P10, professional).

Without their presence, it might not be possible to access certain information "They bring things that I might never remember or never know if they were not in that dialogue. I'm only hearing one person's perspective" (P9, professional).

Families recognize the importance of their participation "No, I can't stay out of it. The problem is mine too" (P6, family) and that despite different roles between professionals, family, and PCC, there is mutual recognition of them "(...) I know what your place is. And you also know what mine is" (P6, family).

Furthermore, having several therapists (co-therapy) is seen by professionals as supporting the development of polyphony, promoting alternatives, and giving space to different voices.

Professionals felt that "this has an impact on the user and the family and it is very beneficial to have another voice and the conversation between two professionals, in my case, from different areas, I feel that this is very enriching for the

therapeutic process" (P12, professional) and that the possibility of co-therapy expands the possibilities "because if it is at an individual level, it's me, my thoughts, my emotions, and the patients. Together it is much richer" (P10, professional).

Theme 4: Impact on PCC, families and professionals

Subtheme: Co-construction of change

OD promotes a collaborative approach to change, recognizing that both professionals and PCC are active agents in this process "Sharing the responsibility for the process of change with people means recognizing that change is a co-construction process and that professionals are not the only agents of change" (P12, professional).

This perspective promotes a sense of lightness as it removes the pressure on professionals to produce results:

> It is something that is shared and co-constructed together, and that also brings some lightness to the profession itself (…) the view of an 'I' as a tool, as a facilitator, and not an 'I' as responsible for the change in the other (P12, professional).

Furthermore, it is emphasized that instead of professionals focusing on providing answers and quick solutions, the importance of active listening and reflecting on narratives is highlighted:

> There is another issue that has to do with the need, often felt by health professionals, to provide answers, and the approach moves away from this vision. It is more related to active listening, reflecting on the narrative that is brought to us, and these different roles and how this resonates with us, rather than producing results and objectives, strategies that come here to alleviate suffering in a faster and more urgent way (P12, professional), which can allow a deeper understanding of people's needs and experiences.

The ability to slow down and truly connect with people can strengthen the therapeutic relationship. When professionals take the time to listen attentively and respond empathetically to people's concerns, it can increase trust and engagement in the therapeutic process:

> This, by the way the system is organized, is not allowed. It's not because professionals do not want to, but they are not allowed to act in another way. And we have had some references from users who complain about this being very fast, professionals almost not being able to look them in the eyes, writing on the computer, just looking for a list of symptoms and never the narratives (P12, professional).

Professionals also shared how the adoption of OD not only influenced their professional practice but also impacted their personal lives and interpersonal relationships "This approach also helps us in the relationships we create daily because we end up deconstructing many ideas and even the way we manage certain conflicts, how we position ourselves in some family dynamics, or how we are building certain professional relationships, this approach fits into our lives" (P11, professional); "it is a change in the way of being. I think that as professionals and as people too" (P9, professional); "Open dialogue influenced my way of being with others, I think it even influences our personal life, the relationships we maintain in our daily lives" (P13, professional), mentioning improvements in active listening, empathy, and valuing others' concerns as results of this approach "(...) we are much more able to implement active listening, empathy, all those concepts that seem obvious, that should always be included, with open dialogue it seems that everything makes more sense" (P13, professional).

Subtheme: Interactions and communication

The meetings provided a safe and mediated space where families felt comfortable addressing sensitive topics "At home, I do not talk about this. I avoid it. I do not even talk to my husband because we always end up disagreeing" (P5, family) and potentially conflictual ones:

> They serve as a moment where there is mediation and my son feels at ease to talk about issues that he sometimes doesn't touch on in conversations just with me, or that he touches on and gets very inflamed, and here there is attenuation because we are in a space that is not his because we are with people who help in the mediation (P7, family).

Furthermore, the meetings were perceived as a valuable opportunity to know perspectives "Sometimes my parents say things here that they wouldn't say at home (…) and here, I get to know that, which maybe if I didn't come here if I didn't have this meeting, I would remain unaware of (…)" (P2, PCC), concerns, and needs of each other "By making some issues conscious, it takes them out from here. What is done here we then take to the family, and we are all more attentive and we all have that issue more present. And with... the care that we feel that issue deserves" (P7, family), which otherwise might remain unknown.

The improvement in intrafamily communication is perceived by professionals as an opportunity for greater openness, mutual understanding, and problem-solving. They observe a positive change in family dynamics, where everyone feels free to be authentic and genuine

> People feel they can be themselves without judgments, they feel that therapists come free of prejudices and stereotypes (…). And the fact that it ends up being a topic brought by them, but still guided by the professionals, can help them feel more and more at ease to have assertive communication, where it is free from hurting or wounding the other's feelings (P13, professional).

