Katia Dupret Søndergaard

INNOVATING MENTAL HEALTH CARE

- A CONFIGURATIVE CASE STUDY IN INTANGIBLE, INCOHERENT AND MULTIPLE EFFORTS

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Innovating mental health care – a configurative case study in intangible, incoherent and multiple efforts

Katia Dupret Søndergaard
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Katia Dupret Søndergaard
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List of publications relating to the thesis

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Part I - Introductions

This thesis investigates innovation processes in mental health care through the lens of micro situations analyses from an Actor-Network theoretical position.
1. Introduction

Initial trajectories

When I was working in the research unit of the psychiatric department of Southern Denmark part of my job was to make contact with psychiatric personnel both through my teaching and through qualitative interviews in order to establish their reasons for leaving their jobs. Through these interactions in these interviews I discovered a strong sense of frustration in the personnel as they described their motivations and reasons for being in the mental health care profession and why they left. They expressed that they were trying to make a difference to the lives of the patients and in some respects this, in practice, had become difficult for them. This sense of frustration has been the motivating puzzle for writing this thesis. The frustration per se, however, is not what I am going to investigate. Rather, I am puzzled and want to understand what this frustration is an expression of in the everyday practices of the mental health care and how the wish to make a difference is translated into these everyday practices. Loaded with this initial drive towards finding out how the personnel themselves tried to surmount their frustration, I started to look for how they might formulate approaches that would take away this frustration in their work.

This search led me to an article in a social psychiatric journal about the treatment approach ‘Open Dialogue’. It was written by a head nurse in charge of a ward that tried to renew its practices around this approach. When reading this article I found a link to the staff members’ search for a solution to the problem of how to reintroduce meaningfulness into their working practices. I wanted to investigate how they found out which practices should be changed and, indeed, how practices could be changed. I was intrigued to investigate what kind of practices psychiatric professionals would find that would be ‘making a difference’. The Open Dialogue approach presented in the article was formulated as proposing an approach that offers this. My curiosity had now shifted from trying to understand what promoted the frustration of the personnel in mental health care to wanting to investigate how mental health care staff aspired to make their practices different in order to surmount this frustration. Many initiatives have been made nation- and worldwide to make treatment better. The Open Dialogue approach is one such initiative. The reason why my investigative trajectory ended with this approach is due to a number of juxtaposed interests and incidents.

Firstly, in brief, the Open Dialogue approach is proposed as an alternative that improves the treatment and, more importantly, makes the approach to the patient better. This formulation of offering itself as an alternative is also linked to a broader
criticism of psychiatry in general that in line with the anti-psychiatric movement of the 70s, to an increasing degree, has been criticised for being objectifying and reductive and therefore only taking into account isolated aspects of the patients’ lives (e.g. Foucault, 1973/1979; Illich, 1976; Schepers-Hughes & Lock, 1987) or for creating whole new conceptualizations of the individual that cut out substantial parts of how one is to understand the whole human being (e.g. Rose, 2007). Further, psychiatric governmentally funded services have been criticised for mixing matters of economic and neo-liberal arguments, framed in terms of individual choice, with understandings of care practices (Mol, 2008). Or for an increasing focus on managerial monitoring strategies rather than focusing on quality in the treatment (Rankin & Campbell, 2006) as represented in the so-called ‘neo-liberal’ era of the health field in general and the mental health field in particular. The Open Dialogue approach adds to this criticism by proposing a mental health care that is based on dialogue rather than standardisations and a decision making process in treatment that is taken collectively with the patient and his or her relatives.

Secondly, the Open Dialogue approach resonates with initiatives focusing on qualitative values that are found in many places in the Danish health care system in general. For example the initiatives formulating value guidelines of respect and autonomy towards the patient found in the national code of conduct for adult psychiatric services in Denmark (Lindhardt & Christensen, 2005) and this is therefore a good initial example to answer how ‘making a difference’ is taken up specifically in this approach.

Thirdly, the county that facilitated the formulation of, and part of the funding for, this research project had taken different steps to encounter the Open Dialogue approach. This is also the reason why I discovered that an outreach team in Southern Zealand, Denmark had actually started the process of introducing Open Dialogue in their daily practices.

Approaching this outreach team with my initial questions and a project outline, the team members explained to me that the introduction of the Open Dialogue approach was an attempt to make a difference in the mental health field. To them Open Dialogue provides an approach that makes mental health care practices more respectful towards the patients and therefore more meaningful to themselves as staff members. In that sense I was given a fantastic opportunity: I was offered the possibility of following this outreach team in their struggles to introduce a treatment approach that offered a

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1 Further explanation of the outreach team is given in chapter 4 introducing the case.
potential solution to their expressed frustration.

For the team, Open Dialogue offers the ethical values that they feel are absent in their existing working routines. The team members’ expression of absence of ethical values in the traditionally organized psychiatric setup links to what has already been raised as a critical issue in the ‘anti-psychiatric movement’ in the 1960s (Laing, 2001/1960)\(^2\) that was briefly mentioned above. In the Open Dialogue approach the team members find ‘respect’, ‘listening’, ‘dialogue’ and ‘inclusion’. To the team members these ethical values should, ideally, come before anything else in psychiatric treatment. Due to prioritizing these values, other more traditionally prevalent issues such as; professional knowledge on psychiatry, hierarchical positions, patient journals, nationally conducted questionnaires and surveys or diagnostics are constructed as secondary or absent in many of my investigations of the practices in this team.

But the story does not end with the innovative efforts. In retrospect something else happened as well. The practice of the Open Dialogue approach disappeared during and after my field work. This was not something that was clear during my field work. However there were signs; during my stay with the team, the team members started to look for other jobs, and resigned. Afterwards, I learned that no managerial decision was taken to keep on trying to apply the principles of Open Dialogue after the disappearance of the people who had introduced it in the first place. In spite of the interesting possibility to pursue this disappearance I have remained loyal to the ethnographic study that was conducted in the first place. The analytical focus is thus not primarily to post-rationalize the cause of events. As such the material at hand had the focus of how the effort to introduce something new was done. The ethnographic material was collected at a certain time and this temporality has to a large extend been kept in the analyses. Also, I do not have the information at hand to explain its disappearance fully. Therefore, the focus remains on how to understand the efforts of something that was initially formulated as being an important contribution to meaningful changes within mental health care practices. Thus, what will be my matter of concern in this text is to investigate how innovating mental health care is a matter of continuous, negotiating efforts.

\(^2\) The movement was most clearly formulated in the 1960s, where the psychiatrists David Cooper and Ronald D. Laing were among its supporters. The term was invented by Cooper in 1967. Laing and Cooper argued for example that schizophrenia is not an objective phenomenon, but an interpretation of the traditional psychiatry and making part of its scholastic diagnosis. Psychotic symptoms are considered as normal reactions in a sick society. The distinction between practitioner and patient was to be dissolved and it was important to go through the mental crisis rather than disrupting it as in traditional psychiatry.
The research problem

These initial trajectories and connections between several points of interests and people with a focus on wanting to change mental health care pointed my research in the direction of investigating how this change is aspired to be obtained and how it is done in practice. The introduction of the Open Dialogue approach is one such attempt at introducing a new ‘good care’ practice to renew and innovate the psychiatric system. To renew and innovate something new needs support. The protagonists of what is argued to be innovated must try to convince others to relate to the new project.

“To get Aramis past the paper phase into the prototype phase, you have to get a whole list of things interested in the project.” (Latour, 1996a, p. 57).

The innovation requires acceptance, participation, time, resources, resolution of eventual conflicts, and other direct or indirect ways of showing support for the initiative. The efforts to persuade others may be difficult and long-lasting. The research problem which the thesis investigates will be to investigate how such an innovation process travels into an already established practice of psychiatric care.

Innovation in classical terms is thought of as an effort by one or more individuals to create economic profit through a qualitative change (Schumpeter 1934 in Darsø, 2001, p. 93). Likewise most models of innovation originally integrated an economic aspect as Schumpeter was an economist. However, innovation models have gained greater scope and flexibility. Innovation can be a new product, a new production process, a new form of organisation or management, and a new form of marketing or general market behaviour (Darsø, 2001, p. 94). One way of trying to include the process element in innovation rather than only the end product is formulated by Van de Ven & Poole (1995):

“...a good process model of innovation development does more than simply define its component events; it strings them together in a particular temporal order and sequence to explain how and why innovations unfold over time.”
(Van de Ven & Poole, 1995, p. 163)

This approach seems to acknowledge that innovation is not only about the end product. However, it also keeps a strictly linear and causal line of explanation. It suggests that innovation is about an accumulative cause of events that added together will bring the end product. Even though it might be that the end product of an innovation process is rational, it does not mean that the innovation process in itself is that too. Innovation processes include both the irrational and the relational aspects of the creation process. And both elements are important to explore in order to understand its creativity and ways of coming into being.

The mental health field has also been the subject of innovation studies. To mention but
Innovation within the field of mental health has been concerned with everything from improving treatment, to introducing new computer technology, to using sports, to training staff members and measuring different types of outputs. I will give an overview of the research themes and approaches in the chapter on innovation and mental health. Briefly, I have found that the approaches that apply innovation to mental health to a great extent resemble and apply slightly amended versions of the definition of innovation presented above. This body of research often reports on studies that have a clear criteria of measurement: what is to be measured and how, and the output: what is to be improved. Thus, most studies that I have come across operate with an approach to innovation processes as something that is linear, accumulative and causal. With linear, I mean linear in time, with accumulative I mean if the working practices are adding something it adds to the productivity, efficiency, knowledge and the value of the work and third by causal I mean that it is often assumed that when influencing working practices with, for example, training staff in a new technology, the causal outcome will be more knowledge in the new technology. In contrast to this reading of the field of innovation and mental health I do not produce neither linear, accumulative nor causal research. I aim to further add three dimensions to this body of research of innovation in mental health. These are multiplicity, heterogeneity and intangibility. These are terms that have a theoretical heritage, and they will be explained in the following.

In order to grasp the multiplicity, when speaking of innovation processes and efforts in the outreach team I do it with reference to the readings of STS and ANT rather than to innovation models specifically. In those readings the irrational but also the material aspect becomes important when investigating innovation processes. As such it has to interest both people and things (Latour, 1996) and the question of added value is therefore not only defined by supply and demand or by management or some other human actor, but by a collective interest. I will come back to this in chapter 2 on the
scientific approach.

An actor network approach to innovation

At its broadest, most general level, this thesis, thus, investigates innovation practices in mental health care. But it is not about innovation in general. Neither is it about overall organisational innovations. Rather, I investigate how a newly introduced mental health treatment approach is attempted to be put into action by a specific group of personnel. It is the struggles of the personnel of the team and their experiences and the destiny of their newly introduced practice that is to be the focus of the thesis.

Actor-Network Theory (ANT) and Science and Technology Studies (STS) have dealt extensively with processes of innovation in socio-technical and technical-scientific systems. To mention but a few: (e.g Bruun Jensen, Lauritsen, & Olesen, 2007; Callon, 1986; Callon & Latour, 1981; Laet & Mol, 2000; Langstrup Nielsen, 2005; Latour, 1987a, 1991/2006, 1993/1984, 1996a, 2005; Latour & Woolgar, 1986/1979; Law & Moser, 1999/2003; Law & Singleton, 2005; Mol, 2002; Mol & Law, 1994; Pols, 2005, 2006; Svenningsen, 2003; Sørensen, 2005). Their field of investigation is vast; from the disappearance of scallops, to artificial insemination, to technologies in class rooms, to Zimbabwean water pumps, to electronic patient records, to the development of aircrafts and subway trains etc. This extensive research in innovation processes is therefore my first reason for choosing ANT and STS as the theoretical and analytical sources of inspiration for this thesis.

STS and ANT research do not only have a vast empirical field of coverage. STS and ANT are not closed theoretical paradigms. They are constantly relating to and negotiating with other theoretical and disciplinary fields and finding inspiration in anthropology, cultural studies, feminist theory, history, information studies, communication and media studies, informatics, educational studies, philosophy, social psychology and sociology. However STS and ANT researchers are strict in their use of specific overall meta-theoretical principles. These shared principles will be elaborated in chapter 5 on analytical resources where ANT is also described as an important constituting contributor to my investigations and part of the broader field of STS. But briefly, for the purpose of introducing my positioning here in the introduction, I divide my inspiration within this scientific field between two sources. These two sources of inspiration are usually named: Traditional ANT (e.g. Callon, 1986; Latour & Woolgar, 1986/1979) and Post-ANT or a Post-Human position (e.g. Bruun Jensen, 2005; Gad, 2005, 2009). The traditional principles of ANT inform the thesis with the principle of generalized symmetry which implies that both humans and non-humans potentially make a difference to the construction of practice. Traditional ANT also initiated the idea that
scientific facts, practices and all phenomena in the world are constructs and therefore applicable to ethnographic analysis (Latour & Woolgar, 1986/1979). The post-ANT position is particularly known for its focus on how scientific facts and practices are fragmented and multiple.

Rather than explaining these concepts in depth here I will take the reader through the description of a few studies that represent each of the above-mentioned positions. Through this I hope to make clear in what way I theoretically and analytically position the analyses of this thesis. The differences and development within the field of STS is, thus, explored through three central empirical contributions: Namely a study of the pasteurization of France which represents classical ANT, and two studies representing a post-ANT position where incoherence and multiplicity are added. These are a study of an allergy to onions and a study of a UK cervical screening programme.

The Pasteurization of France is a classic ANT study about how a scientific innovation became a success (Latour, 1993/1984). Latour’s work is a description about trying to understand how irreversible changes can be explained. The success of the invention of penicillin in this work was explained by there being a supporting heterogenic collectivity. What we learn from this study is that Pasteur’s success depended upon a whole network of forces that were drawn together, including the public hygiene movement, the medical profession, and colonial interest, laboratories, experiments etc. Latour argues here that it is the operation of these forces, in combination with the talented “spokesperson”, Pasteur that disseminated pasteurization worldwide and made it a persuasive and irreversible process.

From this study we learn how the innovation of penicillin was introduced and applied through “drawing things together” (Latour, 1990, 1993/1984). Similarly, in order to understand the efforts3 of the psychiatric personnel to introduce a new treatment approach in their daily working practices, I ask what and how things are drawn together. The result of the efforts of drawing things together I call a ‘configuration’. In line with this thinking, I ask: How is this new treatment approach Open Dialogue configured?

3Throughout the text I use the term “efforts of the team” or “innovative efforts” interchangeably. These terms signify that the team have aspirations and try to make changes in their working practices, but these aspirations are often subtle and not always successful. The term ‘efforts’ therefore signify that the efforts taken to do something different and to make a change is not only a matter of taking an overall decision but is hard and subtle work and is always in movement that meets obstacles, and is in many ways incoherent.
This is one version of innovation applied to the introduction of Open Dialogue which I could present to the reader. However, when listening and observing the outreach team in their efforts to renew their practices, it became clear to me that in order to understand these efforts I could not only raise the question of how things were drawn together. The process of introducing the approach was not only about winning allies. It was also about the quality of what the team wished to change. We need to ask different questions, therefore, in order to learn from what happened in the outreach team.

**Invisible and intangible work**

Traditionally STS and ANT have focused on material and technological processes and have to some extent been criticized, especially by feminist thinkers, for asking questions that forward the position of strong white males or programmes that are likely to remain powerful. These voices started drawing attention to changes in agency in relations between humans and technologies (e.g. Adrian, 2006; Cussins, 1998; Haraway, 1991a; Moser, 2003). However, these researchers’ common concern seems to have been how to talk about humans in human-technological relationships. It has been of central importance in their research to investigate how the agency of these human actors changes. This is indeed interesting, but not my primary concern here. But what I find useful in their approach is what I have translated as an awareness of how to apply the principle of generalized symmetry to entities that have not traditionally caught the attention of STS or ANT research. The principle of symmetry in ANT and STS has been accused, especially by psychologists, of being somewhat programmatic in its focus on materialities (Højgaard & Søndergaard, 2006; Jensen, 2005; Juelskjær, 2009). What I would like to contribute to the debate by this text, however, is not a focus on either humans or non-humans, but rather on the heterogeneity of entities. I take the symmetrical principle further in suggesting that it can be applied to the study of elements in practices that are, like the microbes in Pasteur’s microscope, at first invisible, and through this principle make intangible things such as temporality and silence visible and important to the configuration of practices. The inspiration to do this is taken from the feminist critique and has, thus, opened up an awareness of surprising and “silent work” that also constitutes innovation processes.

Further, the inspiration from STS and ANT research on various innovation processes led me to expect to find the introduction of the Open Dialogue approach mobilized and stabilized with the help of particular highly technological materialities and standardizations. The reason for my expectation is found both in the above-mentioned readings within STS and ANT that claim technologies and materialities to be the “glue of sociality” (e.g. Latour, 1996c) where technologies are seen to bind practices and relations together, and in the organisational history and set up within health care, more
specifically within the psychiatric field. For example clinical evidence, monitoring tools and diagnostic systems are increasingly prevalent in the psychiatric field in the Western world (e.g. Rankin & Campbell, 2006). Contrary to my expectation, it turned out that the ways of configuring Open Dialogue in fact take a distance from those technologies of the medical and psychiatric world. When a practice is configured through taking distance and excluding specific types of materialities and technologies what does it then produce? On the one hand this raises an analytical point, as the conceptualized change does not happen along the ‘hard technological lines’ that we know from the current practices of monitoring, standardizing, diagnostics etc. but rather along lines that, paradoxically, if it does not use those types of technologies, can render itself invisible. My aim and contribution is to show that it is possible to conceptualize innovation processes with an empirical material that seems very transient at times, but that in spite of its transient nature, processes of mobilisations, alignments, translations and black boxing are taking place. My analysis shows that ANT may usefully be applied to mental health practices, as well as showing that what constitutes and innovates practices might, in fact, be much less linear and causal than expected.

Star (1991) is one of the thinkers who has criticised Actor-Network theory for its focus on the central spokesperson in the encountering of successful innovation processes. She argues that socio-technical systems also depend on invisible work to survive and endure. Star (1991) wrote an important story that has been referred to as one of the central contributions in the negotiations of the stories of success. This is a contribution that has developed into what is assembled as post-ANT (Hassard & Law, 1999). Law (1997) has suggested that the primary difference between classical ANT and later ANT-related work has to do with coherence and centredness. Star’s (1991) study was the starting point for this development. What her story shares with the success story of Pasteur is the attendance to the heterogeneity of the elements of what creates the construction of a stabilised practice. But she also adds that these types of studies tend to view the construction of a stabilised practice from the standpoint of the manager, the innovator or the victor (i.e. Pasteur)4. Star (1991) thus accuses classical ANT of managerialism5. She suggests that not only the stories of success should be voiced. The

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4 Another study that can be accused of being managerial is the classical ANT study on scallops in St. Brieux by (Callon, 1986). Where Callon follows the three biologists, not a particular fisherman, nor a particular scallop when arguing for how the scallops regain interest in reproducing themselves in the bay.

5 The target of the managerial criticism seemed first and foremost to be Bruno Latour, with an often mentioned reference to the study on Pasteur. This study is to some extent unfairly denounced. It is much more complex. See for instance the introduction with its reference to Tolstoy and his “War and Peace”, that Latour compares with Pasteur, where Latour writes that “Tolstoy has forever subverted the notion of leader, strategy and chain of command: ‘If in the accounts given us by historians, especially French historians, we find their wars and battles conforming to previously prescribed plans, the only conclusion to be drawn is that their accounts are not true’ (p. 1184).” (Latour, 1993/1984, p.4)
construction of new practices stabilise themselves by constructing certain standards (obligatory passage points) which entities may either easily or with difficulty fit into. The entities that do not easily fit must do a lot of work – in Star’s words, “silent work” – to fit into the practice. As an example Star cites her allergy to onions. Onions are standard in burgers but when asking for a menu without onions, it never appears. She ends up ordering a standard menu (with onions) and scrapes off the onions herself. What she does in this example to get what she wants, i.e. a burger without onion, is what constitutes the silent work, and it is important in order to keep the practice of making burgers stable and standardized. But this is also a kind of work that is almost impossible to notice from a managerial perspective. Another study adding to the multiplicity of networks is Singleton & Michael (1993). Singleton & Michael (1993) have studied the British cervical screening programme. This programme could be approached as managerial in traditional ANT terms. However, Singleton’s fieldwork reveals that the participation of the general practitioner (GP) is fraught with ambivalence because, on the one hand, the general practitioners promote the programme as easy and free of pain and, on the other hand, they know that this is not always the case. To simplify, the success of the programme is due to the GPs and their ability to navigate between conflicting positions. The coherence and stability of the programme, as it appears from the managerial perspective of the health planners, is dependent upon supportive networks which are not visible to them. Contrary to the study on Pasteurization, in the study of the cervical screening programme, things are not drawn together. There is no centre from which everything is organised. And neither is there any higher authorising position that could itself reduce the ambivalent positions of the GP to a singular (pasteurian) mode of practice. The project is a success exactly due to its incoherence and its decentredness.6

To anticipate the critique of ANT as only dealing with large, stable, successful socio-technical systems, Latour responded to this critique in his description of the innovation process of the Parisian subway train, Aramis, which failed (1996a). He describes how it was not any particular actor that did not successfully contribute to the process of innovation but it was the configurations of particular situations that did not work

6 A part from the criticism of managerialism (Star, 1991) and its radical argument on extending the symmetrical analysis to nonhuman actors (Fuller, 1996), ANT has been criticized from various other fronts: For formulating a reductionist theory of subjectivity, science and the world (e.g. Haraway, 1991b). Latour was criticized also by Haraway (1997) for studying only strong, heroic male actors, and so also of reproducing these men even bigger and more heroic while the rest of the world is performed as silent and passive. Some accused ANT of being so preoccupied with productivity and network-building that it could only see what fitted into its images of system builders making their way to power – and that it therefore lost sight of contradictions, ambivalences, and complexities as well as other forms of traffic, agency, being, speaking or reasoning (Singleton, 1993). Yet others criticised ANT for its gender blindness, and failure to study the mutual shaping or co-constructions of gender with science and technology (Juelskjær, 2009). See also Moser, 2003, p. 30 for further critical references.
(Latour, 1999a). The ability of ANT to look at what occurs (or what is done) in particular situations, including people and things in its optic, is adding to the reasons for choosing ANT as an analytical tool for my material in this thesis.

The heterogenic and performative interest means that ‘process’ in STS and ANT terms provides me with the possibility to include elements in the investigation that are not only about human interaction, but also space, meeting routines, absences in practices and silences gain importance. In STS terms this is called a heterogenic or symmetrical approach to investigate practices. Also, with an STS and ANT inspiration to innovation processes I depart from the assumption that it is not a linear nor accumulative process that I will encounter, as Van de Ven and Poole (1995) suggest in the citation above. “Innovation development” in Van de Ven & Pooles writing associates a beginning and an end. The introduction of Open Dialogue does, in some respects, have beginnings and ends, however the focus in this thesis is on how it is constituted in multiple ways in the daily practices and this makes a linear logic inappropriate. Rather than focusing on beginnings and ends I will have a focus on the instantaneous, intangible and subtle efforts that seem to be so important for something substantial to be mobilized and changed. Thus, when asking my question of research, I take all these elements, heterogeneity, multiplicity and subtleties, into account when trying to grasp the efforts of the team to innovate their working practices.