In turn, the family reports feeling supported, valued, and closer to each other due to the opportunity to share and be heard:

> I think my son values very much the fact that we make time to be here, and he feels more accompanied and more loved and more valued, and that also goes outside, it affects him and all of us in the family (P7, family).

Subtheme: Wellbeing and recovery

The OD has been recognized for its positive impact on people's well-being and recovery.

By participating in the meetings, people are encouraged to make decisions about their own lives and identify their own goals "(…) people feel more empowered to make a change, to be able to make their way in a much better way autonomous (…) is the person with experience of mental illness the one who knows best about themselves" (P9, professional).

This empowerment promoted can also contribute to reducing dependence on health services "(…) these are practices that can be implemented at home, when we are not there, so as not to create that perspective of dependence" (P13, professional), strengthening the people's ability to deal with their challenges independently.

Furthermore, OD was also recognized by professionals and PCC as a factor in reducing stigma, since when people feel heard, understood, "here people understand me well" (P1, PCC) and respected in their experiences, this not only strengthens self-esteem but also challenges stigmatized perceptions that can hinder the recovery process:

> I think that open dialogue also comes a lot in this sense of reducing stigma, reducing prejudice, not listening to expressions like people who have an experience of mental illness, they do not know what they want, they will never know what is best for them, they should hardly have an opinion, because they are not in a position to think about it (P13, professional).

The promotion of hope also appears as a fundamental element of the recovery process "I do not see a light at the end of the tunnel, but when I leave here, I leave with the hope of seeing it one day" (P5, family), as it incorporates the ability to believe in one's own ability to recover, as well as the ability and flexibility to act and overcome future obstacles (McCarthy et al., 2023).

OD, by promoting empowerment, hope, autonomy and reducing stigma, can contribute to a greater sense of individual well-being "I feel better, whenever I come here" (P8, family) and in the family "Because he feels good, because I feel good too... Because well-being is also contagious" (P7, family).

These meetings create a symbiosis between the PCC and their families, where the well-being of one directly influences the well-being of the other "Because if a person is as healthy as possible, the family context will be as healthy as possible" (P13, professional).

Finally, after participating in the meetings, a PCC reported feeling improvements in terms of participation in domestic tasks and personal organization, which may indicate an increase in functionality, important aspects in the recovery process "It contributed more positively, the level of recovery, on a cognitive level, on a mental level, on a developmental level, more on a health level, because I recovered a little better (…). I improved in terms of domestic tasks (…)" (P4, PCC).

Reflecting on the impact of OD, the principal investigator recognizes that her trajectory as a researcher, team member, and person has been and continues to be profoundly influenced by it. She realized that true transformation occurs when space is opened up for dialogue, co-responsibility, genuine listening, and presence, where new possibilities emerge when all voices are heard, and a deeper understanding of self unfolds in the presence of others.

Discussion

This study aimed to explore the experiences of PCC, families, and professionals regarding network meetings during the implementation of the OD approach in a Psychosocial Rehabilitation Unit, identifying four dominant themes that illustrate the professionals' experience with the approach and how PCC and families received it: implementation challenges; impact of principles; impact on PCC, families, and professionals.

Overall, the majority of participants reported that their involvement in network meetings was positive, aligning with the findings of Freeman et al. (2019), who concluded that the approach was generally well-received by participants and the network. Additionally, in the study by Wusinich et al. (2020), participants in a community-based mental health program valued the time spent in dialogue and the decreased focus on medication.

The experiences reported by PCC indicate a clear need for reformulation of mental health services, which should go beyond medication and include strategies for personal development and skills acquisition. These findings are consistent with most results published in the literature on previous experiences with mental health care, where participants felt an undesirable focus on medication (Gidugu et al., 2021; Tribe et al., 2019). However, adopting a dialogue-centered approach requires significant changes in the attitudes and practices of professionals as well as organizational restructuring.

Implementation challenges

For professionals, implementing OD represents significant challenges related to changing established practices, lack of time, resistance to change, difficulties in engaging families, and adopting a non-hierarchical approach. Although professionals identified these challenges, resistance to change and non-hierarchical positioning were not significant difficulties for them, unlike what has been described in other studies where the approach often generated resistance from professionals who saw their positions being challenged (Buus et al., 2017; Buus et al., 2021; Kinane et al., 2022).