**Research question**

Classical ANT with the example of the pasteurization of France on the one hand, and a Post-ANT position with the allergy to onion and cervical programme on the other, has given me a way into my story about how to understand complexity in the innovation processes and a way to understand how I could begin to grasp the specific complexities at stake when a new practice such as the Open Dialogue approach tries to establish itself. It was not because I started with these studies, but because they methodologically and analytically gave me the tools to ask relevant and interesting questions of the material I had at hand. With these initial stories about heterogenic successes and failures, I would like to attach my story of how the daily struggles of the outreach team introducing the Open Dialogue approach are configured. The researchers mentioned here have provided me with the tools to ask important questions which I aim to unfold and translate into new contributions. In overall terms, the argument of this thesis suggests that the outreach team’s attempt to mobilise a new treatment approach in their daily practices tells us a lot about organising mental health care in general, both at that time and now, and about how we can grasp innovation processes in mental health care practices. I therefore ask the following research questions:
How is the newly introduced treatment approach called ‘Open Dialogue’ configured in the daily working practices of a psychiatric outreach team? And how can its local configurations teach us anything about innovation processes in mental health care?

These research questions will be explored through empirical micro-analyses where I draw on material such as videos, interviews and observations.

In the previous sections I have described the problem which the thesis addresses as a problem of meaningful innovation in mental health care. I will now proceed to discuss how the thesis contributes to the field of Actor-Network-theoretical research within mental health care.

**Care research and its adaptability with ANT/STS**

The Open Dialogue approach is a particular and unique treatment approach that is socio-technical, but it is not a high-technological approach, it is low-technological. It is about how to perform ‘good care’. Within the field of Post-ANT there is an increased awareness on care. My work is positioned within these contributions. This is the fourth reason for choosing an ANT/Post-ANT approach. (The first reason is the extensive research done on innovation processes within ANT and the second reason is its concern with invisible work and its third reason is its performative approach including people and things). The research on care is interesting because it differs from what can be called the highly technological processes that traditionally have been the focus of research about socio-technical innovations. Care is low technology. In many respects it is intangible and invisible, it often involves mechanisms not usually requiring electronic input or much capital. With my work I wish to show how ANT can be applied in studies about care that are configured in intangible and subtle ways.

Whereas there is a plethora of STS and ANT-studies on somatic medicine, there are surprisingly few studies of psychiatry and mental health. In comparison the field of somatic medicine and health in general is widely explored by both STS and ANT scholars. (e.g. Berg & Mol, 1998; Danholt, 2008; Dodier, 1998; Harbers, Mol, & Stollmeijer, 2002; Langstrup Nielsen, 2005; Mol, 2002, 2008; Mol & Law, 1994; Moser, 2007; Moser & Law, 2006; Pols, 2005; Singleton, 2005; Svenningsen, 2003; Timmermans & Berg, 2003; Valentine, 2007). The answer is to be found, of course, in the field of interest in this particular tradition. Namely, the interest in the construction of knowledge around, through and in the midst of technologies. And the somatic medical field is full of technologies and laboratories for that matter. The research within the field of medicine and ANT in the post-ANT era (which, as I have indicated,
was initiated with Star’s allergy to onions example) has indeed focused on the symmetrical relationship between humans and technologies, with two main focus points: Either on what kinds of knowledges are produced by incoherence and decenteredness, (e.g. Mol, 2002, 2008; Singleton, 2005; Singleton & Michael, 1993) or on what types of subjectivities, either for professionals or patients, it produces (e.g. Adrian, 2006; Cussins, 1998; Dodier, 1998; Moser, 2003). However, with the inherent interest in the relationship between technologies and humans one would presume that the field of mental health would be of central interest to the researchers within the STS field as well, precisely because it apparently raises the same questions of concern in respect to relations between humans and technologies.

That area of research, however, seems to be marginal. There are a few studies that I would like to mention here that have been influential on the development of this thesis. Gomart & Hennion (1999) have not written directly on mental health care but on the abandonment of self in drug addiction and amateur music performance. This taught me to focus on “what occurs” rather than on who acts in a practice. What happens in addiction and music performance seems to be specific to understanding how those practices are constituted. Gomart & Hennion (1999) argue that ANT allows the possibility to talk about “action of the collective” without reducing it to the effect of a system or a structure. In Gomart and Hennion’s text (1999) events of occurrence are effects of moments when passionate amateurs enter a certain “dispositif of action”, that is when disciplines create new competencies, (p.220) and the amateurs are transformed by their attachment to that collective (p.225). My focus has not been on how professionals per se are transformed in the newly introduced practices, neither has my focus been on how patients are transformed. However, I have been inspired by Gomart & Hennion’s (1999) conceptualization of the event as an occurrence in order to understand how both heterogenic and human collectivity is produced in my analyses. In this sense Open Dialogue personnel do not abandon forces or agency to the objects, but they abandon forces to the socio-material collectives.7

Several research projects have taken the point of incoherence and decenteredness further in showing how treatments are multiple (e.g. Mol & Law, 1994; Moser, 2007). Further, Berg & Mol (1998) argue in the introduction of the anthology “Differences in medicine” that there is no one medical gaze, logic, discourse and construction of the body, but many. There are only different representations and performances of the body,  

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7 As will be shown, this point is particularly highlighted in the analytical chapters on the intensive naked dialogue and the collective dialogue.
or rather parts of the body – but no original whole from which to reduce (Moser, 2003). One specifically ANT-inspired mental health study was conducted on ADHD (Attention-Deficit/Hyperactivity Disorder) (Hawthorne, 2009). Drawing on ANT, Hawthorne (2009) argues that alliances between groups and individuals with coinciding values establish policies and social structures that contextualize ADHD and help co-construct the diagnosis of ADHD. Another study within the psychiatric diagnostic field combines ANT and social science theory and policy networks. The study analyses the development of a new psychiatric classification DSPD (dangerous and severe personality disorder) in the UK (Manning, 2002). Yet another study investigates how extraordinary experiences among patients diagnosed with schizophrenia, such as encounters with UFOs and of angels, are translated and transformed by professionals within the psychiatric field of knowledge (Terkelsen, Blystad, & Hydle, 2005). The explanatory frame of this study resembles the paradigmatic division between reductionist vs. holistic health care; economic vs. choice etc. that I referred to in the opening section of this chapter. The authors explain that the dominant paradigm in Western psychiatry is grounded in biomedical thinking, and biological explanations appear to take the lead. There has been a shift from a psychological approach to the treatment of such experiences to a biomedical framework, with medication and medicine compliance at its core (ibid.).

These studies, very interesting in their own situated sense seem, however, to replicate very much the theoretical conclusions on multiplicity, heterogeneity and incoherence that have been produced in the recent ANT research on somatic diseases. But what of course should be taken from them are the situated empirical and analytical conclusions that they draw in each study.

A similar study to mine takes an organisational angle, and aims to use methods adapted from readings in ANT to identify organisational interventions necessary for the development of an information infrastructure for inter-organisational mental health services in a Swedish municipality (Timpka, et al., 2007). Three organisational interventions were identified as necessary for the information infrastructure to be successful. With this identification, the researchers concluded that they were necessary for the development of sustainable inter-organisational mental health services with the purpose of correcting (aligning) inconsistencies in mental health policies and strategies between agencies and government departments (Timpka, et al., 2007). The focus in the Timpka et al. (2007) study is directly interventionist in order to find out how to make something become a success. The criterion of success is homogenous alignment across different practices inside the organisation. In comparison, this thesis is not directly interventionist in the sense that it does not attempt to give homogeneous directives as to how Open Dialogue becomes a success or how it comes to align with the inter-organisational psychiatric services. First, I argue that failures are important lessons to
learn from, and should not be omitted. Second, Post-ANT, also within the medical field, has taught us that knowledge production is also happening along incoherent, (not aligned) lines. My study is thus an attempt to capture these elements.

The last study within ANT and mental health care that I will mention here is by Pols (2006). She analyses how accounting (the creation of values of what good health care is) is performed in long-term mental health care practices in the Netherlands, and she studies how it is constructed as a good or a bad thing. How do nurses and other caregivers account in practice, and how does this relate to their aim of making daily care good? The interesting study that Pols (2006) describes in her paper follows the lines of both heterogeneity and inconsistency of mental health care practices.

What Pols (2006) does so beautifully is to make an invisible care practice in (mental) health care visible. The activity of washing the patient is not usually considered as important in mental health care, however, it is performed as such in the daily practices. Dealing with filth is performed more importantly than dealing with hallucinations:

"To quietly hallucinate in a corner is seen as less disruptive than not being clean." (Pols, 2006, p. 413)

In the practices that Pols is describing there is little of her text devoted to the care of washing (Pols, 2006, p. 414). She addresses the lack of text and makes the invisible visible. With this focus and a practice approach she teaches us not to be ignorant or blind to the way the field performs new knowledges. Her study shows that we should keep an awareness of practices that do not fit with our tendency to categorize certain things as important. I will take this idea and try to keep open minded about what elements, such as specific entities and activities, are taken for granted as making a difference for the introduction of Open Dialogue. My ambition, thus, is not to ask if the Open Dialogue approach is effective, but rather as Berg and Mol (1998) suggest, to look for what effects are brought about by the introduction of Open Dialogue. As Pols (2006, p.427) also concludes, these types of approaches also enable analyses that make health care practices understandable without erasing troublesome situations or rendering them invisible.

As the previous section shows, the research done within the mental health field and STS/ANT is rather scarce. The four above mentioned studies are, as far as I know, exhaustive of this combination and represent all that I have been able to find which directly address mental health care. Why is that?

Why are mental health practices of knowledge production not objects of investigation? They are no less filled with technological-human relations than other spheres of research. On the contrary. Possibly there might be a problem for STS and ANT inspired
researchers in translating the types of relations that traditionally occupy the investigation of the soul (Foucault, 2003/1962, 2005/1971; Rose, 1999) that presumably seem rather intangible to researchers who are preoccupied with finding out how things work, and making things visible. As Latour mentions, invisible agency is not an agency (Latour, 2005, p. 53). In comparison, washing as a part of care is not particular to mental health. However, the way it is performed in the study of Pols (2006) could be said to be particular to mental health due to the connections, for example with patient’s resistance or fear towards the activity of washing. But the activity in itself is not particular. In the case of the Open Dialogue treatment approach, I will likewise show that there are practices that are particular to mental health. This particularity is to do with its intangibility and its only slight difference from a very visible but unacknowledged activity, such as washing. It is not that there is not a lot of intangibility in other types of practices. However, due to the mental health care field’s preoccupation with the soul of the patients, it potentially magnifies the intangibility of the practices of care, basically because souls are not visible.

I do not describe how patients’ souls are configured or perceived in the newly introduced treatment approach. However, I do try to describe how this treatment approach configures itself and comes into being, with all its tangibility and intangibility. What I would like to show, and what is part of my aim to contribute to the field of STS and ANT, is that it is possible to address intangibility and to make it visible through an ANT analysis.

In this introduction I have argued that using ANT and STS as my inspiration is based on three things:

1. The heritage of extensive studies of innovation processes within the field of relations between humans and technologies have provided a vast tool kit of analytical concepts and basic approaches to understand these relationships that will be explored further in the analytical resources chapter. Importantly, most studies within the field of innovation and mental health deal with how what people say matters in innovation processes. I would like to describe how actors, like absences of tables, ways of settling into a study group session, silences, absences of technologies etc. not only influence but have an important constituting role in what innovation in mental health care is.

2. The basic meta-theoretical tools provided by ANT and STS enable me to explore the tedious efforts of negotiations in innovation processes such as the Open Dialogue approach. Likewise I would like to explore how innovative processes are not always something that can be predefined and categorized, but develop in unpredictable and surprising ways. Innovation processes in this light are incoherent and multiple.
3. The heritage from the few ANT/STS inspired studies within the field of somatic health, together with critique forwarded by especially feminist scholars, has encouraged me to ask how ANT can be a productive and relevant approach in studies where care as a low-technical human-technology configuration is at its core. This adds to the fact that the existing knowledge within the field of innovation and mental health do not extensively touch upon innovation processes that are difficult to grasp and pinpoint exactly because they are in the making, that are new and therefore often very intangible and difficult to standardize in parameters or indicators. This subtle work is what I would like to address.

Aims

Thus this thesis aims to contribute with an empirically informed conceptualisation of innovation in mental health practices. As such it contributes to both an academic setting and in the professional field in the following ways: Scientifically, practically and politically.

Theoretically I wish to explore how ANT/STS can be a relevant, applied approach. I wish to discuss how research within the field of care, and more specifically within the intangible field of mental health care can be further conceptualized.

Further, in this text the empirical contribution is not thought to be normative in the sense that it does not establish an answer of what good care is. However it is neither apolitical in the sense that this analysis, like the investigations put forward by the ANT and health researchers referred to above, always participates in making certain voices heard and certain types of knowledge salient. The configurations presented in this thesis, thus, offer a way to see innovation processes in health care drawn along multiple lines that are surprising, incoherent and unpredictable rather than along lines that can be defined a priori, standardized and controlled. The practical contribution is a deeper understanding of the possibilities of how professionals in the psychiatric field negotiate the introduction of alternative practices, and the dilemmas they encounter as they struggle to apply these practices. I will through the experiences drawn upon in the analysis formulate some propositions about how, what I come to call: sensitive innovation, can be initiated and run.

Finally, with my analyses I place attention on those difficulties that there are encountered when trying to make alternative practices co-exist with traditional medically informed psychiatric practices. I also raise the question about how such difficulties are created precisely because of the professionals’ own ambitions to create purified spaces of performing the alternative practices. This raises more normative
questions about how we are to organise our mental health care services, what kind of approaches are accepted and how this attracts interest to certain groups of people. After this principal introduction we will now continue to the thesis outline.
Thesis outline

This thesis offers a situated investigation of how the introduction of a new treatment approach happens in practice. More specifically, the thesis investigates how a newly introduced mental health care approach is negotiated and made real and “right” in the practices of the psychiatric team of personnel that I have studied in Southern Denmark.

The thesis is composed of four parts: The first part of the thesis consists of six chapters:

*Introduction* describes the problem of the research and outlines the research question. The introduction also places the contribution of the thesis within a theoretical framework of ANT and within the field of mental health care and innovation studies.

*Style and approach* is discussing the conditions for doing the kind of research that I have been doing. I discuss how knowledge is partial and local and how the criteria of quality in science can be defined along lines of raising interest.

*Innovation studies and mental health care* is giving an overview of the research done within the vast field of mental health and innovation studies. I suggest here that the strength of these studies is that they often provide the reader with a clear definition of what innovation is in terms of how it can be measured. I aim to add three elements to this research: It is sensitivity towards heterogeneity, intangibility and multiplicity.

*Introducing the case study* presents the new treatment approach, called Open Dialogue, as it is described internationally and shows how it has travelled into the organisation where I shadowed an outreach team that has introduced the approach. In overall terms this chapter also forwards the argument that Open Dialogue is introduced in the particular psychiatric organisation at a point in time when it is possible for it to be introduced due to developments and reforms within health care in general.

*Analytical resources* contain the explanation of the meta-theoretical point of departure of this project. It posits that the approach in the thesis does not draw on a specific categorical premise. The meta-theoretical point of departure also implies that this new initiative to change existing practices can only be understood through a local analysis of what people are doing. This in the chapter is described as *performances*. The chapter presents the minimal analytical concept that is the fundamental principle of the thesis, namely the concept of *generalized symmetry*. It is used as an argument that explicitly refrains from defining things in advance of an investigation and, thus, turns towards a more methodological conceptualisation of the use of theory. With the concept of symmetry I discuss the ambition of flattening my analyses in order to not approach individual categories or actors, but rather to focus on what occurs in order to explore the performance of new practices. Thus, the theoretical position of the thesis is constructionist. This means that practices are crafted as effects of multiple network relations, what I conceptualize as *configurations* in the chapter. A third analytical concept is presented in this chapter, namely *actor* derived from a semiotic definition.
that is closely linked to a way of understanding how configurations are taking place. *Methodology and methods* deal with the concrete applications of the analytical positions taken in the chapter on analytical resources. In this chapter I discuss the scientific consequences of having a symmetrical approach. I present how the applied scientific standard as constructionist poses a different scientific ideal that displaces the ideal of producing universal truths by an ambition of producing descriptions of local practice configurations which pose points of interest to certain communities. This chapter also deals with how researcher and empirical material has been co-constructed in a particular time and through a specific rhythm, through geographical movement, and through the slowing down of conversations in the eagerness to draw conclusions or find answers. It explores what kind of material has been produced as a result of this process.

After these introductory chapters, the analytical parts of the thesis follow.

In **part II** of the thesis I present the first body of analyses. These analyses I call ‘*dialogues*’. In these chapters the innovative efforts are composed as different dialogues that refer directly to how ‘dialogue’ in the treatment approach can be understood and made real, and thus I make it clear that the Open dialogue approach cannot be grasped as one singular thing. Further, the chapters in this part of the thesis all have in common uncompromising, exclusive and closure effects. The dialogues presented are multiple. The different dialogues are:

**Alternative dialogue** offers an analysis of how innovating mental health care can be about establishing the practice as exclusive and very different from existing practices. Here the Open Dialogue approach is configured as an alternative to the medical world view. The main theoretical concept used for the analysis is that of *cutting connections* (Strathern, 1996). The chapter explores the configuration of an ‘*alternative dialogue*’ as performed through the exclusion of entities and technologies representing the medical world view. The alternative is established by creating a distance from the medical world view but simultaneously depending upon it to be able to define itself as a counter possibility. At the end of the chapter I raise the question, what happens to a practice when, on the one hand, creating distance from the outer world establishes a platform of purified (undisturbed) performance and, on the other hand, also renders the practice invisible to the parts of the organisation that do not align with this alternative?

**Universal dialogue** discusses how innovation in care sometimes needs to involve compromises and adjustment to existing practices. Here I argue that Open Dialogue is *fragmented* into universal values and non-applicable elements, but that this is also necessary in order for Open Dialogue to be introduced in the organisation. The chapter explores how Open Dialogue would not have been possible to introduce if it was invisible to the management and therefore that such an innovative process needs to
involve compromise to gain a foothold in the organisation. However the chapter also raises the problem of the danger of compromising to such an extent that the uniqueness is no longer recognized as the practice becomes part of existing working routines.

Closed dialogue shows how the innovative efforts in the team are also constituted heterogenically. It is an analysis of how the Open Dialogue approach is also configured by cutting connections to the past and future through performing a specific temporality. It is performed as a presence. It is what I call a present temporality. The focus is on the inner platform of performing Open Dialogue with no reference to the outer world, hence the title ‘closed dialogue’. At the end of this chapter I discuss how this type of present practice configuration creates a type of knowledge that in many ways seems mutable in the present space that it is created in, and yet which has difficulties travelling across other practices that do not align with its form.

Intensive dialogue follows the heterogeneity of the previous chapter and shows how the innovating processes in the team also create spatial forms. The chapter shows how Open Dialogue is not only a matter of a shared human experience but a matter of an intensive equality composed by the help of a circle of chairs. This creates a naked intense room. The concept of ‘intensity’ is developed to analyse the effects of this configuration. Firstly, intensity is a way of contrasting with the “hard-technologies” outside the room, for example diagnostics, hierarchies, written down agendas and decisions about future actions that are prevalent in other settings of the governmental owned psychiatric services. Secondly, intensity is also about specific alignments between the different actors in the room – human bodies. This means that the human bodies are defining how the practices are performed rather than the agenda, for example. Thirdly, intensity is an effect of the hard work to sustain an inner order. I argue that the analysis of the room in which intensity is produced suggests that this intensity can be characteristic of the field of mental health where the use of low-technology is prevalent.

Part III of the thesis I have called ‘negotiations’, and is composed of four chapters that each show the types of performance that do not have exclusiveness or isolation as an effect, but which demonstrate the struggles involved in different types of compromise. In these chapters I talk about tensions, adding together and fragmentations of the innovative efforts. The last chapter in this third part of the thesis is on silent work. The chapter is placed here because it draws upon an example of the negotiation of expectations about the insertion of expert knowledge within the practice. However, these expectations are declined by the silence and as such, in spite of the negotiation, no compromise is made. Thus, this third part of the thesis consists of:

Multiple presences shows that innovation processes cannot be controlled and fixed by, for example, changing the spatial setup. The seemingly ideal spatial setup of the circle
of chairs is challenged to show that it is still open to variability in participation possibilities. The chapter describes a process where ideals are mixed with hierarchical stereotypical trails and governmental technologies. It is argued that when the ideal of collectivity and dissolution of hierarchy gets blurred and disturbed, the spatial setup also makes available performances that do not necessarily correspond with that ideal. Consequently, for example, who has the right to define the agenda, who has the right to participate as a manager, and who has the right to give advice to fellow colleagues becomes a more fluid field of negotiation. The chapter raises the question which forms of governmental technologies are produced when one seeks to innovate with new treatment approaches that question the existing decision making processes?

*Adding together the psychiatric doctrine and humaneness* shows that innovation processes are not always about conflicting programmes. This chapter offers an analysis of a configuration that is neither antagonistic nor in tension. Rather it is configured through positive relations where the mixture of extensive and singular knowledge claims and collective and singular professionalism co-exist. In this analysis the considerations of the staff member show that innovation processes are also about renegotiating an ability both to care (being present in the present temporality, include the patients and colleagues in decision making processes) and at the same time treat and cure (make diagnoses, taking decisions on the basis of expert knowledge).

*Fragmenting diagnostic recruitment procedures* is an analysis of how the introduction of new practices is sometimes also about fragmenting existing practices in order to create space for the new. This analysis discusses how the recruitment of patients through the diagnostic system is handled when wanting to organise Open Dialogue network meetings that are not diagnosis based. It is done through fragmenting the recruitment procedures into a merely logistical tool and, thus, disregards its therapeutic abilities.

*Silent work* is the last analysis. This chapter is adding to the particularity of the previous analyses with a focus on the neglected role of ‘silence’ in innovation processes. This analysis positions silence as a central actor in how to compose collectivity as a specific Open Dialogue configuration. The argument in this chapter is that silence distributes authority, responsibility and decisions. The chapter raises questions about how knowledge claims in the realm of silence are produced as something that is not singular and not fixed. Silences make available a fluid heterogenic decision making process. Silences are shown to be important to understand the subtle and invisible efforts constituted in innovation processes.

*Part IV* of the thesis is the *conclusion* and here I come back to the initial question of the thesis about how a new practice approach can gain a foothold in mental health care. In this chapter I discuss what insights the research process has given in terms of what conditions are produced by a new practice that is, in many respects, performed in a
very transient manner. I also discuss the survivability of new practices that are performed as alternatives, in various respects, and are different from the existing organisation. Lastly, as a fulfilment of my practical aim with the thesis, I formulate seven propositions about how one can develop innovative projects that are sensitive to heterogeneity, multiplicity and intangible work.
2. **Style and Approach**

In this chapter I discuss the conditions for doing the kind of research that I have been doing. I discuss how knowledge is partial and local and how the criteria of quality in science can be defined along lines of raising interest.

**From universal truths to local surprises**

While being interested in what is done this interest does not arise out of the blue. Performativity is a trend and has been so for a while. It is fashionable to be occupied with changes, complexities, movement and ambiguity. As Åkerstrøm Andersen (2003) writes, social sciences are in a trend of constructionism (p.IX). This trend is represented by a vast amount of disciplines. Among others are those within social psychology (Elgaard Jensen, 2001; Kofoed, 2005; Kofoed & Staunæs, 2007; Staunæs, 1998, 2007; Svenningsen, 2003; Søndergaard, 2000/1996, 2005; Dupret Søndergaard, 2009), anthropology and ethnology (Jespersen, 2007; Mol, 2002; Sandberg, 2009), and sociology (Latour, 1996a, 1999a; Law, 1986, 1992; Serres, 1995)\(^8\). One can be constructionist in many ways, but common traits can be drawn from at least two places: Partly from a common interest in understanding and exploring change (Åkerstrøm Andersen, 2003), that contributes with challenging questions about what we see and do. Partly from a contribution by Kuhn (1962) the separation of sciences and their absolutist truth reifying role was opened up for debate.