Additionally, studies have shown that professionals with less formal therapeutic training were often more successful in applying the approach's principles in their work, possibly making it easier for them to adopt the model (Skourteli et al., 2023). As described by Buus et al. (2021) an adjusted organizational preparation is necessary, including institutional willingness and readiness for change, which can be seen in the present study. Furthermore, cultural and contextual adaptations of the approach must be considered, which involves actively incorporating local perspectives and adjusting practices to respect cultural differences (Mosse et al., 2022).

Professionals also emphasized that overcoming challenges requires coordinated commitment, including continuous training, awareness-raising, and gradual adaptation of daily practices to facilitate their involvement and that of other professionals. Furthermore, professionals mentioned that inviting families is sometimes met with strangeness. The exclusion of families from care was also confirmed in the study by Gidugu et al. (2021), where in their previous experiences, they were intentionally or passively excluded from the care provided to their family members. Eassom et al. (2014) highlight various reasons for the absence or scarcity of family involvement in care, including marginalization and distancing from care planning, lack of recognized roles, and/or not being heard.

Impact of principles

The adherence to the principles in OD was reflected in prioritizing immediate assistance, flexibility and mobility, tolerance for uncertainty, impact of reflections, and multiplicity of voices. However, the implementation of these principles posed some challenges, especially regarding the principles of immediate assistance and the network perspective.

Meetings were quickly organized in response to received requests, prioritizing flexibility and the needs of participants. However, as observed in the study by Gidugu et al. (2021), professionals are not solely dedicated to conducting meetings, which can be difficult to organize. Other contextual contingencies relate to the lack of a dedicated means of transportation for conducting meetings outside the institution. Tolerance for uncertainty and dialogism were considered positive aspects of the approach by professionals, with all service users and families mentioning that during meetings, they felt that all their needs were heard, respected, and validated equally. This fact may have resulted from the space created by professionals that allowed for the sharing of multiple perspectives and understandings, as described by Tribe et al. (2019), aligning with the goals of dialogism.

Professionals acknowledged that tolerance for uncertainty is strengthened by creating a safe environment where everyone feels like an integral and collaborative part of the process, where there is no predefined agenda for meetings, but rather availability and openness to listen to and respond to narratives. Reflections, based on what was said during the conversation, formulated as ideas or suggestions, promoted confidence and transparency.

Professionals felt that sharing their own experiences and feelings humanizes the therapeutic process, which, according to Olson et al. (2014), fosters a greater therapeutic connection and prevents being too distant from people. Some participants in the present study expected to receive direct advice and solutions from professionals. Considering the traditional care culture, this result is aligned with the observations of Skourteli et al. (2023), who report that families with a strong belief in

authority and an expectation of being guided by professionals may find the approach format confusing.

Impact on PCC and families

Consistent with the study by Jacobsen et al. (2018), the meetings provided a safe and mediated space, characterized by transparency, where participants could address sensitive and potentially conflicting issues more easily, get to know each other's perspectives, concerns, and needs better, contrasting with their previous experiences of care where they found it difficult to talk about their problems and concerns.

While two participants felt that the presence of the network was seen as an invasion of their privacy, the remaining results showed the opposite, the presence of the network was experienced by families and service users as an improvement in intrafamily communication, accessing multiple perspectives, avoiding premature decisions, understanding others, and slowing down (Florence et al., 2021).

In the study by Tribe et al. (2019), certain PCC, felt the unexpected levels of authenticity and emotional expression were uncomfortable. The PCC noted that the clinicians showed more openness and actively promoted honesty and openness in meetings. However, some PCC felt torn between the desire to be open and the desire to retreat into privacy, with one PCC reporting her experience of the meetings as distressing. Furthermore, the presence of a support network was felt as a way to promote empowerment, hope, autonomy, and stigma reduction (Bergström et al., 2018; Florence et al., 2021; Gidugu et al., 2021).

Hope, in particular, plays a crucial role in enhancing well-being, as emphasized by Murphy (2023). Recovery is understood to encompass two key components: clinical recovery, which involves the reduction of mental health symptoms, and personal recovery, which focuses on fostering well-being and hope for a meaningful life. Recovery is a deeply personal and ongoing process that enables individuals to lead fulfilling lives despite their challenges. Ultimately, hope is a cornerstone for both recovery and well-being, as noted in Acharya & Agius (2017). The interconnection between a PCC's well-being and their family environment underscores the importance of inclusive therapeutic practices. OD advocates for the involvement of family members in the care process, recognizing that a healthy family context can significantly contribute to the PCC's well-being and recovery.