The connection to this heritage is the principal foundation on which this text has been produced. It is a platform that also acknowledges that the knowledge production and the analyses produced in this text have been constructed in a morass of political trends, disciplinary interests, emotions, random meetings with people, geographical distances, access to and absence of things, persons and a whole lot more. The constructionist approach, thus, argues that research is not a matter of discovering and reifying reality and matters of facts, but about making salient how relations between things and people construct how and why realities are constructed into certain matters of concern (Latour, 2004b).

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\(^8\) The listed references are absolutely not exhaustive of the researchers that have made complexity sensitive analyses. They are mentioned because they are the ones I have been especially inspired by.
Science as construction, with reference to Kuhn, was path-breaking at the end of the seventies, but not today. Latour and Woolgar's "Laboratory life" attracted attention in 1979, because they introduced ethnography as a method in the construction of natural scientific facts and participated at that time in the dissolution of the gap between natural scientific and human and social scientific methods. But what one can say is new today in the new millennium is the discussion that refines the debate about complexity and multiple truths that takes place among researchers within the theory of science and especially among researchers working within the field of material constructionism and material semiotics (e.g. Despret, 2004a; Latour, 1996b, 2004b, 2005; Law, 1999; Serres, 1995; Stengers, 1997; Svenningsen, 2003), and also within the field of post-structuralism (Juelskjær, 2009; Kofoed, 2005; Staunæs, 2007). One of the questions raised in this discussion is how fixation and stability is conceptualized in order to be able to talk about the construction of scientific facts. What these researchers propose as alternative is the work of different criteria of scientific quality (e.g. Søndergaard, 2005). These criteria are more in line with a processional thinking about how knowledge is constructed rather than a static thinking. I will return to that point below when I talk about raising interest.

Within the field of health research, and more specifically mental health, a constructionist and performative approach is also fairly unexplored and the criteria of research quality within this field has not been extensively debated. Although a vast amount of qualitative research has been produced, for example in medical anthropological studies (Johannessen & Lazar, 2006; Lock & Farquhar, 2007; Steffen, 2007), and, for example, in the area of the research in social networks in mental health care that the Open Dialogue approach can be said to be part of, extensive qualitative research has been made especially in the United States, in Italy and in Scandinavia (Thylstrup, Hopfenbeck, Holmesland, Brottveit, & Dupret Søndergaard, 2010 forthcoming), it seems to offer more a kind of parallel approach which raises discussion about how the different humanistic qualitative approaches contribute with other more explorative aspects to the objects studied than is done in the natural quantitative approaches (Elsass & Lauritsen, 2006). In that sense health research does still, to a great extent, refer to what one could call classical natural scientific reifying rules of method as a basis of validation of 'good research'. My proposition, however, is a little more radical in its ontological outset. Together with the reference to research that challenges the natural scientific methodological approach that is especially presented by Berg & Mol (1998), Dodier (1998), Pols (2003, 2005), Singleton (2005), Svenningsen(2003), I would like to add that it is not a matter of qualitative or quantitative nor objective or subjective approaches to science. Rather it is about asking ontologically different questions. The researchers mentioned above who do pose different questions are social scientists and, therefore, only to a limited extent create a bridge to and challenge natural scientific knowledge on, for example, the construction
of how to define illnesses (Mol’s work on atherosclerosis and anaemia however are such examples). The research questions posed and the methodology developed to investigate that question is not a matter of disciplinary affiliation but a matter of the actors and situations one investigates.

Engaging in a dialogue with the contributions mentioned above to challenge reifying realist scientific ideals I reinsert my own performative outset.

“To be is to be related”

A performative logic implies that the empirical questions posed to investigate relations and connections address situated and local practical complexities.

"to be is to be related. The new talk about what is does not bracket the practicalities involved in enacting reality. It keeps them present." (Mol, 2002, p. 54, my emphasis)

This outset is contrasting a realistic or object reifying scientific approach that would formulate the criteria of method slightly differently (Søndergaard, 2005). Truth in a realistic understanding is assumed to be determined by an identifiable amount of entities and processes that can be discovered (Law, 2004, p. 9; Søndergaard, 2005). With the analytical performative and material semiotic resources at hand to be further explored in the chapter on analytical resources, the efforts of the team to innovate their working practices cannot be understood as a pre-definable, linear, static and ordered process, but rather it is full of surprises, contrasts and movement.

The innovative efforts are performed through many different contrasting situations. However, I also acknowledge that with such a claim of incoherence, movement and complexity that I also link to a heritage from research conducted by Star (1991), Singleton (2005) and Mol (2002), to mention but a few, they also produce the phenomena of my research. This means that the link between research questions, methodology and conclusion, together with this heritage, nearly constructs an a priori expectation to find movement, complexity and provisional fixations of truth. This is not the same as claiming the necessity of a methodology that is constructionist, - something that is under construction - to understand the constitution of something stable (Latour, 2005, p. 254). Rather, the difficulty of positioning oneself within a

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9 However, especially Svenningsen (2008) and Bruun Jensen (2008) have explicitly within a Danish context taken the classical relevance and rules of method up for revision within research of health. Elsass & Lauritzen (2006) have also written an introduction to “humanistic health research.”
certain frame of methodology or scientific ideal is that these premises also make other constructions of knowledges absent. Singularity, for example, is difficult to find with my methodology. That is the premise of this approach. One could, therefore, claim that it makes it both predictable and rather scientifically irrelevant.

However, on the one hand I suggest that complex and situated analysis is what is needed to acknowledge subtle and invisible work that also takes part in innovation processes (what has been argued for in the introduction of the thesis). On the other hand I would like to elaborate the argument about how scientific work that wishes to be complex and incoherent still poses relevant and important questions. When science is perceived as performative, science is transformed from providing answers to becoming risky (Despret, 2004a; Vikkelso, 2008). When science does not per definition deliver objective representations and essences what it means 'to be scientific' is transformed. Science becomes a practice that performs particular realities, which entails concerns about how these practices are conducted and why they, thus, become pertinent (Danbolt, 2008). These matters of concern are productive, since we as researchers are then urged to consider if and how other types of configurations of the object of study would produce different and novel types of knowledge.

**Giving place to the world’s multifariousness**

"That is the rather comprehensive aspect of a performative logic that one cannot know by ‘referring backwards’. As the world in a performative logic is created in retrospective there is nothing that ‘is’ science that one can refer to, but only something that becomes science as one says that it is what it is (was).”

(Lindstrøm, 2007, my translation)

When attempting not to verify a predetermined world we establish a criterion of constantly expanding our understanding of the world’s multifariousness. This thought is based on the basic scientific ideal about science and knowledge as not being established through the application and postulation of general regularities that are put forward through explanation and interpretation (Lindstrøm, 2007). Rather, every phenomenon has its method and its explanation (Serres, 1995). As he says, a single key cannot open all doors. Knowledge about these phenomena is only gained by describing the connections and translations that the phenomena are working through. That is a method that foregrounds descriptions rather than categorizations:

"[I]t is always felt, that description is too particular, too idiosyncratic, too localized. But [...] there is a science only of the particular. If connections are established between sites, it should be done by more descriptions, not by suddenly taking a free ride through all-terrain entities like Society, Capitalism, Empire, Norms, Individualism, and so on. [...] God is in the detail, and so is
everything else, including the Devil. It’s the very character of the social to be specific.” (Latour, 2005, p. 137).

Taking up this ambition of describing practical performances I therefore take a stand away from framing a 'before' and 'after' in the introduction of the Open Dialogue approach. To understand what the efforts of the team are about is a matter of describing it.

If one wishes not to disclose a predetermined world but rather to work with the premise that facts and realities are constructed in practice and in the eyes of the scientist, is it, then, a matter of free choice as to what kind of knowledge production can or should be produced? One could come to think so with this formulation by Law:

“the suggestion that specific forms of out-thereness are enacted and re-enacted makes it possible to think about which realities it might be best to bring into being” (Law, 2004, p. 39).

However, Law himself expresses that it is not that simple to choose because in fact the possible choices are connected to what he calls ’hinterlands’. Hinterlands are the material, technological and discursive connections that together support and create statements of truth (Law, 2004, s.39). However, with reference to Stengers (1997), Law (2004, p.39-40) nuances the possible constructionist production of scientific knowledge by saying that it only gets a stamp of truth quality if it raises ‘interest’.

**Interest**

“no scientific proposition describing scientific activity can, in any relevant sense, be called ‘true’ if it has not attracted ‘interest’. To interest someone does not necessarily mean to gratify someone’s desire for power, money or fame. Neither does it mean entering into pre-existing interests. To interest someone in something means, first and above all, to act in such a way that this thing - apparatus, argument, or hypothesis... - can concern the person, intervene in his or her life, and eventually transform it.“ (Stengers, 1997, p. 83).

How do I translate interest as the criterion of quality in performative research in my own case? Interest can, in the above situation, be understood as something relational between “this thing” and the person, the scientist\(^\text{10}\). Interest is, thus, a suggestion to the

\(^{10}\) Interest as a necessary academic component is argued for by Latour (2004), Despret (2004) and Stengers (1997, 1999). They all use the term in both an ordinary sense and a specific sense, which is related to the etymology of the term. *Inter-esse* is the composition of the two Latin words for between and being, which is why Despret equates interest with
scientist to bring the research questions and the object of study into conversation in order to ensure that they have “intervening” consequences to each other. However, interest is not only a matter of a symmetrical engagement between scientist and object of study, but also about an engagement with the world and with how one wishes to raise interest. However, the point of interest is not the one made by social constructionism where what is true is what is socially constructed, that is, what people think is true is true. Rather, it is socio-technical and pragmatic work, meaning that scientific propositions have to be linked to other practices in order to be true (Johannsen, 2009, pp. 20-21). Pasteur’s ideas about micro-organisms became true, not because they were accurate references to matters of fact but because, through the work of Pasteur and his laboratory, they were able to connect to the practices of, for example, farmers with sick animals. Pasteur’s proposition consisted, thus, of micro-organisms as an alternative to the proposition about generation equivoca. This proposition was able to interest farmers (Stengers, 1999, p. 30).

I wish to raise interest in my research in three ways:

Firstly, in line with the request to describe, to a great extent I let the field speak its own language. When, for example, focusing on equality, common values, circles of chairs, 'settling in', and silences as the reader will find in the analyses, it is not because at the outset I have found these actors important but because in various ways I have been told it is so by the actors themselves. This is what I will be calling the heterogenic listening. The heterogenic listening makes me able to acknowledge the noise we, as researchers, experience in the field material when nothing yet is clear to us or ordered (Law, 2004), and it also makes me able to take into account other elements in the field besides people’s talk. The heterogenic listening will be described in more detail in the chapter on methodology.

Secondly, I follow the same strategy as many STS-inspired (and others) researchers who deal with the aspect of interest by taking as a point of departure well-known and delimited objects or practices. Basically it means that it is very difficult, if not impossible, to define an object of study from no-where. One cannot justify a research

making a link (Despret 2004, p.124). I thank (Johannsen, 2009) and (Danholt, 2008) for the elaboration of this point in their dissertations.

Thus, I move slightly away from Åkerstrøm Andersen’s interpretation of Luhmann and the scientific ideal of “putting something at stake”. (Åkerstrøm Andersen's session at the PhD. Course 17.Jan08). To put something at stake in this reading is to settle with one's own truisms. But in an STS reading, one does not "put" differences. Rather, differences are matters of continuous established effects. They are not merely "put" by the researcher but are continuously put by the connections between entities, in the field, with theory, and the researcher. These differences are, thus, not central tools of analysis, but rather the product of an analysis.
project by formulating a project saying: “I wish to investigate the practices of the outreach team”. This question does not define a problem and in order to define a problem one needs to frame the object of study. The fact that the objects of study may be well-known makes them likely to be recognized in their professional communities and maybe even beyond. This means that although both ANT and STS inspired research disagree that objects and practices are static, ANT and STS research often does take a point of departure in such well-known apparently stabilized objects. For example the electronic patient record (Bruun Jensen, 2005; Langstrup Nielsen, 2005; Svenningsen, 2003), Artherosclerosis (Mol, 2002), Artificial Insemination (Adrian, 2006; Cussins, 1998), Paris subway train, Aramis (Latour, 1996a), teaching in the classroom (Benjaminsen, 2009; Sørensen, 2005). Their research take a point of departure in apparently well-definable objects of study and conclude that they are multiple and complex and should, just as I claim, be understood in situated and heterogenic ways. Of course this is very simplified. The situated construction of the objects of study has a central importance as to how one can understand these objects and their transformation. However, I find it interesting that this research, like my own, describes objects that we know to exist in the world already. Very little research within this research community deals with unknown inventions like the Pasteurization of France (even that was a retrospective study). The reason for this is logically that we as researchers connect to the world and our choices of study objects also have to do with interest and the possibility of dissemination of knowledge. There are always parties of interest, financially and intellectually, that contribute in framing what can be recognized as relevant and interesting research. However the challenge would then be that it is not enough to be recognized by an intellectual community or by a financial partner but also, as Stengers puts it, needs to raise interest in a way that intervenes both with the object of study and the scientist and consequently it also, hopefully, raises interesting questions of discussion to all parties. I have intervened with the object of study by being “the fly on the wall” as the psychiatrist once commented about my presence at a supervision session with an external supervisor. I hope by my presence I have made the outreach team that I shadowed enthusiastic about trying to develop and qualify their ideas. As a scientist my concern about not getting the answers right at first made me annoyed but then subsequently it made me listen more. I hope that with my analyses and suggestions of interpretations of what I experienced in the field I raise interesting questions for discussion both to the field and the scientific community about how efforts to innovate can, at times, be challenging because so many connections between entities have to be renegotiated and enrolled in new ways in order for innovative efforts to gain foothold. Also I hope it raises interest about how efforts to innovate sometimes configure themselves in ways that, paradoxically, seem to undermine those very same innovative efforts.
Thirdly, to awake interest is about talking to and with a collective. Collective here is not only human but also non-human. I hope that the fact that I raise awareness about a circle of chairs and silence, to mention just two examples from the analyses, at the one and the same time is a contribution to how the Open Dialogue approach can be defined in practice in novel ways. In this sense awakening interest is proposing configurations that, on the one hand, are recognizable (and therefore are plausible) and on the other hand are new.
3. **Innovation in mental health care**

In the previous chapter I outlined the approach to my scientific contribution. This chapter is laying out in which scientific community I inscribe myself. There is a growing body of literature on innovation in mental health care services. Actually mental health care has been subject to innovation from the point of view of organisational and institutional development, to staff training, to treatment improvement approaches, to contracting between different care institutions, to infrastructural working practices, to encounter various client populations etc. Even with this broad scope of research I aim, firstly, in this review to summarize some interesting tendencies in this body of research and, secondly, to show how my study adds to this in novel ways.

Before reviewing them I will briefly describe what types of innovation studies have not been included for this review. The method used to get an overview of the existing research within the field of mental health and innovation was through searching in: Psychinfo, PubMed, ERIC, Web of Science and sociological abstracts. I used the search phrase in the subject line: ‘innovation’ and ‘mental health’. I found nearly 800 articles with this theme. Due to my focus on innovation processes, rather than on innovation outcomes solely, I added ‘processes’ in the search line. This search resulted in 49 hits. However, when looking through this search line I found that ‘processes’ were not necessarily directed to innovation, but could be all sorts of other processes. Therefore, I remained with the first search, but made my selection of the research referred to here dependent on a number of criteria described in the following:

I started to look through the first search to learn more generally about the area; mainly themes, methodologies used and conclusions drawn. I have excluded studies that only in their conclusion address the role and importance of innovation, or where it is only in the conclusion that they address how the findings of the study can be implemented as innovations. These studies could be classified as having a peripheral innovative output approach.

Secondly, I have not addressed innovation in the voluntary sector, neither have I dealt with aspects other than in the mental health care services. This means that I do not refer to social services innovation initiatives nor social child welfare initiatives for example. I have also not included studies that do not define what innovation is. Further, I have not included book reviews and handbooks. Finally, studies that did not have a focus on mental health care services were omitted.

The following will take the reader through some of my readings within the field.
Studies that raise methodological issues

To a large extent, innovation studies apply methods that are developed within a clinical setting or studies on innovation sometimes critique other research for not being systematic and fundamental in their methodologies (e.g. Magnabosco, 2006). This, of course, reflects that in innovation and mental health research it is widespread to apply a certain perspective on what innovation is and how it can be studied. One editorial paper argues that for clinical innovation targeted at children to be successful:

“innovation can only be built on systematic and fundamental analysis of the causes and underlying processes responsible for mental ill-health and disorder in children.” (Sonuga-Barke, 2007).

However, not all innovation mental health studies apply an approach to neither mental health nor innovation through a medical, causal or linear lens. And some studies also apply a critical view of how innovation studies in mental health care should be done.

One overview article suggests that there has been a tendency that medical sociologists define psychological and behavioural problems as medical disorders (Winnick, et al., 2000). Another study raises the concern that with the approaches to treatment innovation that are prevalent today, psychotherapeutic approaches in mental health care are in danger of being extinct (Alperin, 1997). The author argues that governmentally funded care has lost sight of the fact that it takes considerable time for most patients to unlearn old behavioural patterns and learn new ones, since the preferred model of treatment is either short-term psychotherapy or medication for the alleviation of these symptoms (ibid.). Support for socially-constructed models of mental disorder are re-emerging from professionals (Shaw & Middleton, 2001), academics and social scientists (Duggan, Cooper, & Foster, 2002) and service users (Faulkner, 1997; Faulkner & Layzell, 2000). These commentators question how directly analogous mental health is with physical health, as mainstream service providers themselves recognise increasingly the interplay of symptomatology and social context.

“Diagnosis describes the process whereby the whole problem is understood. Medical diagnosis is the identification of a specific health condition, how it arose and its likely course. As such, medical diagnosis can be seen as distinct from the assessment of wider health and social care problems. However, the inter-related nature of specific health conditions with social, physical and mental health issues and problems makes undue separation unhelpful.” (GB, dept. of health 2001 in Shaw & Middleton, 2001)

A stronger focus on social factors can permit workers and clients to see the possibilities, not just the pathology, inherent in adversity (Firth, Dyer, Marsden, & Savage, 2003; Shaw & Middleton, 2001). In practical terms, this can involve client and worker collaborating positively in “the experience of vulnerability, the receipt of needed support,
and the search for meaning in adversity" (McMillen, 1999), with improved resilience as a common outcome (Firth et al., 2003).

The concern of how innovations and changes in mental health care have been defined along medical and diagnostic lines has brought a scientific journal to reflect on how to validate best practices in a more nuanced way. Thus, an overview article made by the Canadian Journal of Community Mental health (CJCMH) reflects on the development the organisation on community mental health care has undergone in recent years. It puts forward that, increasingly, management techniques in mental health are rationalized in the context of processes based on accountability, effectiveness, and efficiency. Evidence and standards of practice notions, that were rarely mentioned in the 1980s, are now taken into account in establishing guidelines for introducing changes and innovations (Mercer, 2007). The author finds that community mental health needs to take up the challenge of re-defining itself in light of this new culture. The author suggests that the CJCMH is called upon in establishing a balance between validating best practices through rigorous research and recognizing the forces of innovation at work in different contexts. Thus, this article places innovation as something that is also a matter of scientific paradigms and as a result highly political in terms of how to organise community mental health services (Mercer, 2007).

In line with these concerns of reducing the field of innovating mental health to a matter of right medication and the reduction of diagnostic symptoms, my concern has been to draw upon an approach that includes heterogeneity and incoherence. Again, this is the fruit of both my theoretical readings within ANT and especially within medical research already inspired by ANT (e.g. Berg & Mol, 1998; Dodier, 1998; Mol, 2002, 2008; Pols, 2003, 2005, 2006; Singleton, 2005) which are also mentioned in the introduction. This research puts attention to how health practices are not always a matter of standardizing medical treatment or diagnostic definitions, but rather accentuate the fact that realities are multiple and health care practices are multiple. As such it is irrelevant or even impossible to reduce innovation initiatives to be a matter of introducing standards along lines that are defined by singular ideals of treatment, such as, for example, the medical one.

**Studies that innovate treatment**

Many studies on innovation and mental health are concerned with the development of better treatment for the patients.
For example, one study with a gender focus evaluated that the establishment of so-called wraparound services\textsuperscript{12} helps decrease women’s substance abuse. Innovation in that study is about addressing especially social needs of the women through the provision of child care, employment assistance, or mental health counselling (Oser, Knudsen, Staton-Tindall, & Leukefeld, 2009). Innovation is measured by the output of decrease in women’s substance abuse. Further, in the field of FASD (fetal alcohol spectrum disorders) research and clinical service, a common theme reported by families has been that clinicians and professionals have been reluctant to diagnose their children because of not known effective treatments (Bertrand, 2009). The purpose of the project was to develop treatment approaches that make families feel more secure about the value of the treatment services offered. Innovation is here to develop treatment that to a greater extent can correlate the difficulties of the babies and children that are likely to have FASD with the treatment services offered. Strosahl et al. (2005) argue that innovation is about adapting ongoing clinical problems and adjustments to special populations to a treatment model called ACT (acceptance and commitment therapy) which is a relatively focused clinical model with a limited set of core processes. Common for these papers is the application of an approach to innovation as reliant on essential definable parameters taken from the psychiatric and medical doctrine.

Another article reports on a big project (the Evidence-Based Practice (EBP) Project) that has been investigating the implementation mental health practices (Assertive Community Treatment, Family Psycho education, Integrated Dual Diagnosis Treatment, Illness Management and Recovery, and Supported Employment) in public mental health systems in the United States since 2001. This paper reports results of an effort to identify and classify state-level implementation activities and strategies employed across the eight states participating in the Project. Content analysis and Greenhalgh et al.’s (2004) definition of innovation were used to identify and classify state-level activities employed during three phases of EBP implementation: Pre-Implementation, Initial Implementation and Sustainability Planning. The definition of innovation is:

"A novel set of behaviours, routines, and ways of working that are directed at improving outcomes, administrative efficiency, cost effectiveness, or users’ experiences that are implemented by planned and coordinated actions.” (Greenhalgh et al. 2004 in Magnabosco, 2006 p. 3).

\textsuperscript{12} Etheridge and Hubbard (2000) define wraparound services as “psychosocial services that treatment programs may provide to facilitate access, improve retention and address clients' co-occurring problems” (p. 1762).
The innovations identified in this study show that "interactions...occur[ed] on various levels, between top and bottom actors" – and that a variety of interrelationships were necessary to launch, initially implement, and plan for the sustainability of the Project EBPs. Here, state agencies set policy for the clinical practice and voluntarily engaged in a cooperative relationship with local services to meet the needs necessary to solidify the project. Therefore, interactions between the macro- or top down actors (state agencies) and the micro- or bottom-up actors (local service organizations or boards) were required to successfully implement and plan for the roll-out of the EBPs (Magnabosco, 2006).

The paper is well-described and the interaction between the project that was initiated and other stakeholders proves to be of important value to the project's sustainability as written above. This is a point which this study has explored in a qualitative way through micro-analysis (and not through cross state surveys) in its investigation of how the Open Dialogue staff members connect and disconnect when practicing the treatment approach that, to them, is novel in their practices. This will especially be illustrated in the chapter on alternative dialogue, closed dialogue and intensive dialogue. Moreover, this study also takes into account how external and sometimes contradiction or tension making factors that are influencing the team’s working practices connect with the innovation processes of the team. This is particularly the topic of the chapter on universal dialogue and the chapter on laughter.

Even though the Magnabosco (2006) paper is very thorough and does identify how innovation parameters are to be defined, it does that with its point of departure in an innovation model that is linear and fairly static, as it identifies three stages of implementation: "Implementation, Initial Implementation, and Sustainability Planning phases of the EBP Project" (ibid. p. 2). The Magnabosco (2006) study applies a definition of innovation which is linear, causal and measurable in order to develop mental health care improvements along standardizations and effectiveness lines.

The following article (Amiel, 2001) focuses on the process of engaging young people who have experienced a psychotic breakdown before coming to the Brandon Centre in London. The author shows that despite the severity of their symptoms, it is possible to do useful therapeutic work in once-weekly psychotherapy. The innovative project included providing facilitative structures (physical surroundings, the setting out of procedures, and ground rules) and processes (the style, orientation, and perceived attitudes of the therapist) (ibid.). In her work with these patients, the author also saw liaison with other professionals involved in the patients’ care as essential, and she worked with a community psychiatric nurse, among others. Likewise, another study based on a two-year study in the Canadian health care sector suggests that an understanding of how and why computerized network-based information technologies (NBIT) are integrated in organisational settings and practices must focus on the
significance that the various actors involved invest in the innovation and that innovation is both a matter of “objective matters” (size and structure of the organization, task definition, etc.) and “subjective matters” (conception of professional role, professional ideals, interpretation of organizational conditions, etc.) (Douzou, S. & Légaré, J., 1994).

Both these studies take into account various parameters in the approach to innovation. The two studies combine a linear with a processional approach. In the case of the study by Amiel (2001), she further takes what could be called a professional collective approach when including other professionals in the treatment. All the innovative parameters are well-defined and measurable from the outset of the innovation process.

What I share with these types of innovation studies is that it is heterogenic matters that make up the innovation process and the product. It means that my analyses will also take into account physical surroundings, the setting out of procedures, the ground rules, and the processes. However, this is done in a slightly different way. The difference is twofold. 1. The reason why I call my approach “heterogenic” is due to my theoretical readings within the field of ANT. Heterogenic means that both human and non-human actors not only influence, but also constitute the processes of innovation. As such, the table and the settling in or the rules of conversation that are practiced in my study do become important but as performing actors. 2. Processes are not detached from the “facilitative structures” in my study as these structures are also effects of processes. Therefore I look at the absence of the table, the settling procedures in the study group session or the talk or silence with professionals as processes that are all part of constituting what is to become innovative; in fact it is all part of making up something new. Further, the initiative that I have followed is new and therefore does not really provide what could be called an established routine or structure. This is another reason why I extensively look on processes of intangible and fragile attempts to make things different. My theoretical readings and the newness of the innovative efforts in the team that I have shadowed are therefore the reason to which parameters or categories (like diagnostics) have not been identified ahead of my study. As it will be described in the introduction to the case study the principles of the Open Dialogue approach, as they are described in the literature, are not the subject of investigation per see (have they or have they not been applied). It is what the professionals in the team perform as innovative in their daily practices that is the focus of the analysis.

**Technological innovations in mental health**

Technology in health care in general and in mental health care in particular has received an increased focus in the last decade. In general, the studies done in the field
touch upon especially computer systems that support the working practices and how they are implemented in the daily working routines through staff training. These studies usually do not question the quality of the technology in itself, but rather how the practices should be adopted to the technological development. However, a few studies are also concerned with the consequences that technology might have for some groups of patients.

For example in a couple of studies of the innovation process of decision support systems in governmentally funded child care services the authors found that in order to be widely adopted the decision support systems needed to respect the natural logic and flow of worker interaction as well as organisational constraints. They found that information technology is the connective tissue that integrate staff groups’ practices and link them with other sectors (Currie, 1996; Foster & Stiffman, 2009). Further, another study was made on an evaluation and accountability system in Florida’s sector on child mental health care along parameters of the number of children served in the project, demographics regarding those children, what kind of services were provided, and cost for those services (Overstreet et al., 2001). The study concludes that the data facilitates the administrative capacity to track goals for both the individual child and the overall system of care. This type of innovation is of an administrative and organisational character.

Several studies are exploring the innovation of technologies that are applied in the treatment. They usually suggest that adaptations of technology to clinical mental health practice are possible within the framework of building evidence-based interventions and maintaining humane engagement (e.g. Budman, Portnoy, & Villapiano, 2003; Caso-Morris, 2007; Looi & Raphael, 2007) and they offer new opportunities for communication and empowerment (Bunning, Heath, & Minnion, 2009).

Another of the treatment oriented studies suggests that web-based educational sessions are only effective to change families’ dysfunctional behaviour if different questions of resource, both in terms of finances and time, are addressed (Horwitz et al., 2008). Psychiatrists found access to the web-based system time consuming. Moreover, at the place of the study the psychiatrists received no reimbursement for the screenings because the billing code for the screening activity was carved out of most of Ohio’s privately insured contracts. Psychiatrists were unenthusiastic about the local resource guide because the resources were not rated for quality. This study demonstrates that there are not easy solutions to practice change, and it highlights the need for implementation support when introducing new technology (Horwitz et al., 2008). Another study has raised the concern of the social consequences to black people when introducing technology in mental health care (Lawson & Gore, 1989).
My study does not address computer technology; however, there are certain elements in the approach of the innovative technology studies that have raised some concern to me. One concern is that the implementation of computer technology in mental health care, both as an administrative tool and as an element in certain treatment strategies, somehow does not seem to be questioned. In the more administrative studies and studies where the innovation of computer technologies is supposed to ease working procedures, it is often taken for granted that the use of these technologies does ease working procedures. Also in the studies that focus on computer technologies in treatment I have only found little reflection on the consequences of the implementation of those technologies. This has motivated a further justification of my metatheoretical approach. The fact that the outreach team that I shadowed wishes to change their practices has its source in a practical frustration with their work. I do acknowledge that frustration which I described as kicking-off the initial ideas for the project. However, it does not mean that what the team seeks to innovate per definition is good or should not be questioned. With a metatheoretical approach that focuses on practices and how things are done in practice, I aim to be able to show that what is done in practice is always an effect of multiple interests and struggles between actors to make something appear as true or right.

Studies that use staff training as a means to innovate

In other studies, staff training is also addressed as important to encompass the success of different implementation strategies such as new technology systems (Fetter, 2009). Several articles are addressing innovation or changes in working practices as a cause of events that staffs have to follow, be trained to adapt, and accept.

The following paper investigates which factors are influencing the introduction of prevention support systems in substance abuse prevention. Through statistical tests the authors find that the prevention programmes are more successfully implemented when staff is trained. The staff found the prevention programmes complexity lessened when they had had training (Hunter, Paddock, Ebener, Burkhart, & Chinman, 2009). Furthermore, a study evaluated a project of reducing restraint in psychiatric care (Barton, et al., 2009). In this study innovation is approached as a principal change in culture and is addressed as something that needed the engagement and training of staff.

The following paper investigates and proposes a specific innovation model that consists of training police officers in dealing with psychiatric patients (Laing, Halsey, Donohue, Newman, & Cashin, 2009). Laing et al. (2009) argue that services offered by the police department in the management of mental health crisis in the community are essential.
in minimising the risk of individuals with psychiatric problems. The police training innovation model has been taken further by Perez, Leifman & Estrada (2003) and has shown to be effective in reducing the use of force in incidences involving individuals with mental health problems and results in positive attitude changes within the police force (Klein, 2002; Steadman et al., 2000 in Perez et al., 2003). This innovation model is based on human interaction and training in the medial doctrine of what it means to be a psychiatric patient in that respect. Innovation is measured by the end product of the decrease in police injuries. As such, this innovation approach is also temporarily linear and has a causal relationship between what the police officers are trained in and the outcome that is measured in the reduction of injuries on patients and arrests.

An exploratory study examines the ways staff members’ cultural knowledge is applied in their contact with children and youth from various backgrounds in mental health services (Williams, 1999). Although staff members have information about the diversity in cultures, it does not appear that staff members are able to use this information to change the programme policy and practice. The author suggests that utilization of cultural knowledge is constrained by insufficient information and ability to operationalize the construct or cultural, political, and interpersonal processes within the organisation (Williams, 1999). Further, Kinney (1992) argues that mental health professionals have the opportunity, perhaps even the responsibility, to work to facilitate individual and institutional creativity in ways that are less reactive and more proactive than has traditionally been the case for most therapists. To the extent that this entails a break from traditional practice, adopting more creativity-enhancing roles may in turn require some creative restructuring of how therapists think of themselves and how they organize their individual and professional group activities (Kinney, 1992).

Shadowing the outreach team has to a large extent been about observing staff training. But it has been staff training in specific ways and from a specific perspective. Nor has it been staff training that was planned by an external party, as for instance the management. Neither has there been an established programme of training where the staff had a course of events they had to fulfil in order to check whether they succeeded or fulfilled the training requirements. However, the staff I shadowed reflected to a great extent on their role as professionals and how their role was influenced with the introduction of the new approach. To the team the way of thinking of oneself as professional in new ways was one of the core sources of innovation. I investigate how that is done. My analyses on multiple presences and my analysis on closed dialogue and intensive dialogue explore that in different ways.
**Staff involvement**

In my study it is the group of staff that has initiated the idea of introducing a new treatment approach. I found an interesting study from Brazil that investigates work relations from an ergonomic point of view where staff members’ practical use of the innovation is in focus (Sznelwar et al., 2008). For ergonomics, work is a human activity resulting from restrictions and affordances coming from the tasks to be accomplished and the properties of the human being (Sznelwar et al., 2008, p. 501). With this approach, innovation processes are about balancing the requirements from the working tasks and the abilities of the staff, which according to the authors help create meaning in their work that give them a sense of autonomy:

“For workers, meaning is also related to establishing rules and procedures that allow them to develop their own activities with this broader perspective, and to reconstruct the rules and modify their operations. In many situations success is not guaranteed by strictly following rules and procedures. Discussion and processes for redefining the rules and making explicit what really needs to be accomplished reduces covert rule violations.” (Sznelwar et al., 2008, p. 501).

In a public health system workers make decisions in real time related to users’ needs and the technical specifications of the process. Therefore, the authors argue, it is very important to understand how the changes impact on employees’ activities and on the quality delivered for citizens. The authors apply an approach to innovation processes as something that is a mixture between suggested programmatic changes and practical day to day judgement on behalf of the workers and their abilities. The innovation process as such is not seen as a necessarily causal or linear process, but as a process that is continuously adjusted to a project of change which is suggested by the management (Sznelwar et al., 2008).

My approach to innovation adopts elements from the above study. That is the elements that are to do with the practical day to day adjustments of how the innovation is performed. In the case of the outreach team that I have followed the project of change is not suggested by the management and there is not, as such, a plan of implementation. The efforts of the team in my study are solely defined by the team itself. There have been no change requirements from the outside.

**Leadership responsibilities in innovation**

Quality improvement and innovation are often linked with leadership because mental health organisations (like other organisations) are accountable for their standards of care. Mostly, innovation processes are initiated by management, however, studies also show that clear leadership also influences the success of such decisions. The purpose of the research that the following article draws upon was to outline the
principles of continuous quality improvement that can be utilized to develop a clinical governance framework in a mental health service (Arya & Callaly, 2005). The term clinical governance is used to describe the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. The authors found that implementing a clinical governance framework requires clear leadership, particularly clinical leadership, the development of structures and processes to facilitate communication, and the development of systems for monitoring and evaluating services. Effective implementation can be supported by the development of an open culture that promotes organizational learning from experience and supporting innovation (Arya & Callaly, 2005).

However, another study suggests that little is known about how leaders create and manage effective teams or promote effective team processes (Cohen & Bailey, 1997; Zaccaro et al., 2001) including how leaders create and maintain favourable performance conditions for the team (Hackman, 1990, 2002). The research reported in this paper investigated the contribution of leadership to promoting team innovation in multidisciplinary health care teams. The focus is on the role of leadership in developing team processes that facilitate innovation. These include developing clear objectives, encouraging participation, focus on quality, and support for innovation (West, 2002; West & Anderson, 1996).

The authors in the study define innovation in the following way:

“They include technological changes such as new products but may also include new production processes, the introduction of advanced manufacturing technology, or the introduction of new computer support services within an organization. Administrative changes are also regarded as innovations. New human resource management (HRM) strategies, organizational policies on health and safety, or the introduction of teamwork are all examples of administrative innovations within organizations. Innovation implies novelty, but not necessarily absolute novelty.” (West & Farr, 1990 in West et al., 2003, p. 394).

The relationships among leadership clarity (i.e., team members’ consensual perceptions of clarity of and no conflict over leadership of their teams), team processes, and innovation were examined in health care contexts. The results revealed that leadership clarity is associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation. Team processes consistently predicted team innovation. Team leadership predicted innovation, and there was some evidence that team processes partly mediated this relationship. The results imply the need for a theory that incorporates clarity and not just style of leadership. For health care teams in particular, and teams in general, the results suggest that a need to ensure leadership is clear in teams when innovation is a desirable team performance outcome.
In the team that I have studied innovation is, ideally, a collective. Ideally it does not have a leadership in the sense of somebody taking decisions or steering what should be done. On the contrary, it has an ambition of taking decisions in a collective way. However, two pioneers are often mentioned as the ones who initiated the thoughts of introducing the new approach in the team. Also, I have an analysis that deals with the fact that it is a difficult process of letting everything be decided in a collective manner without any hierarchies. This analysis deals with multiple presences. Another analysis deals with how an expectation of leadership is dealt with through silence.

**Studies that raise issues of what influences innovation**

Few studies I found deal with the fact that innovation processes are sometimes initiated without any successful outcome. However, Arthur and Lalande (2009) and Deakins (2009) stress the importance of addressing cultural diversity when assessing the implementation success of new working practices (e.g. Arthur & Lalande, 2009; Deakins, 2009). Moreover, one study deals with the fact that sometimes practice innovations make staff leave their job (e.g. Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). They found that effective communication strategies have been essential to the integration of the new working practices into the team of personnel (p. 127). From this study, one can suggest that innovative sustainability seems to be dependent upon attracting and sustaining the interest (fidelity) of the participating parties (here staff members).

In this light, the following study has reviewed variables that affect dissemination of the improvement of treatment within PTSD-specific treatments. The authors have found that: (1) Practitioner factors, (2) Training methods, (3) The practice innovation(s) being disseminated, and (4) Organisation or system factors are variables that influence the success of treatment improvements. The authors further evaluate what should be done to accommodate these variables. They are: (1) The content of dissemination (i.e. which treatment protocols or intervention methods should be prioritized), (2) Strict adherence versus flexibility in the use of treatment manuals and the role of fidelity assessment, (3) The need for collaboration with user audiences, (4) The potential role of web-based technologies in increasing the effectiveness and efficiency of dissemination, and (5) Development of dissemination infrastructures within organisations (Ruzek & Rosen, 2009). Further lack of financial resources and problems related to attracting and retaining qualified staff have also been found to discontinue innovation in mental health care services (Massatti et al., 2008).
Yet another study applies a risk-based decision-making framework to examine the decision to adopt innovative mental health practices, including both evidence-based and other research-guided practices (Panzano & Roth, 2006). The authors found that the propensity to adopt an innovative practice was negatively related to the perceived risk of adopting the practice, but positively related to the expected capacity to manage risk and positively related to an organization's past propensity to take risks. Further, perceived risk, anticipated resource availability, and exposure to field-based evidence explained a substantial part of what differentiated adopters from non-adopters. This research supports the view that the decision to adopt an innovative mental health practice is a decision made in consideration of risk (ibid.). Contrary to popular views that early adopters of innovations are willing to take enormous risks, these data offer the novel idea that early adopters act because they see the risks associated with adopting as lower than their non-adopter counterparts, partly because the risks are seen as more manageable (ibid.).

Another project was predicted to fail but ended as a success (Shapiro et al., 2009). In 2003, the National Institute of Mental Health in GB funded the Child and Adolescent Psychiatry Trials Network (CAPTN). At the time, CAPTN was believed to be both a highly innovative undertaking and a highly speculative one. One reviewer even suggested that CAPTN was "unlikely to succeed, but would be a valuable learning experience for the field." (ibid.). The study describes lessons learned in building a clinical research network in paediatric psychiatry. The study concludes that the success was dependent on stable funding for network construction and maintenance, judicious use of web-based technologies for training, and capturing clinical trials data. When coupled to innovative approaches to network governance, data management and site management can reduce the costs and burden and improve the feasibility of incorporating clinical research into routine clinical practice (Shapiro et al., 2009). This study illustrates that the success of innovation processes are dependent on a variety of interest parties and factors. In this study it both depended on funding, on the right technologies, and the appropriate innovative approaches addressing different aspects of the project. This also informs the approach in my thesis in an indirect way. Basically, my approach to innovation is also about the heterogeneity that develops the possibility of something new to happen. In my theoretical terms, it is called heterogeneity; more precisely it is called the principle of generalised symmetry. I will explore this in the chapter on analytical resources.

The fact that innovation failures or invisibility is not so often addressed in the reviewed research suggests that there is a tendency to think that one cannot learn from failures and invisibility. Or, may it also be that the way innovation projects are broadly defined does not leave room for the possibility of failure? This means that innovation projects, when described in the literature, will very often appear as successes, even though they
have undergone many adjustments and transformations along the way. This becomes invisible when reporting in publications unless the focus is on what we can learn from such a process. The errand of this thesis is, among other things, to suggest what we can learn from such a process of innovation that did not succeed in becoming sustainable.

Unconventional approaches to innovation

Other papers explore more untraditional ways of innovating mental health. The following has described the national and regional initiatives of using football as a vehicle for mental health interventions (Pringle, 2009). Chaves & Moro (2009) made an international collection of data where they approached innovation from a policy level and defined it according to visible publications within specific types of psychiatric diagnoses coupled to different countries policies, programmes, legislations, treatment and mental health funding methods. They found that countries with fewer publications on a specific diagnosis also had less mental health infrastructure and technology, and thus less innovation within the field.

Further, two studies have a focus on space. The first has a focus on geographical space and how it influences the form and outcome of innovative changes within mental health care services. It is about the Harpurby Resettlement Team, an innovative project which, in the late 1980s, resettled around 20 long-stay patients from a hospital in North Manchester into ordinary tenancies within the same neighbourhood. The paper argues that the particular and unexpected convergence of national policies, local structures, and institutional politics created space for a process of change which, in both form and outcome, could not have occurred in the more regulated psychiatric environments elsewhere in Manchester (Harrington, 2009). It therefore seems that spatial and geographical setups have an impact on how innovation processes proceed. The second study on space deals more with what I will later call spatiality. It is an interesting case study of a day hospital therapeutic community (TC) that explores the emergence of particular spaces of psychiatric contention. The author employs the notion of 'convergent spaces' to understand how particular sites become important in the development of innovative practice and new social movements. The notion of convergent spaces has been used to describe and theorise the development of anti-globalisation networks (Routledge, 2003). It refers to a site of diverse heterogeneous social movements, grassroots initiatives, non-governmental organisations, and other formations wherein certain common interests converge leading to the articulation of new goals and strategies. A convergent space is “necessarily contingent and context dependent” but facilitates the enactment of processes of solidarity, communication, coordination, information-sharing, and resource mobilisation (Routledge, 2003, p. 345). It argues that these spaces of convergence enabled innovation to occur through a
collectivised social setting where commonalities were expressed, new resistant identities forged, and charismatic figures such as 'tricksters' emerge to challenge and subvert psychiatric authority. In discussing some of the problems which beset the day hospital, it is proposed that the notion of 'paradoxical spaces' might also be helpful to understand how contested spaces can avoid imposing new forms of totalization. It concludes by reflecting on the conditions of possibility for new spaces of contention (Spandler, 2009). This study is unconventional and explores untouched ground. I have one analysis in particular that adds to this approach to spatial innovation. My analysis on intensive dialogue, where the spatial setup of the room in which the staff members sit together, gives an insight into how space becomes important when trying to understand how innovation processes are done and made to be a collective matter.

**Summing up innovation and mental health**

The above review of innovation studies in mental health is not exhaustive, but the presented papers and research are representative of certain tendencies forwarded in this field. I will sum these tendencies up in the following:

Innovation in mental health is widely defined as a set of tools that are applied in a causal and linear way to obtain a certain predefined goal of improvement. Only few studies are explorative in their methodologies. The use of tools such as clinical practice guidelines, program fidelity scales, performance measures, standards, and benchmarks is well established for quality assurance and quality improvement (Addington, 2009). With these tools, it is suggested that organisations can systematically address the variety of factors that are likely to affect the success of dissemination efforts (Ruzek & Rosen, 2009).

Moreover, most studies executed in this field are *quantitative*, using statistics, scales and tests with predefined categories and possibilities of answers as their analytical method. The quantitative studies often use an experimental design, with control groups and hypotheses of what the innovative outcomes should be. Further, most studies refer to a medical and clinical knowledge of mental health in the sense that they, for instance, use the reduction of diagnostic symptoms in patients as an innovative outcome.

Nearly all studies have an approach to innovation that is causal and linear in the sense that innovation is defined as an intervention implemented at a certain point in time and then subsequently measured on a number of predefined parameters.

Most studies have used staff recordings either in self-reporting schemes, in interviews
or on scales to measure the outcomes of intervention. Few studies include patients in those measurements. However, some studies raise the importance of methodological issues in including patients, different ethnic groups, and women when developing models of innovation. Innovation in these quantitative studies has been about improving mental health by reducing diagnostic symptoms, improving the criteria of treatment, or improving staff retention when changing mental health working practices, for example by implementing new technology. Sometimes, these quantitative studies also include human stakeholders’ view on how the new technology or changes in their working practices affect their work. Torrey et al. (2003) note that “The literature has an abundance of evidence, whether it is theoretical or empirical, which chronicles the arguments for the need for innovation in mental health services implementation...”.

Other authors have highlighted the need for research to define and identify innovations (Greenhalgh, 2004; Perrin, 2000), particularly innovations grounded in theory and practice (Chen & Rossi, 1983), as well as efforts to identify and evaluate effective innovations (Chen & Rossi, 1983; Perrin, 2000) and plan their widespread dissemination (Rosenheck, 2001). So in spite of the general call for more research on innovation, this call builds, to a great extent, on a scientific tradition that builds up a linear cause of events and is oriented towards outcomes that are measurable in ways where only few possibilities are given. And this is where I would like to position my research.

With this broad scope of research, both in kind and amount, one could raise the question whether another study in innovation in mental health care is needed? Yes, would be my answer of course. And this is especially due to three reasons.

1. The existing research does not, as far as I have seen, touch upon innovation processes that are in the making, that are new and therefore often very intangible and difficult to standardize in parameters or indicators. This subtle work is what I would like to address.

2. As I have explained in the introduction, I have been inspired by studies that investigate health care practices (e.g. Mol, 2002, 2008; Pols, 2003, 2005, 2006; Singleton, 2005). Likewise, I would like to explore how innovative processes are not always something that can be predefined and categorized but develop in unpredictable and surprising ways. Innovation processes are in this light incoherent and multiple.

3. Importantly, most studies deal solely with how what people say matter in innovation processes. I would like to describe how actors, like absences of tables, ways of settling into a study group session, silences, absences of technologies etc. not only influence but have an important constituting role in what innovation in mental health care is. This is
what I have mentioned as my application of the principle of generalised symmetry.

Summarising this, I aim to contribute to the field of innovation in mental health in three ways: (1) through investigating subtleties and intangibility, (2) giving space to incoherence and multiplicity and finally (3) to take into account both human and non-human actors. As mentioned, it is the Actor-network theoretical approach that has inspired me to explore innovation in mental health in that way.
4. **Introducing the case study**

This chapter introduces the reader to the outreach team and the organisational framework in which the outreach team operated at the time of my observation. I will first give a brief description of the movements and reforms in the psychiatric field that paved the way for the team to develop innovative initiatives in its working practices. These movements are connected to the de-institutionalization process not only in the district of the team but in the Western world. Then I will present the team to the reader and the kind of working tasks the team fulfilled. This is followed by a detailed description of the types of meetings that were a major part of the team’s working routines that I would shadow. The meetings that are described are not all included in the analyses section, however, the description is here to illustrate the material upon which the analyses is based (as well as to give the reader a fuller picture of the work of the team). Finally, I will describe what kind of initiative the team had aspirations to introduce; the Open Dialogue approach. I will describe its principles and how the team worked to create routines around the introduction of the approach.