The systematic review of Reupert et al. (2017) analyses interventions that integrate parenting into recovery practices in adult mental health services. The study highlights that the role of families can take different forms, such as increasing the sense of understanding and emotional support, which are essential aspects for well-being. One participant even shared that their involvement in the meetings positively impacted their engagement in day-to-day activities. These results indicate that the principles of OD are aligned with the essential elements that contribute to the recovery process of people with lived mental illness, concurrently with flexibility, a focus on the person, working with the support network, and co-construction of decisions (Jaiswal et al., 2020).

Impact on professionals

The professionals recognized that both they and the PCC are active agents in the therapeutic process, not placing themselves in the role of "solving problems". The shift to a more collaborative way of working in mental health has also been indicated in other studies (Florence et al., 2021; Schubert et al., 2021). However, as professionals tried to adjust to a new way of working, they found it difficult to abandon their more conventional expert and decision-making positions (Einboden et al., 2024).

Additionally, in the study by Schubert et al. (2021), the impact of OD on professional identity was, in some cases, perceived as an exposure and placement of professionals in a vulnerable position, which in the present study was not mentioned by any of the professionals.

Professionals reported that sharing responsibility for change (co-construction) alleviates the pressure on professionals to produce results and that the possibility of slowing down and truly connecting with people strengthened the therapeutic relationship, increasing people's trust and engagement in the process. In general, professionals felt that the approach aligned with their professional and personal values and improved the quality of care, results that were also reported in the study by Tribe et al. (2019). The literature has essentially focused on the need to make positions horizontal between professionals and the people they serve (Seikkula et al., 2006), devoting little or no attention to what occurs between professionals themselves in this process (Buus et al., 2021).

Our findings show that the implementation of OD brings several significant implications for professionals, PCC, and their families and can be seen as a form of democratization of mental health care since professionals see themselves as partners in collaborative and dialogical processes, where they recognize the unique knowledge and skills of PCC and the support network, meeting their needs and rights about their participation in care.

Limitations and future research

The study aimed to explore the experiences of the PCC, families, and professionals regarding the network meetings during the implementation of the approach in a Psychosocial Rehabilitation Unit. The research was conducted during the professional training process; therefore, caution is needed before generalizing the results to other services where the OD practice is already well established. It would be important to explore the internal dynamics among professionals during the implementation of OD.

Furthermore, this study included a small sample of participants at different stages of participation in meetings, with one family having already stopped attending, which on the one hand can create guidelines at a local level, but can make it somewhat difficult to generalize to other contexts. The sample was also not diverse in terms of gender and ethnicity, as most of the participants were predominantly women and all participants were Caucasian, although this reflects the demographics of this organization service users and mental health professionals in general.

The fact that one of the researchers was an integral part of the team (practitioner-researcher) and that the researchers identified the participants may have introduced biases in the sample. Voluntary participation may have been influenced by the fact that participants knew the researcher. On the other hand, a distortion of data towards social desirability would be expected, in our view, especially in the levels of implementation of fidelity criteria.

Additionally, we consider it relevant to evaluate the long-term impact to deepen the understanding of the OD impact in this context and future research should also assess the potential negative impact of network meetings by the OD approach and explore the contributing factors, including challenges related to the implementation of this method, once two participants perceived the presence of the network as an invasion of privacy.

Since one participant said that taking part in the meetings had an impact on her participation in day-to-day activities, it would be pertinent to assess the impact of OD on occupational participation.

Aware of researchers' potential biases, we strove to maintain the plausibility of our interpretation through data triangulation. However, it was not possible to do this due to a lack of control over external factors, such as the participants' time constraints or the fact that some participants had finished the sessions in OD. In addition, it was important to ensure that the research did not prejudice the therapy and vice versa, which was safeguarded through continuous monitoring, flexibility to adjust the methods as necessary, conducting the interviews in a different environment to the one used for the sessions, asking open-ended questions, being available to clarify doubts and ensuring easy access to the main researcher.

Lastly, this study made it possible to evaluate the local implementation of the approach, something that had not been done to date, to become aware of possible changes and adaptations.

Conclusion

The experiences of the participants indicate that the approach was valuable from each of their perspectives. Some elements, including transparency, respect, and collaborative involvement, as well as the promotion of hope and new ways of seeing and hearing others, were fundamental to the satisfaction expressed by the participants. Among the reported strengths, the involvement of the family and the support network stood out as a vital component. In summary, the implementation of OD in a Psychosocial Rehabilitation Unit proved to be a valuable approach, despite the challenges, promoting closer collaboration and a more humanized therapeutic environment. The results suggest that adopting a dialogue-centered approach can significantly improve the quality of mental health care, if it is accompanied by adequate organizational preparation, as well as ongoing training and supervision of professionals.

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