In the following I will give a brief account of the reforms in the organisation of psychiatric care as a consequence of the de-institutionalisation processes that especially took form in the 1970s (Blinkenberg, Vendsborg, Lindhardt, & Reisby, 2002; Nielsen, Henriksen, & Sivertsen, 2004) of which the development of the Open Dialogue approach is also part of. With de-institutionalisation came the development of a new way to structure mental health care. It was called ‘district psychiatry’ (or community psychiatry). The first time the term ‘district psychiatry’ was used in an official document in Denmark was in 1965, where it was mentioned as a possible way of structuring the psychiatric services in Denmark (Lindhardt, 2002). Until 1976 the psychiatric services were organised under the state in asylums with between 500 and 2000 beds in each. Deinstitutionalisation is the fundamental idea of modern Western psychiatry. It is much more than just a change in the organisational setup of the psychiatric services. It is a change in how to perceive psychiatric illnesses (Ibid.). It is described as a process that has the purpose of integrating people with mental illnesses into the ‘normal’ society (Ibid.). It contrasts with the psychiatry of the big asylums where patients were isolated and rejected by civil society. The deinstitutionalisation process built on the idea that people live and develop in interaction with others. Also people with mental illnesses (Blinkenberg, et al., 2002; Nielsen, et al., 2004). In Denmark the development of district psychiatric models have taken their departure in the governmental document formulated by the ministry of internal affairs in circular 4.4.1977 in the report no. 826. District psychiatry is here described as the treatment of psychiatric patients that is provided outside the hospitals, as close to patients’ own environments as possible, and in as much avoidance of hospitalization as possible.
(Lindhardt, 2002). However there are no overall guidelines for how the organisation of
the district psychiatry is to be run and the of the field is still developing (Lindhardt,
2002).

More recently the deinstitutionalisation process has also been connected to a rhetoric
(discourse) of questioning of ethical values and freedom of choice (e.g. Mol, 2008;
Rankin & Campbell, 2006; Rose, 2007). The tendency to stress ethical values in health
care has resulted in different initiatives which tried to formulate policy papers in the
field of psychiatric care. In a nationally formulated code of conduct for mental health
care services in Denmark the following is written: “The point of departure is the
competent and free individual with the right to self-determination concerning his own life
and health” (Lindhardt & Christensen, 2005). Similarly at the county level, a policy
paper formulated by the Social- and Psychiatry committee in Storstrøm county, reflects
the national values: “Every person is unique and should be treated as such. Everybody
starting from their own resources shall be given the possibility to experience zest, curiosity
and desire to seek new challenges that creates self-worth. Briefly speaking, everybody
should be the main character in his own life.” (Storstrøms Amt, 2002). The policy papers,
thus, reflect awareness in health care of the ‘free individual’ and the right to be self-
determined. The fact that these papers are taken into account at an organisational level
is part of an argument about how something new is made available. In the county
studied for this thesis, at an organisational level, the management has initiated
investigations as to how patients may be included more in treatment decisions (Lisberg
Management, 1999; Storstrøms Amt, 2000, chp. 4).

This awareness can be seen at both the county and the community team level in the
district of Southern Zealand that I observed. At the county level overall organisational
changes in the psychiatric field in Southern Zealand took place in the years following
the structural plan of 2000. The structural plan formulated the entire psychiatric
measures in the county. It is a structural psychiatric plan where the ambition is to co-
ordinate all services independent of what sector (social services and psychiatric hospital
based services) the different services have previously been connected to (Storstrøms
Amt, 2000). The plan seeks to dissolve formal and informal borders between the
services offered in the area of mental health and is, as such, an example of the
deinstitutionalization and reform process that mental health care has been part of in
the latest years. This structural change can also be said to be a product of an awareness
of some of the tendencies that were raised through the national discussions on values
and ethics in health care at the national level. It involved a change in professional tasks
and responsibilities. A so-called “case manager function” was established in 2000. This change was a result of the desire of local politicians and management to focus upon the continuity of the treatment. Continuity means that ideally the patient should have the same professional contact person when being in contact with all the psychiatric services. A case manager would be assigned as the primary contact person who, on behalf of the patient, negotiated with all the relevant institutional contacts. The case manager should provide the link between the patient and all treatment institutions (community care and psychiatric care). One could argue that already in 2000 the seeds were planted which would promote changes in practices and professional identities.

In addition, in recent years patient satisfaction questionnaires (Amtsrådsforeningen, 2005; Lisberg Management, 1999) and lobby groups (like SIND and LAP) representing patients’ and relatives’ wishes to be better informed and more included in the treatment have raised awareness about their cause. Landsforeningen SIND (the Danish Association for Mental Health) is an NGO that advocates understanding and tolerance of people with mental problems and illnesses and their families (www.sind.dk). LAP is a NGO, founded in 1999, of Danish (Ex-) Users of Psychiatry. LAP works to raise awareness of alternative views on psychiatric treatment (www.lap.dk). The wishes expressed by these different parties were partly met by the head manager and the head of the education and research unit in the organisation in which this study took place. They were both attentive to these expressions of desire for change and they supported my formulation of my initial project.

Besides the attitudinal and structural changes at the national and managerial level, one community team had responded, in a very specific way, to the awareness of the issue of self-determination and inclusion of patients. This community team was the team that I ended following in its aspirations to change their working practices. Below I will give an organisational framework in which the team is placed.

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13 The term ‘case manager’ is also used in Danish.
14 As will be described further down, ‘continuity’ is also one of the core principles in the treatment approach that is investigated in the thesis.
15 All professions besides medical doctors can carry that title and function. In some outreach teams, however, psychologists do not hold that position. There has been an ongoing discussion in the psychiatric institution whether professions with so-called “responsibility of treatment” (and not only caring personnel) should be exempted from the case manager duty, because they have other responsibilities. In the team of the case, however, all staffs are also case managers besides the psychiatrists.
**Organisational framework**

The organisational diagram shows that the team (the outreach team is highlighted) is only a small unit within a much larger organisational structure. The organisational framework shows too that the team is placed in a district psychiatric setup\(^{16}\). The community team is connected in various ways to the rest of the organisation. These connections contain, for example, responsibilities, finances, managerial decisions, decisions of educational focus, policy decisions and so forth. It also includes patients who are hospitalized for shorter periods and therefore are placed for a while in other parts of the organisation in spite the continued contact with the team. In general although the team is not working in an isolated manner, the team members do have autonomy in the way they structure their work on a day to day basis.

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\(^{16}\) District psychiatry is under the jurisdiction of the Law of Psychiatry and refers to the hospital management rather than to the social services.
This organisational diagram was put into function from 1. January 2002. Amendments to this structure were initiated in the end of 2006 and the structure is therefore not representative of the psychiatric organisational set up at present.
The diagram shows that in this county the psychiatric services are covering both social psychiatric services and hospital psychiatric services. A research and education unit is serving both the management and developing projects addressing psychiatric issues in the county. There are different specialist units that the team is only occasionally in contact with. For example if the team has a patient that is also a traumatised refugee, there is a specialist unit offering therapy and targeted treatment. The diagram shows three districts (North, South and Mid), where each district is more or less organised in the same way: In each centre there is an open ward, and a closed ward, supported housing facilities and local psychiatric services where both social service personnel and the community teams provide care and treatment for the patients. As can be read from the diagram the highlighted team that I shadowed is sharing the patient uptake of the district with another team. They work independently from one another and have different treatment focuses, but have the same responsibilities. The staff members visit patients in the hospital in their district, they visit them in the housing facilities, and they conduct meetings with staff from social services. In the following I will give further details about the team and its working responsibilities.

**Description of the team**

The team is a multi-disciplinary team that at the time included a consultant psychiatrist in charge of treatment, a psychiatrist, a psychologist with a systemic therapeutic background, a team leader (nurse, with administrative responsibilities), a social worker, a social- and health care worker, a psychiatric worker, and a secretary (the last two staff members I did not shadow).

The community team was established 1st of January 2002 and is placed in a small town of 16,500 inhabitants in a rural district 130km South of Copenhagen. The team gave services to the whole region of Southern Zealand including approximately 75,000 inhabitants in rural areas and small towns. The community teams in the county were established in an attempt to change the district psychiatric system. The goal was to treat locally, and it was therefore attempted to treat patients, to a larger extent, in their own homes in order to prevent hospital admission. The team I was to work with at the time was sharing a two-storeyed building with one of the other teams in the district. The ground floor was mostly used by the team I shadowed, while the first floor was mostly used by another community team. It is a long rectangular building with exit doors at each end, the main entrance had the reception counter and a secretary who received the patients at the entrance. On the first floor a conference room was used for communal meetings and for the study group sessions. The main entrance gave onto a long corridor with offices on each side and a lunch room on the left. The lunch room also was used for supervision sessions and morning conferences. Most of the offices
were individual and the staff members at times held their consultations with the patients in their offices. An office has a desk, a desk chair, a computer, a telephone, a cupboard, a couple of plants, drawings or art on the walls, a pin board, a couple of extra chairs and sometimes an extra meeting table.

The patients affiliated to the team are both men and women of age 25-69. They are usually diagnosed with long term illnesses. The diagnostic groups are for long term psychosis, schizophrenia, bipolar and manio-depressive disorder, psychosis and such like illnesses. The team provides a service for patients with a double diagnosis, forensic patients, eating disorders, and patients of foreign origin. The team had a caseload at the time of approximately 100 patients. The average caseload per case manager in the team was around 20 patients.

The usual system for referring patients to the team is through either the general practitioner or the emergency ward, and occasionally the acute team. There is no waiting list directly connected to the team as the affiliation to the team is organised through a selection process and administered by the county manager (a consultant psychiatrist with administrative and financial responsibilities for the district). The county manager is responsible for the open and closed wards in the hospitals and for the three teams in the district. He distributes the patients on the basis of where they live, the severity and nature of the illness (diagnostic codes) and on the basis of availability. He makes contact with the team leader for an initial visit (pre-visit at the patient’s home). Patients can also be admitted through an acute team that has contact with patients with acute problems, if the patient needs extended service for more than half a year.

**Type of activities and meetings in the team**

The delivery of services by the team is of a coordinating and consulting nature mainly through home visits in social psychiatric cohabitation houses. The conversations at the home visits are about treatment and well-being of both a medical and social nature, and can include social training (how to take the bus, how to do shopping etc.). In general the team is not offering special treatment or training for the patients, but the staff cooperates with other institutions and authorities that have these services to offer, and they coordinate the activities for the patients. If patients are admitted to hospitals temporarily, the case manager from the team visits the patient at the hospital. The meetings with the patients are the core purpose of the team’s existence. But the team members also participate in a whole range of other types of meetings. Below I show a matrix of the types of meetings and activities that are part of the team’s working tasks and that I participated in.
### List of observed meetings

| Patient visits                  | Approx. 20 visits with 14 patients.  
|                                 | 3 sessions with couples, 2 visits that were ‘pre-visits’ |
| **Morning conferences**         | Every morning the team meets to go through the activities of the day. |
| **Team meetings**              | A few day meetings were held where more general themes would be taken up for discussion. It could be the restructuring of the organisation, or how to work as a professional in an Open Dialogue way. |
| **Meetings with other members of the organisation** | Middle management and psychiatrists meeting on the audit of NIP (National Indicators of Psychiatry) that is a system of standardizing measurements within schizophrenia that all psychiatric institutions participate in. |
|                               | Regional thematic workshop. About the national restructuring of the counties. |
|                               | Meetings with members of staff from other teams and district management on changes in the organisation of the district. |
|                               | Meetings with members of staff in collaborating institutions (municipality and other care facilities) |
| **Supervision sessions**       | 3 times: 07.11.05, 24.11.05, 24.04.06  
|                               | The team meet approximately once a month with a psychologist that has experience with Open Dialogue for two hour sessions to talk about their work with the approach especially with a focus on their relations with patients. |
| **Study group sessions**       | 4 times: 14.11.05, 12.12.05, 23.01.05, 28.08.06  
|                               | The team meet every fortnight on Monday mornings to discuss and practice the Open Dialogue approach |

In the following I will elaborate on the meetings I shadowed (see table above). I also indicate which meetings have not been included as part of the active empirical material of the thesis but offer background information (see methodology chapter for justification of the selection) The supervision sessions and the study group sessions are activities that are directly connected to the innovative efforts of the team and their wish
to introduce the Open Dialogue approach, and these two types of meetings will be described further in the section where I introduce the principles of the Open Dialogue approach.

**Patient visits**

The visits with patients were of varying character. Most patient visits that I participated in were at the private home of the patient (both in cohabiting housing facilities with helping staff and in individual homes). A few were in the office of the team member responsible for the patient. Some visits were at the ward if one of their patients were hospitalized. I would be taken by the team member for a pre-scheduled visit, where the patient was prepared for my presence.

Usually these visits were of a follow-up nature and the staff and the patient spoke about life, concrete experiences and how to deal with those things. Here are some examples: On one visit a young man, with a girlfriend and a baby, has returned home from a hospitalization period due to a manic disorder. The visit includes the girlfriend, and the social worker talks about practicalities with the patient and how to get out of the debt he has put upon himself during his period of illness. The social worker talks with him about making a practical “to-do-list” and talks about the possibility of starting an education. On another visit the social- and health care worker is meeting with a group of staff at the social services department concerning a patient that has her child in custody. The social services staff members have raised a problem about the patient having the child visiting her. The social- and health care worker represent the patient and inform her about what it means to have a psychiatric illness. A third example is when a patient comes into the office to meet the psychiatrist. They sit in her office and discuss how the patient says she is not satisfied with the medicine she is taking and the psychiatrist looks at the computer for alternatives and discusses with the patient how it could be possible to change the treatment. On another visit the consultant psychiatrist is going to the closed ward where a new psychotic patient has been hospitalized. They meet in a special consultation room and the consultant psychiatrist talks with the patient about his experience and his psychiatric history and more generally about what makes the patient feel ill.

I attended treatment sessions at the office which the psychologist held with couples, and also I attended a recurrent session that the social and health care worker held with a patient who said she liked to get out of the house.

There were also visits at the patients’ homes that were pre-visits. A ‘pre-visit’ or pre-visitation is a session where usually two staff members meet the patient and have a talk about the needs of the patient and what can be done. Subsequently the team members
discuss whether the patient should be connected to the team on the basis of what the team can offer and how it matches the needs of the patient. The patient is usually connected to the team after these visits.

**Morning conferences**

Another important recurrent activity in the team is the morning conference. The team meets in the lunch room on the ground floor at 8:30 for the half hour that the morning conference takes. The purpose of the meeting is to run through the patient list, illustrated below, and take decisions on who is taking responsibility and will be in contact with each patient and when. The group goes through the patient history of each patient, and describes its status and what needs to be done. It is usually run like this:

A patient list has been printed out for everybody to follow and make notes on. The patient list contains the information of either new patients that have been affiliated to the team or one of their ‘old’ patients who has been hospitalized during the night or the weekend when the team has not been in the office. For new patients there is a discussion of which staff member will be the primary contact with the patient, to become his or her case manager. At the morning conference each team member also briefly informs about what working tasks they have planned for the day. For example one staff member says: I visit Mr. so and so at that hospital and I have a consultation with Mrs. so and so at the office. The conversation at the morning conference is characterized by a one-to-one dialogue, where team members ask questions, for example, about a medical adjustment in the treatment of a patient and the consultant psychiatrist provides answers. Decisions are taken and there is also a follow up of former decisions taken (for example if a patient had to end treatment and a staff member reports back on how it went).
Illustration of patient list used for morning conference

<table>
<thead>
<tr>
<th>Case/team member</th>
<th>Wished discussion</th>
<th>Eventual arrangements and appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running through of hospitalization lists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of the patient: x</td>
<td>Condition and situation</td>
<td></td>
</tr>
<tr>
<td>Name of the patient: Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of the patient: Z</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The morning conference is not, in itself, analyzed in this thesis, but what is analyzed is how the team performs knowledge claims in different ways that are performed in the morning conference. As such, the morning conference stands in contrast to the innovative efforts of the team. In that way the morning conference is not explicitly included in the analyses, but works as important back-ground information in how initiatives come to be different than this type of meeting activity. It is what I come to call a present absent, and is a point of reference in those chapters where I analyze the study group meetings with the circle of chairs, present temporality and the analysis of silence and its production of human collectivity.

**Team meetings**

Team meetings were held two times during my stay. These were organized to discuss in depth a topic of the team’s own choice and lasted for an entire working day. One time it concerned the ways they could continue working with their initiatives of Open Dialogue in spite of the structural changes that were going on in the district. The other time it concerned how to work as a professional in an open dialogue way. I have not explicitly used material from these team meetings but I have two analyses that deal with how the innovative efforts also perform professionalism in new ways and, as such, touch upon the topics debated at the team days. The one is called multiple presences (chapter 11); the other is on how the psychiatric doctrine and principles from the Open Dialogue approach can be intermingled without tension, called adding together the psychiatric doctrine and humaneness (chapter 12). I found the empirical material used for these
two analyses more suitable for describing the subtleness and details about how the initiatives would also perform professionalism in new ways. Especially in the first example where the material used is the spatial set up of the room that makes an important difference as to how professionalism is made available. I would not have been able to make these nuanced descriptions simply from the field material available from the team meetings.

Meetings with other parties

The staff members also meet with representatives from the municipality. If it is needed the case manager establishes contact with patient organisations and other relevant authorities in contact with the patient (the social services, medical practitioners, housing facilities etc.). It could be with staff at the municipality where meetings concerning a patient who also has a social service problem, are taking place (for example a patient that has a child in custody). Or the legal system because a patient needs to go to court, if she or he has committed a criminal offence during a state of psychosis. The staff members also meet with social service staff at the housing facilities where patients live. This could be about the discussion of the psychiatric problem and ideas for solving the challenges presented by a patient having difficulties living in community homes. In those housing facilities they train the patient in social abilities such as what it means to live in a society and to live together with other people, and also about hygiene, making food, taking public transportation etc. At times the psychiatric difficulties pose challenges for the patient to participate in those things, and the staff member of the team would discuss how to deal with this with the staff members at the housing facility.

Responsible staff members (team manager and consultant psychiatrist) also participate in audit meetings concerning how to fill out questionnaires such as the National Indicator Project on Schizophrenia. The Danish National Indicator Project (NIP) measures the quality of care provided by the hospitals to groups of patients with specific medical conditions. The aim is to create awareness about the extent to which the completion and outcomes of the treatment are up to the standards defined by health specialists who daily work with the diseases in the clinical practice. Within mental health the National Indicator Project is developed in the area of schizophrenia.18 Other types of meetings from the team’s existing working practices are information

18  http://www.nip.dk/about+the+danish+national+indicator+project. In 2009 depression will also be part of the indicator project.
meetings conducted by the district management on information of restructuring the organisation or about management decisions of initiatives involving the conduct of the team’s working practices, for example on electronic versions of the monitoring of activities or the Electronic Patient Record.\textsuperscript{19}

In none of those meetings the innovative efforts were visible. Potentially one could have raised the discussion of why this is so. One reason is that the team had not yet gained the routine of working with the approach in all aspects of its working practices. It was still in its initial stages in terms of how comfortable or uncomfortable the staff felt when having to present their ideas of the approach (see for example the analysis on multiple presences (chapter 11). But the reason for this is also explained by the fact that when something is new it has not yet enrolled allies and thus gained stability. This is a continuous process and when Open Dialogue is performed in a national questionnaire audit or at the municipality, or being instructed on the electronic patient record, the Open Dialogue approach is in a difficult and invisible position. This is because the way those meetings are performed have a much longer institutional history and, hence, multiple alliances in and out of the organisation. National questionnaires, electronic patient records and municipality meetings are therefore hard to convince being performed differently than with a reference to the medical world view. And this is a plausible reason as to why the Open Dialogue approach was not yet visible in those settings. The process of enrolling allies and gaining strength is further explored in the section “Gaining strength and stability” in the chapter on analytical resources.

Lastly, the Open Dialogue approach has, in several cases, been performed as unique, closed and invisible. These three performative effects are also possible reasons as to why the innovative efforts were difficult to see in meetings that involved parties other than the team. These performative effects produce a purified version of the innovative efforts that is difficult to translate and compromise or even engage in dialogue with.

This brief presentation of the team gives a sense of the responsibilities and the working tasks the team had prior and during the efforts to innovate their working routines. In the following section I will present the overall principles of the approach the team decided to introduce as a means to innovate their working practices. I also describe the supervision sessions and the study group sessions as two types of meetings that are central to the team's efforts to introduce the innovation in treatment and which are central to the empirical material I analyze.

\textsuperscript{19} In January 2005 the county administration started the use of electronic referrals for the use of all general practitioners and medical doctors in Denmark.
The Open Dialogue approach

The Open Dialogue approach is designed as a tool to renegotiate ways of professionalism and approaches to the patient (Seikkula, 2002/2000; Seikkula & al., 1995; Seikkula, Alakare, & Aaltonen, 2000). The approach is based on social constructionist language theory (e.g. Gergen, 1985) and has a network based approach inspired by systemic therapy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). These two primary sources of inspiration give psychiatric staff the opportunity to work with an approach through which they attempt to innovate psychiatric care.

The Open Dialogue approach has its roots in Northern Lapland. It took off in the mid 1980s with a similar motivation to the one in the community team shadowed for the field work in this thesis, namely to develop an alternative to the existing psychiatric practices (Andersen in Seikkula, 2000, p.9). In Northern Lapland the approach was developed in consultation with families who were not satisfied with how treatment and meetings were taking place at that time. At the beginning of the 1980s the psychologist Jaakko Seikkula and consultant psychiatrist Jyrki Keränen became responsible for the emergency psychiatric services, and later for the whole psychiatric services in Western Lapland with 72,000 inhabitants. Later they also moved the network meetings to the patients’ home. They changed the form of the meetings and the way the meetings were conducted and, with time, more families wished to participate in the treatment meetings.

Open Dialogue revolves around seven principles that include: instantaneous help, dialogue, social network perspective, responsibility, flexibility and mobility, continuity, tolerating insecurity (Seikkula, 2002/2000; Seikkula & al., 1995; Seikkula, et al., 2000; Seikkula, Alakare, & Aaltonen, 2001; Seikkula & Olson, 2003). These principles will be elaborated below. Each of these principles is the product of a larger argument and they refer to a specific way of defining care. The definition of those principles is to a large extent formulated as ‘alternative’ to existing mental health organisational standards. Defining what Open Dialogue is, is therefore also in opposition to what is still prevalent in existing (governmentally funded) health care systems, such as diagnostic measures, efficiency and cure measured through clinical evidence parameters, and, not least, the traditional position of experts. Counter to this the aspiration in Open Dialogue seems to be to teach professionals to perform Open Dialogue principles in order for them to be

20 Also called the ‘Lapland model’ due to its geographical place of origin. Further, it is deliberate that I use the term ‘approach’ and not ‘treatment’ or ‘model’, because these terms connote alliances with a medical world view where treatment is a way to find solutions to a problem. As will be clear in the analyses, the performance of Open Dialogue in this team is very much about finding an alternative to that form of health care.
able to perform psychiatric health care as an alternative to existing practices. Defining Open Dialogue treatment as an alternative means, for example, to dissolve expert positions and for them to become facilitators that enable the patients to define in their own terms the prevention, care and cure. In overall terms Open Dialogue treatment approach as such is more a way of thinking about the relationship between patients and professionals rather than as a set of statistical parameters that can be met.

The international literature refers in more detail to the seven main principles in the following way (Seikkula, 2002/2000; Seikkula & al., 1995; Seikkula, et al., 2000; Seikkula, Alakare, & Aaltonen, 2001; Seikkula & Olson, 2003):

Instantaneous help – the first meeting is organised between the patient, her family and other key persons in her network, together with the psychiatric contact person and relevant professionals preferably within the first 24 hours of contact with the psychiatric organisation.

Dialogue – The focus is primarily oriented towards the creation of dialogue, and secondarily towards changing the patient or her family. The approach is inspired by constructionist language theory (e.g. Gergen, 1985), and a psychosis is described as a crisis that has not yet developed its vocabulary (Seikkula, 2002/2000). The diagnostic system (DSM-10 is prevalent in mental health practice working under standardized mainstream criteria) is in principle, therefore, secondary or, in isolated terms, irrelevant as Open Dialogue attempts to operate with a minimal preset definition of what mental illness consists of, and does not have predefined criteria based on measures of symptoms.

Social network perspective – The network of the patient is always to be invited to the first meetings. The conditions, needs and reality felt by the family are in focus. The employer or colleagues can also be included in the network. Network meetings have as a primary objective to let patient and relatives develop a language and a dialogue around, and about, the crisis (psychosis). These meetings have as a core ambition that nothing is said and decided without the patient in question being present and able to speak his/her mind.

Responsibility - The personnel that receive the inquiry from the patient or her network is responsible for arranging the first meeting. At the meeting all decisions about treatment are made and the psychiatric personnel that are present take responsibility for the whole treatment.

Flexibility and mobility – The meetings are to be held somewhere where the patient and her network feel comfortable. Most often the network meetings are held in the patient’s own home. The frequency of meetings, the issues of discussion and choice of
treatment is decided upon individually.

Continuity – The psychiatric team in Lapland usually consists of three interdisciplinary personnel. It is important that they represent different areas in the psychiatric organisation – hospital as well as district psychiatry. They take responsibility for the meetings and the treatment as long as is necessary. This ensures continuity in the contact with the patient whether the patient is hospitalized or in outpatient treatment. The descriptions of the previous meeting are taken along to all the subsequent meetings.

To tolerate insecurity - Nobody participating in the meetings should be prejudiced about what the solution to the problem is or might be. Open Dialogue builds on the idea that the network and patient create a new meaning to the problem at the meetings. It creates insecurity not knowing what the solution is from the beginning. It also means that, ideally, only tranquilizers and not psychopharmacia are prescribed as the first remedy in order not to blur experiences.

From these principles, therefore, Open Dialogue treatment is constructing a patient-professional relationship that formulates challenges as to how care should be conducted. The principles in Open Dialogue, thus, formulate an ideal of a relationship between patient and professional that is not based on a set of statistics or stable parameters, but one that is trying to develop a language and practice to discover a way to meet the patients first as human beings before seeing them as patients. This, according to the Open Dialogue performers and developers, does not necessarily mean to neglect the need for relief and care of the patients.

**Summing up on Open Dialogue principles**

This thesis is not an analysis of the extent to which the above defined principles are implemented in the daily working practices of the team. As will be elaborated more fully in the chapter on analytical resources the argument for this lies in the point of departure taken in a performative approach. Briefly, it means that in spite the formulation and inspiration of those principles, Open Dialogue is performed locally. Some elements may be left out in a local practice. Other elements might be added and adapted. The way the Open Dialogue approach is configured locally depends on how these principles are taken up, and how Open Dialogue is performed in relation to the local organisation’s working practices. By this is meant that the principles described above stand as a point of reference for the reader to get a sense of how the Open Dialogue approach has influenced the team that has been shadowed for this project. When reading the analyses of how the approach is made up locally, the reader will, to
some extent, recognize the transference of some of the principles. However, the Open Dialogue approach is also composed in other ways and thus Open Dialogue is seen to be performed in ways that are about much more than the seven principles and their implementation.

The aspiration of Open Dialogue in the community team

In the following section we will travel from the Lapland formulation of the principles of Open Dialogue to the community team that I shadowed. What is it that makes the Open Dialogue approach so particular in this place? Why is that the approach that the team decided to introduce to innovate their working practices? The following gives a sense of why this is.

The quotation below is taken from what the staff members have stressed to be important when explaining what good care is about:

The social and health care worker explains what reflection does to their relations with the patients: “we are not know-all, we are more knowing21. This is because we know that we don’t know”

And the team leader says in the study group meeting 14.Nov05: “To reflect is to a large extent about holding one self and ones opinions back”

I find that these expressions precisely describe what the team is aspiring to in their wish to change health care practices and for what the team is trying to perform with the introduction of the Open Dialogue approach22. They want to make space for reflecting upon what knowledge is and what it is made of. But it is also about collectivity, about how knowledge and care is not something inherent in an individual or an expert or a questionnaire. The initial inspiration to start the process of introducing Open Dialogue treatment in Southern Zealand is, on the one hand, similar to the motivation in Finland23. On the other hand, locally in the team the team leader and the consultant

21 This translation into English does not put justification to the nice play of words. In Danish ‘know-all’ connotes knowing better in an arrogant way, while ‘knowing more’ connotes, as the social and health care worker says, being aware that being a professional you cannot know better, but you can know that you do not know.

22 It is difficult to say what initiated the wish for introducing reflection into health care in this team. Is it the Open Dialogue approach introducing reflection and the discussion of meanings through its roots in language theory or is it the staff’s wish to change psychiatric care and the approach to patients making them introduce Open Dialogue and hence ‘reflection’ into their practices? It is difficult to say and in this approach not important either because it is about the way reflection is performed and not about its origin.

23 The following description is composed from information written down in my field notes. As there are none of the psychiatric staff members from the shadowed team left, it has not been possible to double check the precise details of this composition.
psychiatrist are especially referred to by their colleagues in the team as the initiators of introducing the Open Dialogue approach within the team. As mentioned above in relation to the construction of the case-manager function, the initial process of starting to talk about the ideas and values of Open Dialogue happened shortly after the restructuring of the whole psychiatric services in the county in 2000 (Helhedsplanen 2000. This change was part of the deinstitutionalization process and involved an increase in the establishment of community teams and a decrease in the amount of hospital beds. Due to the recent restructuring of the working tasks and the overall restructuring of the organisation the team, therefore, does not have a long history of existence. Shortly after this restructuring process was started, the team was in a position to employ additional personnel. The staff in the team that had not been interested in working with the new responsibilities laid out in the plan of restructuring had left and the team, as a group, was in favour of employing somebody who could strengthen their work with the Open Dialogue approach. Therefore a psychologist with a systemic therapeutic background was appointed to the job.

Structuring the learning process

The introduction of the Open Dialogue approach has taken place mostly in study group sessions and they were established in this institution just a few months before the initiation of this thesis (Jan. 2005)\textsuperscript{24}. A study group was a two hour meeting held every fortnight, on Monday mornings. The study group was about ‘the what’ and ‘the how’ of Open Dialogue. It means that the group would both discuss the meaning of Open Dialogue principles such as: the meeting with the patient, respect, dialogue, reflection. And also the group would try to act in an Open Dialogue way. This means that their way of organising the room with, for example, a circle of chairs and no table in the middle and how they organise the interaction through rounds of conversation and reflecting teams (Andersen, 1994) mirrors the way Open Dialogue is done in Lapland.

Supervision sessions

The supervision session takes place approximately every two months. It is a videotaped two hour session where an external psychologist is helping to run the meeting. The topic of these sessions is usually about the staff members’ relation to patients. So rather than talking about the problems of the patient, they would try to focus on how they, as

\textsuperscript{24} The reason for that is found in both the fact that the team had spoken about this for a while and at the same time the formulation of the research project in collaboration with me made an opportunity to stress the Open Dialogue introduction process more in their daily work routines.
staff, relate to the patient. The sessions are video recorded for the purpose of learning from them. I subsequently obtained permission to see the video recordings. This type of activity is used in the analysis on silence (see chapter 14).

**The Study Group**

In the study group participation was opened to members of personnel from other teams and hospital wards. Two nurses from outside the team participated on a regular basis\(^{25}\). At a more formalized level the consultant psychiatrist and the psychologist attended a course on network therapy in Tromsø in Norway. Whenever they had been away on a training week they would report back to the group. For this feedback they would usually, but not only, use the study group sessions. Often a theme of their training, for example how the term ‘reflection’ would take form and be discussed, would be brought to the study group, and reflected upon again. The way they would bring new knowledge to the group was not prescriptive, nor would it directly impose decisions on how to conduct the Open Dialogue approach.

The study group was conducted only with the staff and without patients. The decision to start these sessions only with staff was based on the argument of building up confidence and knowledge about how to perform Open Dialogue before, so to speak, taking it out to the ‘real’ practice where the staff members encounter the patients. The organisation of network meetings in principle should be organised within 24 hours after patients have been referred to the community team – this is one of the structural elements of Open Dialogue treatment that has only, to a limited extent travelled into the daily practices of the community team. In spite of the fact that the Open Dialogue approach has not been institutionalized very much outside the study group, each staff member would tell me about how they felt that Open Dialogue has had a great impact on how they approached the patients in their work. They explained that the way they see themselves as professionals has changed. In that respect several of the staff members, on different occasions, explained that they do perform elements of Open Dialogue in their usual meetings with patients: for example the dialogical approach, trying to refrain from giving answers and advice but rather listening, not being diagnostically oriented, and also other elements that refer directly to the principles formulated as core in the Open Dialogue approach. Therefore, according to the staff, a learning process and change of practices has indeed been commenced. However, the study group settings are the most salient situations where conclusions about what Open

\(^{25}\) The external nurses are not at any point in focus in the analysis. However they were included in my use of the empirical material where they participated.
Dialogue is within the team can be more categorically deduced.

These sessions are important material because they show how the team, ideally, would like their practices to be performed. These sessions gave me an insight into how the teams’ practices could look like if their efforts gained a foothold beyond the study group sessions. Observations from the sessions are both used directly and indirectly in the analyses. Directly they are used in the analyses on ‘closed dialogue’, ‘intensive dialogue’ and ‘multiple presences’. In those analyses spatial set ups and temporality have been of central importance.

**Network meetings**

However some network meetings including patients and their relatives have taken place\(^{26}\). Prior to deciding whether to hold network meetings with patients and their relatives, a very thorough discussion would take place amongst the group of staff. Generally, they discussed the ethical aspects of it with the specific patient in mind, and discussed whether the member of personnel who was the contact person (the case manager) would feel ‘ready’ and comfortable conducting such a meeting. Another factor was the requirement that three face-to-face meetings a day with patients had to be reported to the organisational monitoring systems of all activities. This was felt to be an obstacle to holding the network meetings where several team members had to participate\(^{27}\). Most meetings were, therefore, still held with just the patient and his/her contact person from the social services and the case-manager. The staff also discussed that network meetings were easier held with patients that were new in the psychiatric system. They were of the opinion that it would be difficult to explain the value of a different treatment approach to an existing patient, and that it would sometimes cause too much anxiety and distress for the patient if the usual way of conducting treatment were changed.

The mobility aspect of organising the work practices is not new to the team either. Being in the structure of a community team, the staff members visit patients in their homes all the time. It is a core part of how their work is organised. But the meetings in the patients’ home are mostly structured as a one-to-one meeting and not as Open Dialogue network meetings where families and several staff members would be invited.

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\(^{26}\) I have not had the chance to participate in any of those.

\(^{27}\) The team members explained this as an obstacle in the sense that only one of the participating staff in a network meeting would be counted in the statistic of team activities by the management.
Summing up the introduction of the team’s work

Summing up, the introduction of Open Dialogue is made possible because of the overall development of the psychiatric health care system through both structural reforms (less beds more community teams) and attitudinal changes (e.g. stressing the importance of self-determination for patients). However, the team members’ focus values like ‘respect’, ‘listening’, ‘equality’ and ‘collectivity’ seem in many ways to align with the already mentioned criticism of a prevalent medical, managerial and economically steered psychiatry. However, there is more to it than that. The struggle to introduce the Open Dialogue approach is not, at least not only, about paradigmatic distinctions between a medical world view on the one hand and a holistic on the other. The distinctions are constructed but only to be challenged and translated in the struggles of the daily practices in the team. Practically speaking these proposed oppositional paradigms are ideal and purified constructs that are challenged both in the forwarded criticism but also in particular in the daily practices of the team members. Further, establishing a new practice requires both to argue for its originality (its newness so to speak, because if it was not new there would be no reason to change existing practices), and to show its compatibility with the existing practices. This thesis explores how that is done.

In the following chapter the analytical resources that have been used to inform and understand the empirical material will be presented.
5. *Analytical resources*\(^{28}\)

It was mentioned in the introduction that the theoretical foundation of this thesis is in the research of ANT and STS. I argue that this theoretical position is highly relevant in order to understand what we can learn about innovation processes from the efforts of the team of personnel who introduced Open Dialogue. The purpose and goal of this thesis is to explore the processes which enable me to talk about and describe the introduction and the innovative efforts of the team. These processes are, as already mentioned, conceptualized through readings that have roots in STS and Actor Network Theory\(^{29}\) (e.g. Callon, 1986; Callon & Latour, 1981; Haraway, 2004; Hassard & Law, 1999; Kuhn, 1962; Latour, 1987b, 1993/1991, 1996c, 1997, 1999b; Latour & Woolgar, 1986/1979; Law, 1992, 1999; Law & Singleton, 2005; Mol, 2002, 2008; Mol & Law, 1994; Serres, 1995). These readings, I argue, provide me with the premises to understand that pasteurization, onions in burgers and cervical programmes or, for that matter, innovation processes in the Open Dialogue approach, can be understood from the perspective of heterogeneity and incoherence.

**Theoretical minimalism**

The readers of this thesis will find that there has only been a minimal theoretical frame constructed. It means that very few concepts are making the foundation of how I have shaped the text. The minimal approach has informed the ways I have approached the material, the selection of examples and the analytical framework. For this STS has been very valuable as it has provided me with the tools necessary for this approach. The reason to which I take a minimal stance to theory is due to the fact that with an STS reading what we investigate in the world is not detached from what we say about the

\(^{28}\) Within the social-constructionist and poststructuralist field “analytical strategies” is commonly used to describe the complexity of theories and terms that are used in an analysis (Esmark, Lausten, & Andersen, 2005a, 2005b). Even though the term “analytical strategies” can be a fine alternative to using the more fixed term ‘theoretical position’ I have chosen another term, namely ‘resources’ to cover the analytical and theoretical inspiration in the thesis. Resources I find is a more precise term, because they are applied in the analysis where it is appropriate, rather than being an established theoretical position or predefined strategy. The terms presented here are thus thought as meta-theoretical points of departure rather than as an overall strategy.

\(^{29}\) STS and ANT have several points in common. A few of those will be elaborated in this chapter. The reason why I still use both terms in this initial reference is due to the fact that ANT can be said to have its own particular history of development starting with its provocative so-called “laboratory studies” (e.g. Latour & Woolgar, 1986/1979) and developed as an independent approach to studies on science, technology and society. Michel Callon, Bruno Latour and John Law are said to be the pioneers who formulated ANT’s initial ideas. I subscribe heavily to their work, but also to others within the field of STS and I will therefore use the term STS when referring to a principle that is generally shared in the field and ANT for terms that are particular to the ANT history.
world and vice versa. I thus approach theory as a practice that together with the material at hand can raise interesting and relevant questions. The theoretical and analytical potential of approaching theory as practice\textsuperscript{30} has as its source the insistence of combining ethnographic studies with investigations of philosophically relevant questions, for example about how reality, truth, specific practices, human or technology are created and constructed. Approaching theory as something that is entangled with and influenced by, and produced by what happens in the world, it is thus more a way to pose specific questions about the matter of the world rather than being a consolidated disciplinary tradition. It thus combines a philosophical interest in posing “basic questions” with an STS and ethnographic interest, something that Mol (2002) also calls “empirical philosophy”. The result of asking empirical philosophical questions might also explain why STS is not a closed theoretical box since it promotes its analytical field as distributed, complex and dynamic. Mol (2002) especially is to be taken as one of the pioneers in formulating this standpoint. Approaching theory as practice can be considered as an attitude or a disposition (Bruun Jensen, Lauritsen, & Olesen, 2007; Gad, 2005, 2009), that takes its point of departure in studies about how reality in ongoing ways is constructed in particular settings, and not as a ‘strong theory’\textsuperscript{31} that is to explain the world. I, therefore, only apply theoretical tools that enable me to ask those interesting relevant empirical questions. This is also the reason why this chapter is also intended to present the reader with the minimal analytical premises applied in the analyses whose purposes are to strengthen the argument about how theory and empirical material are interrelated and constructed. In the analytical chapters there will, thus, be introduced further theoretical concepts that are closely linked to a particular empirical phenomenon.

Raising empirical philosophical questions also implies that the new initiative of Open Dialogue to innovate the psychiatric care can only be understood through a local analysis. This is further the reason for my argument to leave most of the theoretical discussions to develop in the empirically informed analyses.

The chapter presents the fundamental, minimal analytical concept of the thesis, namely the principle of \textit{generalized symmetry}. It is used as an argument that explicitly refrains from defining things in advance of an investigation and, thus, turns towards a more

\textsuperscript{30} This thesis applies such an approach to theory, what has elsewhere been introduced as “empirical philosophy” (Mol, 2002). In Mol’s book “The Body Multiple” (2002) she used the term to define her approach in how to investigate medical scientific practices on atherosclerosis in Holland.

\textsuperscript{31} ‘Strong theory’ is on the contrary an understanding of theory as a general frame of explanation in relation to how the world or parts of the world is and works (Gad, 2009, p. 3). Theory in that respect can be used prescriptively or as a frame of explanation in relation to a whole range of different phenomena.
methodological conceptualisation of the use of theory. With the concept of symmetry I discuss the aim of ‘flattening’ my analysis in order to approach not individual categories or actors, but rather to focus on what occurs in order to explore the performance of new practices. ‘Flattening’ therefore means potentially treating all entities, so called actors, alike. This is explored in the section on the performative turn. The performative turn concerns a shift within research to focus on how things are becoming, rather than how they are per definition. Such a shift in focus on how things are becoming is inviting an investigation of how things are related and connected. Coupled with the ANT informed approach of a symmetrical ambition, my orientation becomes constructionist rather than a social-constructionist. The shape the relations between the performing actors take I conceptualize as configurations.

**Actor-Network Theory**

As mentioned in the introduction I draw on the Actor-Network theoretical framework that is part of the Science and Technology Studies. I will in the following sections describe what I draw from this source of inspiration. ANT was formulated as an independent approach in the field of studies within science and technology and initially was thought of as a provocation towards well-established sociological theoretical terms. Originally, the academic work that led to what today is called the classic ANT took place primarily in Paris with Michel Callon, Bruno Latour and John Law as developers. They drew primarily on elements from semiotics, post-structuralism, anthropology and philosophy. They were particularly inspired by theorists such as Michel Serres, Gabriel Tarde and Algirdas Greimas. Lastly, they included their own empirical studies in the development of their theoretical ideas. Examples of texts that develop and establish the classic ANT thinking are: Latour & Woolgar 1986/1979, Latour 1987, Callon 1986, Law 1992, Law 1994. The ANT position was established through the ethnographic studies of laboratory practices such as those described in the introduction. ‘The Pasteurization of France’ by Latour was written five years after the pioneering laboratory study from the Salk Institute in the US (Latour & Woolgar, 1986/1979). Through ethnographic observations Latour (and other pioneers like Knorr-Cetina and Lynch) studied the scientific innovation processes by the means of methods developed within the social sciences and the humanities. This approach added to the discussion about the social nature of the production of scientific fact, as argued by Kuhn in 1962 in his book on the “Structure of Scientific Revolutions” (Kuhn, 1962). Kuhn argues that the production of scientific facts is not a matter of the discovery of ‘true nature’ but is rather directed by scientific rules and schemes in scientific communities. This is important to my understanding of how factual knowledge is never something static and unquestionable. It is something that is constructed.
**Symmetry**

From the inspiration that the production of scientific facts are not merely a matter of a natural discovery, the principle of symmetry was developed by Bloor and Barnes. Bloor stated that the same types of explanations should be used for successful and unsuccessful knowledge claims alike (Bloor, 1976). The principle states that both ‘true’ and ‘false’ knowledge deserve a sociological explanation and that the explanation of both should be done in the same terms.

**Heterogeneous innovation processes - The principle of generalized symmetry**

The principle of symmetry was developed further with the study of the disappearance of scallops in Normandy by (Callon, 1986)\(^{32}\). What Callon added to the symmetric principle was that knowledge claims should not only be explained in social terms but should be explained by taking into account all the heterogenic entities in explanations and productions of facts. The rather controversial extension of the symmetric principle has to do with the fact that ANT researchers agree with Kuhn, Bloor and Barnes who said that a social dimension should be added to the production of knowledge claims. However, the ANT pioneers added the fact that nature is not a matter of discovery. Nature is already social, and the social is already natural. Nature is enrolled in configurations that are made up by heterogenic entities: social as well as natural. Writing with an inspiration derived from ANT therefore establishes the premise of treating humans and non-humans alike.

> “There are simply more agencies in the pluriverse, to use William James’s expression, than philosophers and scientists thought possible.” (Latour, 2005, p. 116).

Some researchers disagree with this ‘flat’ disposition and have rejected the possibility of treating humans and non-humans symmetrically (Collins & Yearley, 1992; Fuller, 1996). This, however, I find more a matter of an ontological standpoint and will not be taken further in this text. Latour’s point in the above quotation is that it is not possible, a priori, to map out all types of agencies, or ontologies for that matter. The effect of the principle of symmetry is that as scientists we simply cannot presume that we will

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\(^{32}\) Further the principle of symmetry has been extended to discard a whole range of social scientific categories. For example the so-called micro-macro divide (Callon & Latour, 1981). Here the difference between micro and macro is also seen as a network effect. See also (Svenningsen, 2003) for a detailed description of the different divisions that are discarded.
discover truths, but that we engage in collective scientific knowledge making through the acknowledgement that what we investigate will always surprise us, destabilize our knowledge and reinvent realities endlessly.

However, it is important not to misunderstand the principle of symmetry:

“ANT is not, I repeat is not, the establishment of some absurd ‘symmetry between humans and non-humans’. To be symmetric, for us, simply means not to impose a priori some spurious asymmetry among human intentional action and a material world of causal relations.” (Latour, 2005, p. 76).

Put very simply it means that every entity, human as well as non-human has the ability to contain both the role as a signifié and a signifier, which means that it can refer to other things and places and, by this, has the ability of agency. The principle of symmetry implies several things:

Human and non human actants do not have specific abilities a priori. It is the assembly (and not the individual) that constitutes the investigation, which means that it is the work made by the human and non-human actants jointly that is to be placed in the centre of the analysis.

No actants are foregrounded above others just because they appear to have specific a priori qualities.

**Gaining strength and stability**

The principle of symmetry also has the effect that any distinction in level, size and proportion is a result of a fight or a negotiation (Callon & Latour, 1981, p.279) or what Latour has called ‘trials’.

“There are only trials of strength, of weakness. Or more simply there are only trials. This is my point of departure: a verb, “to try.” (Latour, 1993/1984, p. 158).

33 In the studies of Actor Network Theory the conceptualization of agency is broadened out to include both human and non-human. This means that the question of intentionality, subjectivity and interest is not inherent in the human body, it is co-produced in the relational setup. I will discuss agency further in the paragraph on actors/actants.
Trials are the decisive prerequisite to gain order and stabilization. The idea of trials as a prerequisite to gain order and stabilization is an approach that is common in ANT and was especially so in the formative years of ANT. It was inspired by Serres (1982) in his book “The Parasite” (Serres, 1982) where he uses the terminology of war to explain the dynamics of business and science. A trial of strength is happening every time a practice tries to gain new allies to its cause or in the production of fact. This can be explained in another way as well: The entities that compose a practice are not only belonging to that particular practice. At the same time they are also entities in other practices. In order to make an entity part of or stick to a particular practice, trials of strengths between practices are necessary to convince the entity to connect and stay in place (Sørensen, 2005, p.46). However, the concept of trials belongs to the initial developing years of ANT. The term can be added to the criticism against ANT that it is too managerial and that it focuses on how knowledge claims get, and remain, stabilized. One might use an empirical situation, for example the study group session held in the outreach team, and see how the battles between medical paradigms and Open Dialogue holistic principles would shape the performances in the room. However, doing this would build the assumption of exclusive, closed paths, because I would create a model of cause and effect between the study group session and how to conceptualize the innovation process in a particular way. Further I would create a predefined distinction between the biomedical paradigm and the holistic Open Dialogue principles. To create exclusive, closed paths, I would need to homogenise differences between different innovation processes around Open Dialogue and conceal complexities. I would need to narrow down my knowledge claim about what innovation processes are about in this particular site, which consequently with this concept would then produce singularity, as it is difficult to move and shift between trials of strength. The shifts and incoherence somehow become difficult to encounter with this term. I therefore lean more to the concept of performance which is presented below.

The concept of symmetry and trials of strengths means that at the outset everything and everyone is potentially relevant to include in the investigation of the rise and fall of Open Dialogue in the mobilisation processes of the outreach team. However, giving voice is not about giving voice to everybody or everything, but about taking decisions on a basis of informed knowledge and keeping focused on how knowledge is produced rather than on the stabilised facts that are produced (Danholt, 2008).34

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34 In the chapter on methodology I will return to this point about informed knowledge and how being an STS inspired researcher makes me want to add knowledge to the world rather than subtracting knowledge. The scientific ambition of adding knowledge has been very much been inspired through discussions with Nana Benjaminsen. See also (Benjaminsen, 2009).
In summary, the principle of generalised symmetry was productive in showing how innovation processes were constructed heterogenically (e.g. Callon, 1986; Latour, 1993/1984; Latour & Woolgar, 1986/1979; Law, 1986). What I would like to take further from the principle of generalised symmetry, is that it also makes available a heterogenic analysis where both tangible and intangible entities, such as silences and laughter, can be drawn in as important constituting entities. I will come back to this potential in the analyses.

The hidden potential in generalized symmetry

The principle of generalized symmetry, however, did not multiply the knowledge claims and complexity that it potentially had promised. It only multiplied the actors that were included in the analysis. This means that even when including tables, silences, ways of settling in in meetings and hereby being symmetrical in the selection of actors that are important to understand the configurations that are happening in practice, I can still have the aim to reduce possible answers of how configurations are coming into being. This is what I mentioned in the introduction about the concept of ‘drawing things together’ in new configurations. It does not provide an elaborated understanding of innovation processes alone. The pioneering studies within classic-ANT were challenged especially by feminist researchers (e.g. Haraway, 1991a; Star, 1991) who wanted to add multiplicity and incoherence to the studies which they deemed to have been made from a powerful, white, male perspective. (See also the introduction for an elaboration of the study of Star exemplifying this position). This criticism was taken up through self-reflecting texts that started to develop ANT further (e.g. Latour, 1999b; Latour, 2005; Law, 1999, 2004). These are texts that are often called Post-ANT or a post-human position or attitude. These texts emphasize the development of studies and theoretical contributions that have decentredness and incoherence in focus. Many ANT studies today display sensitivity towards multiplicity in the investigations they do (e.g. Benjaminsen, 2009; Danholt, 2008; Dupret Søndergaard, 2009; Gad, 2005; Johannessen & Lazar, 2006; Johannsen, 2009; Mol, 2002).
The performative turn in Science and Technology studies

As mentioned above what has happened between the study of pasteurization and the study of allergies to onions and cervical programmes is a turn towards emphasizing the multiplicity of how practices and objects come into being. With the examples of Star’s and Singleton’s studies, referred to in the introduction, the idea of centredness and coherence was disturbed. Their contributions inspired and informed the development of the so called ‘performative turn’ (Elgaard Jensen, 2001) or the ‘practice turn’ (Bruun Jensen, 2005) in science and technology studies. I describe it here because it is also where I position my thesis. The performative turn refers to the pragmatist’s catchphrase: “if it works it must be true”. The performative turn focuses not only on material effects as they are enabled by scientific ideas, but also on the material, practical, and institutional aspects as they are participative in the construction of scientific content (Bruun Jensen, 2007, p. 5). This is what justifies the choice and conceptualizations in the analysis here of what is done by the outreach team in the innovation processes within the mental health care practices.

Elgaard Jensen (2001) suggests the performative turn can be defined as a:

“Sensitivity to specificities of materially heterogeneous events with special reference to differences and relations between performances.”(Elgaard Jensen, 2001, p.87).

When both scientific facts and all phenomena in the world are perceived as processes of becoming, it has wide ramifications about how we can understand the construction of the world. Linking the general principle of symmetry to the performative turn, then an object is seen not as a singular entity, but rather as a texture of partially coherent and partially co-ordinated performances. What an object is, is thus decentred in a multitude of practices (Elgaard Jensen, 2001, p. 67).

Objects do not exist in and of themselves but only through multiple situated practices.

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35 The term ‘turn’ might be a bit too pretentious here because it is difficult to identify the beginning and end of this ‘turn’. Gad (2009) and Sandberg (2009) have suggested in their theses that this turn is more a matter of a movement towards an increased interest in what is done and the exploration of how multiple practices exist or co-exist rather than a paradigmatic brake. The performative turn, however, is in general terms referred to as a shift from the classic-ANT which started at the beginning of the 1990s (Law, 1999).

36 This shift also expresses another change. Namely the one from focusing exclusively on the content of science to focusing on the intertwining of content with multiple practical and material aspects of laboratory life (Bruun Jensen, 2005, p. 5).

37 For the purpose of consistency I only use one term: performance and performative turn.

38 A number of other authors have done related work on performance. Some of these are Estrid Sørensen, Torben Elgaard Jensen, Tine Jensen, Astrid Jespersen, Donna Haraway, Marilyn Strathern, Bruno Latour, Michel Callon, Vololona Rabeharisoa, Vicky Singleton, Tiago Moriera, Ingunn Moser, Hans Harber and Alice Stollmeyer.
This ontological claim is directly opposed to the Kantian notions of ‘das Ding an sich’ versus ‘das Ding für Uns’. In the Kantian version the relations that make up an object ‘out there’ are somehow closed in on themselves and completely separable from the relations that ‘we’ may forge with them. What we will use the quick reference to Kant for here is to show how the performative turn implies that the putative object ‘out there’ is never closed in on itself. It is always constituted and re-constituted, that is performed, in relations to multiple others. These others may be a contemplative ‘Uns’, a more directly interfering ‘Uns’, or any other sort of material, textual or symbolic relations. So with the performative turn the claim is that an object does not exist behind fixed boundaries that separate its internal essence from the rest of the world. An object is a relational entity (Elgaard Jensen, 2001, p.68).

Being concerned with how things are done in relational patterns, the principle of performativity also implies that performances or doings are never objective or standing on their own, since they are always in relations with others and that is what makes them able to do things. When the idea of the powerful manager and coherence in innovation processes is removed or moderated, it provides us with a scientific ideal where there indeed is room for heterogeneity. With the principle of generalized symmetry we can analyse how things come into being in heterogeneous ways. This means that the knowledge production of how to understand new phenomena in the world is linked with how entities are linked in a myriad of different ways in multiple settings and situations and is only temporarily stable and fixed. Subscribing to this way of seeing the world, ontologies are ambivalent, temporary and also multiple because we do not know, a priori, how the ontologies of the innovation processes that are explored look like or how they are defined.

Performance

To some degree the performative turn is one meta-theoretical position that is shared in the vast multi-disciplinary field of Post-ANT and the core analytical task is then to try to understand what patterns are created. ‘Post-ANT’ researchers, such as Law, Singleton, Mol, Sørensen, Johannsen, Bruun Jensen, Elgaard Jensen have used the term performance to characterise these local patterns.40

39 What is often referred to as the ‘dichotomist divide’. I thank Elgaard Jensen (2001) for his thesis which opened that “black box” and made the Kantian notions more clear to me.

40 Within feminist research, there are different ways to approach the connection between nature and culture, and materiality and culture and how these interconnect. The term performative action is developed to understand how biological and cultural gender can be conceptualized in that respect (Butler, 1990, 1993). However, my business is not to distinguish between materials and discourse. I use the term ‘performance’ as a minimal definition of identifying when
“First, performances are recursive processes. They are continually emergent outcomes of interaction. Second, performances are materially heterogeneous. They are about talk, bodies, texts, machines, architectures, materials etc. Third performances are somehow bounded. They do not exist in and off themselves. They exist in multiple relations to other performances: conflict, inter-dependence, mutual inclusion, tension, interference etc. So if we press the notion of performance in the object-direction, we might say that performances are unbounded, materially heterogeneous, recursive processes or patterns that can be imputed to the social.” (Elgaard Jensen, 2001, p. 87).

Thus, performances are effects of interactions between entities of a heterogenic nature and can only exist in relation to other entities. Other terms such as ‘creations’ (Adrian), ‘enactment’ (Mol), and ‘entanglement’ (Sørensen), or ‘handling’ (Jespersen, 2007), are all terms that focus on the action as an ordering process. These terms mentioned each have the purpose of accentuating different theoretical discussions. I find that each of these terms has advantages and disadvantages but I remain with the term ‘performance’ because of the convincing arguments forwarded by Elgaard Jensen (2001) and Sørensen (2005). In response to the criticism forwarded by Mol (2002) against the Goffmanian use of the word ‘performance’: Elgaard Jensen (2001) with reference to Weick, objects to choosing the alternative term enactment because that term also has other, just as inconvenient, connotations, namely that of human sense making. As no word can ever be pure or unspoiled I therefore keep the notion of performance41 (Bruun Jensen, 2005; Elgaard Jensen, 2001; Gad, 2009; Sørensen, 2005).

Thus, performances are what constitute how things and people connect. And the performative turn in science implies that our scientific contributions should be investigated through description of these performances. In these descriptions we are to encounter the materially heterogenic entities that play a role in what we investigate. With the performative turn we are also encouraged to pay attention to how things are done differently.

As ANT proposes a situated and performative approach to understand the outreach team’s efforts to innovate their practices it thus implies that there is no ontological fixed standpoint. It means that there is not a predetermined way to define how these efforts come into being (factual knowledge) but rather raises more general questions

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41 Mol criticizes the use of the Goffmanian use of ‘performance’ for insinuating that there is a scene behind which the ‘real’ reality is hidden. Second, she argues that performance suggests that what is performed is successful, so that what is performed can be understood as something that is always good. Third, she argues that performance indicates that what happens now always has wider effects (Mol, 2002, p. 32).
(concerns) as to how things come into being (Latour, 2004b). With ANT one approaches the world as effects of these heterogenic patterns. It implies that it is the collective (human and non-human) and not the individual nor the object per se that is the centre of analysis.

To summarize, what can be defined as performance is that it is a way to look upon what is done in practice. It addresses reality without presupposing essentialist assumptions about entities and what connects these entities. There are no a priori categories manifested or essences that are disclosed. Performances are effects of connections between entities that may be substantialized and assembled in configurations into facts. In the following I will describe what it is that engage in these performances.

**Actant**

The generalized principle of symmetry as the way to describe the efforts of the team to innovate their working practices also involves a range of elements that would not be taken into account in non-symmetrical analyses. But how to understand the entities that participate in the configuration of such a change? And how do they participate in the innovation processes? In order to understand this, a first step is to put human intentionality on hold. In line with the principle of generalized symmetry the ability to act is not inherent in the individual as a predetermined force (Latour, 2005). An actor is something or someone that makes a difference. Latour says about the actor:

> “An ‘actor’ is a semiotic definition - an actant-, that is, something that acts or to which activity is granted by others. It implies no special motivation of human individual actors, nor of humans in general. An actant can literally be anything provided it is granted to be the source of an action.” (Latour, 2006/1991, p. 214).

The quality of the actant is thus ascribed the ability of doing something. The key is to define an actant by what it does. From a semiotic materialistic perspective language and things have the same qualities in the sense that both have the ability to refer to other places, times and actors. Both humans and non-humans have a mediating and governing potential. The mediating potential means that it can translate interests and purposes and transport them further (Callon, 1986). By governing potential is meant

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42 I use the term actant (rather than actor), and action (rather than agency) to distance it from the associations to human abilities only.

43 Actor and actant is in this context covering the same definition. Latour sometimes uses the term actant to avoid the human association of the term actor. The later derives from the semiotics of Greimas.
that it has an influence of the conduct and constitution of other things and people. In other words an actant can change the way events take place and it can have effects on presences, meaning what kind of ways it is possible for things and persons to be present in what occurs. Therefore becoming an actant depends on whether that entity makes a difference in the connection to other entities. To define an actant through whether it makes a difference means to define it through the before mentioned performances.

“There is no other way to define an actor but through its action, and there is no other way to define an action but by asking what other actors are modified, transformed, perturbed or created by the character that is the focus of attention.” (Latour, 1999a, p. 122).

Action is thus an activity that makes a difference. However, Sørensen (2005) points out that the term ‘action’ in contrast to the term ‘performance’ emphasizes a single act rather than an involved process (p.30) and, with reference to Hirschauer (2004), the term action is a process with a temporal extension from its beginning to its end. As has already been explained in the section above on the performative turn I use the term performance in the same way as Sørensen, to describe the involvement of a variety of entities that are related in patterns, but I find Latour’s use of the term action in the above quotation illustrates very well how to understand the coming into being of actants through what I have previously referred to as performances. With reference to this quotation, therefore, we can never know for sure what makes us or something act (Latour, 2005, p. 52). And we should prevent ourselves from attempting to define the essence of an actant as something static and predeterminable. An actant is defined through the relations it participates in. Thus an actant is the answer to, and effect of the performances, that when it is stabilised can be connected to a name or a substance (Svenningsen, 2004, p. 57). In order to be able to see whether something has made a difference and, as such, can be defined as an action Latour suggests that there are a list of the features of the elements that are recurrent that can be defined: Action is creating shape (which I will come back to below), which means that the entities connect around a common purpose and interest. Action is always an account of doing something, making some difference to a state of affairs.

Therefore, as mentioned in the previous section, actors are relational entities, which can only be defined through its actions or performances. These actors through their performances are clustering in certain shapes. These shapes are what I call ‘figurations’

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44 The term governing or governing technology is also a theoretical word that is inspiring the use of it in this chapter and is developed within post-structuralist approaches to illustrate how discourses shape the conduct of individuals (e.g. Foucault, 1979/1973; Rose, 1998)
and are that which makes the performing actants have figure, or form.

**Figuration**

“What is doing the action is always provided in the account with some flesh and features that make them have some form or shape, no matter how vague.” (Latour, 2005, p. 53).

But what is exactly a figuration apart from a shape or form? How can one see it? Latour seem to use the term in order to escape dualistic “social explanations” and with it imagine encompassing many more figures than just anthropomorphic ones (Latour, 2005, p. 53). As I read Latour here, ‘figuration’ is the minimal expression necessary that provides the investigated performances with just the amount of anonymity required in order for us to be able to, provisionally, identify it without having to categorize it into dichotomist categories. In this line of thinking the cyborg is an example of such a configuration (Haraway, 1997). Haraway (1997) explains that the term ‘figure’ means face in French. In English this meaning is reserved for the notion of the lineaments of a story (p.11). She elaborates that “to figure” means to count or calculate and also to be in a story and to have a role. So far this sounds rather discursive and reliant on verbal interaction. Figure in this rhetorical meaning lacks the dualistic escape of dichotomies proposed by Latour (2005, p.53). However, it is also Haraway’s ambition to exceed dichotomies:

“Figurations are performative images that can be inhabited. Verbal or visual figurations can be condensed maps of contestable worlds. All language, including mathematics, is figurative, that is, made of tropes, constituted by bumps that make us swerve from literal-mindedness. I emphasize figuration to make explicit an inescapable the tropic quality of all material-semiotic processes,” (Haraway, 1997, p. 11).

Figurations are geometrical but also theoretical and tropic images that help us to think beyond dichotomies, and follow the use of the term by Latour (2005). They are performative which means that they are constituted in ways that are never fixed in a categorical and in a priori definitions. In other words figurations are like imprints that can be reprinted but, because of their performativity and tropes, the reprints are never identical to the first print. Therefore, figurations are not (just) representations, but:

“Figures do not have to be representational and mimetic, but they do have to be tropic; that is, they cannot be literal and self-identical. Figures must involve at least some kind of displacement that can trouble identifications and
Figures are not just (semiotic) representations because they are not self-identical and literal. They are to be understood in relational terms. The advantage of working with figurations (rather than concepts for example) is that they are in motion and variable (Adrian, 2006, p. 9). Figurations are, thus, not to be understood as paradigmatic or stabilized macro-discourses. The term figuration is in this context also used for micro movements and leaks in an ordering process. The term is suitable for seeing innovation processes as efforts in everyday working life that do not necessarily entail macro ruptures and changes. The term ‘figuration’ suggests, in line with Latour’s (2005) use of the word, that performance is not only a human contribution. Figurations are assembled performances. However, Adrian (2006) criticizes the term for not providing any explanation of concrete processes or the changes that fail to stabilize them (Adrian, 2006, p. 97). Even though I agree with the rather abstract description of the term, I find the metaphor sympathetic and will not discard the term just yet. My errand is not just to dissolve dichotomies. I opt for a term that can catch the variations in the efforts of the team that I investigate, and at the same time can convey that performances are sometimes assembled in ways that are unpredictable.

**From figurations to configurations**

The unpredictability leads me to want to add something to the term figuration. Something is given ‘figure’ as an effect of performances that are assembled. In other words it is given figure by configurative situated performances. Figure is given by something else, therefore looking at ‘con’ as a prefix is relevant: configuration.

Configurations in geometry\(^{45}\) can be studied both as fixed and as abstract incidence structures: In simple terms configurations are coordinates that give something form. I have chosen this term, not with a primary purpose of adding anything theoretical to similar terms such as “patterns of relations” (Sørensen, 2005), “modes of ordering” (Law, 1994) or “assemblages” (Latour, 2005) but rather in order to accentuate the performances towards two things:

1. That these configurations in my analysis are preliminary fixtures or structures, and they form the understanding of how the efforts of the team are given form as

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\(^{45}\) The formal study of configurations was first introduced by Theodor Reye in 1876, in the second edition of his book Geometrie der Lage, in the context of a discussion of Desargues’ theorem. Ernst Steinitz wrote his dissertation on the subject in 1894. This is just to say that the term also has a life in different fields of science. www.Wikipedia.org
preliminary, often fragile and intangible.

2. To accentuate the general symmetrical point of departure that includes human as well as non-human components in the analysis because I find the term ‘relations’ maintains a somewhat human focus. In mathematics, specifically projective geometry, a configuration consists of a finite set of points, and a finite set of lines, such that each point is incident to the same number of lines and each line is incident to the same number of points. This line of thought can be translated to the social sciences by suggesting that even if configurations do also contain predictable geometric forms it also offers the potential of conceptualizing abstract incidence structures (www.wikipedia.org). And the term configuration therefore covers all possible ontological ways of ordering the world.

As a final point of clarification, I contrast my use of the term configurations with the concept of reconfiguration. Johannsen (2009) and Latour (1987) use the term “reconfiguration” to imply a performed change. However, I find this term slightly misleading as it connotes that it is possible to clearly determine when something starts and ends. It implies the definition of something that was there before and static to something that may be there and static in the future. This is counter to the basic premises of the network metaphor in ANT, and it is also the reason why I use the term ‘configuration’ to accentuate the efforts of the team as innovation processes. Even though several of my analyses (for example in the analysis of the alternative dialogue, the closed dialogue and the intensive dialogue) will show that the configurations of the innovation processes can happen through a clearly demarcated outside that in turn defines an inside, change also happens along different ontological lines. Not just through defining past and future, or something that is static before towards something static in the future. It is a matter of configurations and, thus, not ‘re-configurations’. What belongs to what was before and what becomes in the future is a matter of compositions that are unfolded in unpredictable ways. With the use of the term configuration I weight more the unpredictable in what the performances show.

**Configuring innovation**

Innovation, then, is not linear, it is not about past and future and it is not even about a stable overall macro change. It involves the coordination of numerous interests and actors, but exactly because of that multiplicity it makes the predictability of the efforts of the team difficult, and the team often arrives at different results than were anticipated or hoped for. Configurations are, thus, a term that implies change but not in a way that defines a before and an after. In the particular case of this study it implies a way that focuses on the creation of innovative practices as potential mixtures, and it
also contains the ability to include the detailed and intangible efforts to change the mental health care.

So the potential mixture is important to my conceptualization of configurations. It allows the possibility to conceptualize innovation processes as dynamic, incoherent and multiple. These premises of heterogeneity and multiplicity are shared by several STS and ANT scholars (e.g. Laet & Mol, 2000; Latour, 1987a, 2005; Law & Singleton, 2005; Mol, 2002; Sørensen, 2005). My conceptualization of configuration adds the perception such that innovation processes in the outreach team are described as configurations that are not macro-breaks in dichotomist divisions, but small ruptures and changes that are continually made, they are heterogeneous and they are multiple and sometimes incoherent.

**Summary of analytical resources**

On a general level interest in an ANT approach has different ontological consequences. From its outset ANT is an approach in which all things that we usually take for granted (for example singular knowledge claims that reduces risk in treatment, the consultant psychiatrist as expert or diagnostics as guiding the advices of care) are to be understood as configurations of heterogenic entities that encompass both historical, material and social trajectories (e.g. Callon & Latour, 1981; Latour, 2005; Latour & Woolgar, 1986/1979). The connection between these entities determines the status and nature of what we investigate. Things (and people), therefore, are not what they seem to be, so to speak. Matters can always be different. What constitutes the efforts of the team in ANT terms can only be explored and temporarily determined through the empirical investigation of how connections cluster entities together in what I have presented here as configurations. All empirical analyses in the thesis are, therefore, to be understood as effects of these situated configurations of entities.

When scientific facts are constructed a lot of trials are required in order to make a single knowledge claim. This is what we learned from the laboratory studies. It requires, for example, experiments, reliance on theories, analysis of materials in the microscope etc. But here I do not only investigate the configurations of singular knowledge claims. This is made possible by the inspiration of Mol (2002) and, with the performative turn in mind, to remain humble about what the efforts of the team might show as innovative configurations. Thus from the outset of the analysis it is not singular but multiple. What will be shown is that the team’s efforts are performed as cracks in existing configurations, they are fragile and intangible. This means that some efforts connect to the existing practices, others do not. The fragility and intangibility are both a matter of how the team performs their efforts in ways that are not widespread in
governmentally funded mental health care and is because of its newness. The efforts of
the team cannot be narrowed down to one singular way of configuring mental health
care, but is multiple, and with the above principle of symmetry, performance and
configurations in mind I will analyse in what ways these efforts are performed. Further
analytical terms will be added to these basic terms as the thesis develops. These are
terms that will help to clarify and explore specific configurative patterns in the
performances of the team.
6. **Methodology**

This chapter is called methodology because it deals with the connections between my research question, my theoretical resources and the concrete actions taken to answer the research question. It discusses the scientific consequences of having a symmetrical approach and of understanding science as performative. I present how the applied scientific standard as constructionist poses a different scientific ideal that displaces the ideal of producing universal truths with an ambition of producing descriptions of local practice configurations. It is affiliated with a constructionist paradigm and I here develop the argument about why realities and what comes to appear as the innovating processes of mental health are matters of concern rather than matters of fact. The chapter then raises the question of how to argue for scientific importance and relevance if one is not ascribing to singular validity and reliability. The proposed alternative is to raise interest. To raise interest means to mutually intervene in the relation between the scientist and the object of study; to raise interest to a research community; and to include heterogeneity in the analyses.

The chapter also explores how the access to the field was not a progressive linear attainment but an ongoing renegotiation process. It describes how I gathered the material through observations, informal talks and interviews and how I ordered the material and what I have done to gather and select from the material for analysis. I introduce my use of the concept of shadowing, moving conversation, slowing down and heterogenic listening. I then explain the tools that helped me select the material for analysis. I explain how I treat the material in a temporarily flat manner and that some objects that have historically been given attention have also been foregrounded in my thesis. I further explain the tools of “surprise” and “interactional emotional make up”. Surprise is used as a methodological tool to help me confront stereotypical presumptions and to help listening heterogenically. The term of interactional emotional makeup is used to justify how affect is part of every performance also in scientific work.

**Mistakenly looking for ‘singular knowledge claims’**

The apparent vagueness in defining what the Open Dialogue approach, and thus the innovative efforts of the team, were actually about came across during the interviews with and observations of the team members as it came across in many other situations as well. It was simply very difficult to define what the Open Dialogue approach in this setting was about, and how it will be seen in a specific way. This matched with the sense that nothing really particular could, in the first instance, be identified as exclusively belonging to an Open Dialogue approach. But what was to be found? What was the purpose? What were the decisions made in these sessions? All three questions seemed
to me to be rather difficult to answer when starting to analyze, at least with the methodological tools and the material I had at hand. I had an expectation of being able to define and classify what Open Dialogue was all about in a fairly straightforward way, for example by getting the answers to the above mentioned questions and how the team members were positioned through the introduction of this approach. But that was not what happened. Actually in various different settings the team members repeatedly stressed that defining Open Dialogue is not such an easy task at all. If the material cannot answer the researcher’s question, who then has the problem: the researcher or the material? I decided that it was neither of us; neither the researcher nor the material having a problem in the sense that the questions are not necessarily wrong but the expectations of how they would be answered are and, therefore, the material is not wrong either because it can actually answer the questions but does so in unexpected ways. What if the actual absences of those answers were actually the key to how to understand the performance of the practice I investigate? Insisting on the presences of the answers to those questions was a typical modernist ‘failure’ (Latour 1991/1993). I was trapped in the ‘great dichotomist divide’ (see note on Kant in the chapter on analytical resources, p. 78ff). All I heard was noise because the answers appeared to be absent. Law (2004) suggests that producing knowledge is the work of categorising and objectifying facts from noise. I became frustrated because categorizations simply did not offer themselves. The absences of the answers made me think of what kind of expectations I had as to what I would find. I started with expectations of there being something to be revealed.

As the text is written today a move has happened from what I expected to find in the initial formulation of the project to the beginning of my field work throughout the analytical work with the material and with my increased puzzlement about why I seemed not to get any answers, and, simultaneously, informed by the continuous reading of literature within the field of STS and ANT. The movement was performative. I cannot say that it is one single thing that made me change perspective. I met the field with certain expectations, and it met me with not being able to answer them. I had to adjust and be creative and find new tools to gain an understanding of what was going on. These tools, therefore, also developed and changed along the way. Today it is written in this text that I wish to capture how innovation processes participate in creating knowledge and truths about mental health care, through a performative and symmetric perspective. This has become the final dot. The stabilization of the text for now. A performative and symmetric point of departure implies a logic that, at the same time, is sensitive to complexity and movement (Law, 2004, p. 9).

So the different means to answer the questions mentioned above are to do with multiplicity in the sense that there is not only one answer. It is about following trails of connectivity rather than only listening to voices. This leads to heterogeneity in the
sense that in connectivity not only what people say matters, but chairs in circles, bodies adjusting the circle, absence of written down agendas, refraining from using diagnostic language when talking about patients matter, and many more things that adds to the crafting of Open Dialogue practice matter. In the following I will take the reader to the middle of the text and I will then describe the journey that brought me to the field and helped the creation of the continuously changing relation I had with the field along the way.

How to avoid object reifying research?

If our objects of study are performative, incoherent and unstable how then are we able to talk about them?

One solution is to approach the ways our object of study take shape in pragmatic ways. Latour, for example, pragmatically says that the investigation starts where it starts. It starts exactly where the network allows it to start.

"We start in the middle of things, in medias res, pressed by our colleagues, pushed by fellowships, starved for money, strangled by deadlines. And most of the things we have been studying, we have ignored or misunderstood. Action had already started; it will continue when we will no longer be around. What we are doing in the field [...] is unclear to the people with whom we have shared no more than a fleeting moment. What the clients [...] who have sent us there expect from us remains cloaked in mystery, so circuitous was the road that led to the choice of this investigator, this topic, this method, this site. Even when we are in the midst of things, with our eyes and ears on the lookout, we miss most of what has happened.” (Latour, 2005, p. 123, original emphasis)

Intellectual affiliation and the placement of one’s knowledge production becomes, in this context, more challenging if one is inspired by multidisciplinary and specific kinds of (performative) ontological questions rather than being occupied with the affiliation of a singular discipline. But to take Latour’s “middle of things” further, in my case the middle of things start where the connection between the aspiration of wanting to change mental health care, described in a lay article on the theme, and the experiences with mental health care staff and their wish to make a difference in their work. But it also starts with discussions with administrative personnel in the Ministry of Health, and management that, for example, made the application of the funding of the project possible. As with most other researchers I do start with an object of study, namely, the efforts of the team to innovate mental health care through the introduction of the Open Dialogue approach.

But it is possible that Latour’s point about starting in the middle is pragmatically understood in a different sense. By this I mean that the description of all the connections that made this project possible at the beginning would, in itself, be worth a
250 page dissertation. A choice to describe that network would pose a whole range of other questions and thus knowledge productions. It would, for example, to a great extent be about how the relationship between science and politics is configured in research. Such descriptions are tied with research that explicitly deals with researcher positioning that has a long tradition, especially in the field of anthropology, for example Hasse (2002) and Hastrup (1992). However, my errand is not to describe the configuration of what made the project possible but to write about what happened in the outreach team when they wanted to change the working practices. I therefore start the text in a different middle than the middle of what made the project possible in the first place. A long process of selection and interaction with supervisors, theoretical text, field material, trends, conversations with colleagues, my own preferences etc. have constructed the “middle”. This selection process was and is continuously developing. I started with selecting an explorative approach and formulated interview questions and an observation premise when looking for places where I would find the performance of the Open Dialogue approach in the daily working practices of the team. Having met the field I was affected by the non-answers of the expectations I brought along. I had to “slow down” my eagerness for answers, and with this meeting of the field I developed a tool to be able to “listen heterogenically”. Once the field work was over I had a material that was produced in interaction with my initial expectations and my readings at the time. A middle (or rather multiple middles) was constructed around “governmental technologies and management”, “professionalisms”, “patient make ups” and “organisational changes” (doc. of working progress seminar 24th April 2008). None of these were, or are, wrong and none of them are not able to qualify as middles. But time and interaction with the material developed further. Where the text has ended today is a rather pragmatic manner but also a matter of what I was able to qualify with the material at hand. The process of how I ended with this text will be elaborated further below.

The other solution to avoid producing object reifying knowledge is to position oneself as a researcher that is interested in things that are in process and on the move. Poetically this can be formulated as taking a position as a ‘care-taker’ rather than positioning oneself as a researcher that expects docility from the material. The material fights back and is made possible to surprise:

“The contrast between a scientist who relies on the availability of both apparatus and animal, and a scientist who requires docility (this scientist being himself docile to the perceived prerequisites of science) may be translated along another contrast: the contrast between the manner of addressing oneself to the system, on the one hand as a care-taker, as somebody interested in its possible becoming, and on the other hand, as a judge or a master.”(Despret, 2004, p 124.)
Being a care-taker is about letting oneself be interested in “its possible becoming” without steering how it should become. But it is also about being empathetic and emotional about the object of study.

The above sections on how to handle the criterion of quality within constructionist performative research by raising interest have given two suggestions. On the one hand, to partly treat the fact that the scientific community and the field should be able to recognize a well determined object of investigation and, on the other hand, to let the object of study have its movements and intangibility. As I explained above, this project is a continual, developing process of interaction with different parties in the project and a long, analytical selection process. It is partly in order to take the position as the caretaking researcher rather than expecting the docility of the material.

Taking a caretaking position partly means letting oneself get surprised by the material. It means that one is not looking for knowledge claims that are singular. This means that when I was initially looking for what Open Dialogue was, I expected a singular answer and a very precise, static definition. I was then a researcher expecting docility from my informants in the field even though I felt that I was respectful of their wish of anonymity and respectful in the sense that I would listen to their answers. I ended up with an emptiness of no answers, because these answers did not fit my expectations. I could have concluded that the Open Dialogue approach is vague, not definable, and without any concrete differential purpose; that the team’s initiative did not make a difference. That would have been to continue my position as a researcher expecting docility of my material. But I found that the material was showing me something different. That the team’s initiative indeed did make a difference in very specific ways. That it was countering my expectations. The caretaking position, thus, allowed me to see these new ways of what, exactly, their initiative was about.

The way to intervene with my stereotypical expectations is through surprise. Briefly, the different tools which I describe in more detail below, mean that I also let heterogeneity be of importance in my field work and what I foreground as analytical focus points, something I will describe as ‘heterogenic listening’. It means that vagueness did not become a ‘non-answer’ but a specificity of my investigation, something I deal with through the concept of ‘slowing down’. Further, using the way I and the field get affected by our mutual interactions, I come to call the ‘interactive emotional makeup’. Lastly, parts of the shadowing activities were performed moving or driving. The concept of ‘moving conversations’ is used to develop a professional intimacy that produces a vast amount of knowledge on the daily practices in the team where the absence of the recorder and the formalised questions make available
knowledge that is not scheduled by me as a researcher. All these tools I will return to in more detail but before I do so I will describe how I gained access to, and became involved in, the field and what material I gathered.

**Accessing the field**

**An ongoing renegotiation**

I thought this section would be about how the access to the field had developed progressively across time: About the management’s acceptance and support of the project, followed by an introduction, a discussion and an adjustment of the project with the management of the team (team leader and consultant psychiatrist). I thought this would have allowed me to be accepted and given me access to the daily work of the team, because it was what we had agreed in common when negotiating the initial methodology. However, the access to the field has developed in just such a complex and incoherent way as the rest of the project. This means that the access to the field cannot be understood in an increasing linear progressive manner, or that the management’s (neither the top management nor the local team management) support per definition would give me access to the daily working routines of the team. On the contrary, it showed that a lot of challenges and obstacles posed themselves when I as a researcher wished to gain access to people and things. These challenges began already in the phase of formulating the project.

In relation to the initial project description, for example, I had to adjust the methodology. Originally the project was formulated as an interventionist study in a high security ward in the psychiatric hospital where situations of psychiatric constraint are occurring regularly. Psychiatric constraint is a situation of juridical justifiable constraint within the psychiatric field where different medical criteria such as, for example, the danger of harming oneself or others needs to be present in order for this measure to be applied. The preventive intervention was to be the introduction of the Open Dialogue approach and the purpose of the project was of a more evaluative nature to see how the Open Dialogue approach would influence those situations. I was the one supposedly who was to introduce the Open Dialogue approach and train the staff members. As it turned out, the county already had a team who had introduced the approach, and so cooperation was established with this outreach team instead of the hospital ward. This is the reason why the aspect of intervention was taken out of the project.

When the project still had the hospital ward as the focus, the methodology also included the collection of statistical material on situations of psychiatric constraint.
The constraint situations became peripheral when the outreach team became the new case study. Usually outreach personnel are not present in the homes or at the hospitals when a situation of psychiatric constraint is happening as the staff members at the hospitals are the ones directly involved. When a person needs to be hospitalised under constraint from their private home, it is often a relative or a neighbour who contacts the police and an external medical doctor who judges the patient’s condition in order to hospitalise the person under constraint. These were some of the initial challenges that I had to negotiate in the project description in order to gain access to the team who finally agreed to participate in the study.

Once the decision for me to develop the project with the team was taken, the contract signed, and the (adjusted) methodology agreed, a lot of practicalities still had to be sorted out to get the collaboration to work, which posed challenges. These challenges were heterogenic. Originally the study included questionnaires filled out by patients and for this purpose a letter of consent was written for the patients to participate in the study and to accept my presence at the visits in their homes (appendix: letter of consent). The letter of consent was translated to an oral consent given by the case manager. The case manager had asked the patient, in advance, whether he or she would accept that I would be present. Often the staff judged that the patients were too vulnerable to participate or to be asked direct questions and so on the basis of this I had to readjust my methodology again, the questionnaires were omitted and the patients became, to a larger extent, peripheral in the study.

**Getting there**

The access to the field was also an enrolment of me to the rhythm of the team through time and place. Physically I was travelling throughout the country, through time, from darkness to light in the beginning of the summer season, from city to countryside and in the afternoon from light to darkness, from countryside to city. I had two hours travel each way to get to the offices of the team. The access to the field was an accommodation for me to get into the rhythm of the time and place of the field. It happened through a rupture of my everyday life at home to a gradual rapprochement both emotionally, in time and place. I disconnected in the evening when returning home again. I call this access to the field a local composition and decomposition of rhythm. The sensation of rhythm starts with departing from my home in the dark usually at 7.15 am in the morning to reach the train going south:

I felt like a stranger arriving from the station. The repetition of the hurry through Copenhagen central station while searching my pockets to have my ticket ready, running down the stairs, remembering to punch my ticket, hurrying onto the train just 30 seconds before the whistle was blown and the
doors slammed, standing in the corridor too damp to sit down immediately, taking off all my outdoor wear because of the heat in the carriage and my exertions. Clothes off and selected readings taken out of my bag and with a pen in hand, I would finally sink into the seat, preferably one facing the direction of travel. All that would usually be done within the 30 seconds before the whistle blew and the train would slowly move away from the station and head south. I would already have readings ready for the day, or I intended to write in my field diary. I would ask myself questions about the activities of the day before or ahead and think about how I felt in relation to those situations. Two hours was usually a good length of working time on the train unless I met somebody who worked in the psychiatric hospital who would get off at a stop half an hour before me. Then we would chat about related issues but only general things that would connect directly to my project. Most mornings were like this. The ride back home was different. I was usually exhausted and often fell asleep in the train. If I didn’t fall asleep I could not work for long anyway even if I had set myself up to do so. The disconnection from the field was instantaneous.


In what way did this connect me to the field? The rhythm of the two hour train ride to the south of Zealand made me connect to the field both through the gradual change of the landscape, in time and emotionally. I was prepared by looking through my notes, by having time to reflect etc. in the train. Emotionally I would be concerned about how I would be accepted in the activities of the day, I would try to prepare myself to be present without causing any feeling of threat to the patients, and I would think about how I could talk with the personnel about my findings when not knowing exactly what I had found. On the return train ride from the countryside I sometimes fell asleep, which disconnected me from the field. This train ride configured the field as both far away (two hours ride from home and two hours back again in one single day is very distant in Danish mobility terminology) but the preparation and work for the day also made the field come into proximity and presence. This little description illustrates how connecting to the field is very much about being in rhythmic tune and is an intervention between the field and the scientist. This travel prepared me to get in alignment with what was happening in the field that specific day. The composition of temporality, landscape and emotional make up preparing for the field made me try to fit into its rhythm.

In the team

In the offices of the team a new negotiation about access would occur. A negotiation that was about how I would get informed about the team’s activities, which was important for me to judge the relevance of my presence in light of the limited time I had in the field and also because the group of staff would work individually. Each team member organised his or her own working day. The visits, the administrative work in
the office, meetings with partners in the municipality and so forth. They organised their work mainly through the use of an electronic calendar where they recorded all activities and continuous appointments with patients. (I will give a description of their working day below). I tried to intervene in this routine by asking to be accepted in their calendars, which only one accepted. I was, therefore, dependent on them informing me verbally about what was going on in the team as I was not there every day. It was, thus, very difficult to judge what kind of activities I was excluded from and what I was included in.

But it was not only a matter of overview that maintained the continued negotiation with the access to the field. It was also a matter of my ‘suitability’ for participating in certain activities. Certain meetings were not suitable for me to attend (as for example if a patient did not wish my presence), and certain working tasks were changed on the day of my presence, so it turned out not to be possible for me to join after all. I did not challenge any of those decisions for ethical reasons.

There were also differences in how each member of staff would approach my presence and how detailed they would describe their working tasks during the informal conversations we had. Some staff members would be involved in reflecting with me and exchanging views on how to apply the Open Dialogue approach and what consequences it had for them as professionals and in their relations to the patient. In those conversations the exchange and the mutual intervention between me as a scientist and the staff member would be most successful. The staff member would, for example, discuss a principle of Open Dialogue such as “reflection” with me and I would give my understanding of the term. In these conversations we would exchange views and even though we often spoke on an abstract level about principles and values in the approach, these conversations also included a lot of information on practical activities and how these were done. Some staff members just reported and informed me about their initiative without exchanging views. Another would be checking with me whether what she executed in her meetings with the patients was, in fact, the Open Dialogue approach. 46 Some of the members of staff willingly took me along, others judged themselves to be too busy or gave other reasons why they could not take me along. For example, I often went out on visits with the social- and health care worker, while I only went out a few times with the psychologist. The reason for this variation is unclear to

46 The staff members profession has on purpose been left out here for the case of anonymity and because I in the thesis do not add an individual approach. For further analysis it could be interesting to follow in depth how these variances in personal relations between staff member and researcher also influence the performance of the practices investigated.
me. I got the sense that the social- and health care worker had the biggest case load of patients, but was also the person that had the greatest experience in having interns and students following the work of the team. The meetings were organised by the initial agreement of me following a specific staff member for a couple of days or just a specific day. The staff member would go through with me what types of visits the person had that specific day, and would tell me if I could join in all of the visits or only some of them. Usually I would know beforehand that a specific day was suitable for me to come, because a patient had agreed to my presence, but I would not know in detail the content of the day. Sometimes the patients changed their mind, for example when I visited a hospitalized patient with the consultant psychiatrist. The patient felt uncomfortable and asked the consultant psychiatrist to make me leave. I waited outside in the ward corridor.

In the study group meetings held on Mondays two external staff members participated. They were asked if they agreed with my presence. They complied. An access to the field that I did not succeed in establishing was interviews with the county manager. The manager of the district had at no point been directly involved in the formulation of either the team’s initiative to change its working practices or in the formulation of the PhD. I tried to intervene with this decision through email. After several exchanges I got the understanding that it was difficult for the head of the district to prioritise time for an interview and I had to leave the wish to follow that trail of connection out of the team.

Also, the initial ambition to see how the working routines would include electronic patient records and how the team would innovate the way of writing these in accordance with the Open Dialogue approach was difficult to pursue, as the members of personnel considered whether each patient was either too vulnerable to ask for permission for me to read their record or to join them on visits. The patient records, therefore, have not been included as subjects of analysis. Other material was more accessible and not ethically problematic. For example patient lists presented at the morning conferences or national questionnaires and monitoring systems. This difference explains the lesser amounts of personalised information.

Overall the composition of the material is, in itself, an interesting configuration of connections and coincidences and negotiations and intervention between actors. With this rather incoherent contact and access to the field I logically ended up being connected to specific individuals or to material that was more accessible than others.47

47 This also means that the methodology had to be adjusted further. With a performative approach I worked with
In many ways the team had let me know that their conduct of their initiative was independent of my project. This was clear already in the initial phase of the adjustment of the project methodology. They logically suggested amendments that suited the activities in the team. However, this quest for autonomy also made it difficult, and at times troublesome, for me to intervene. Through my relations with the team my feelings about their initiatives changed along the way, and due to this I came to develop the concept of the ‘interactive emotional make up’ that I will return to.

Thus, the access to the field has been a continuous challenge to persuade (Elgaard Jensen, 2008) and explain a project that from its outset was on the move and intangible. In order to deal with these challenges and negotiations I asked whether I could participate and observe the different meetings, I asked whether I could be accepted in to see their electronic calendars, I tried to note down what I saw, for example the writing on post-it notes during the supervision session told me something about how important it was not to interrupt in the session, but still important to participate. I tried to explain that my motivation to shadow the team was not affiliated with the management and their support of the project to prevent the team’s explicit worry of control.

Basically, it is rather paradoxical but also logical that to have to explain to the members of personnel that I was attempting to describe the fragility and intangibility of what they were trying to innovate, which to them made what I tried to access itself very fragile and intangible. In a few instances I felt that this made my position unclear and caused insecurity and doubt among the team members. I tried to deal with that by telling them everything that I wrote down in my notebooks and, in that way, gave them access to the knowledge that was being produced along the way. This sense of insecurity and doubt I think connects to the question of anonymity that I will describe in the following section.

Cutting the mutual intervention - Anonymity and objectivity?

As mentioned in the section above the access to the field was not a progressive minimal expectations of my tools of analysis. Basically they needed to grasp what was being done. However, it was only when starting to analyse the material that I discovered how a vast material of interviews and observations still can seem like not being detailed enough for such a symmetrical analysis. A lot of situations that I initially might have sensed important I found were not described in my field notes in enough detail. The way to deal with this problem would be to find a similar situation somewhere else in the material or to omit the situation from the analysis.
inclusion. I suggested one reason for this was connected to the fragility and intangibility of the efforts of the team. This is connected to the feeling of how the innovative efforts can be perceived as stable and well-established and, thus, the eagerness to protect oneself from being exposed and challenged. But one would think that it would be of interest to the team to disseminate, through text and words, to the surroundings the team’s own initiative to innovate its working practice. There is, of course, an issue of protecting the patients from exposure, but from the outset it was the working routines of the staff members that were the focus of research. So I was surprised. This surprise I pursued in my analysis and the reader will find part of the explanation of this wish for anonymity in the analyses on “alternative dialogue” and “closed dialogue”. Briefly, the wish for anonymity I found was connected to the way the team would understand themselves as unique and how these efforts, in some situations, were configured as closed to the surroundings.

Therefore I have been unsure about the degree of anonymity. For ethical reasons there was no doubt that patients would be anonymous but what about the team, the county, and the region? And why? There are no business secrets but rather emotional make ups are at play. Emotions of fragility and intangibility that was expressed explicitly in, for example, the feeling of insecurity in conducting the newly introduced network meetings, and in performing oneself professionally in new ways. Intangibility was also performed in the configuration of the innovative efforts through, for example, the exclusion of papers, furniture and certain temporalities that I will explore in the analyses. The intangibility as such was both an expressed and performed construct that had effects on the emotional make up of the personnel in the team and, therefore, also related to their wish to be anonymous. I, therefore, do not mention the name of their team or their personal names. But in acknowledgement to the support of the management to conduct the research I do say that it took place in the psychiatric organisation of the Storstrøm County, which today is part of the Zealand Region.

Absent actors

The staff members have been my obligatory passage points to gain an understanding of their working day and to follow them on visits to patients. In relation to each patient the staff member that I followed considered, and in some cases discussed, with colleagues whether the patient was too vulnerable to be presented with my presence.

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48 “obligatory passage point” is a term from ANT covering the result of alignments of multiple entities. It is when many competing and heterogeneous entities are homogenised by translating many interests into few (e.g. Callon & Latour, 1981). The obligatory passage point gets the right to define reality. The actants that master the obligatory passage points master the relations that flow from it.
The team works with severely ill patients, some of whom it has taken a long time to establish a relationship. The staff members were very aware that this contact, in some instances, was fragile and should not be lost by my presence or the research. However, their judgement of the patient’s vulnerability was sometimes also connected to the patient’s own ability to formulate him or herself. When they do not have the energy to formulate themselves, it becomes difficult to engage them in a research process. This raises two points of discussion, one ethical and one about voice.

Firstly, it is an important ethical argument that vulnerable people should be protected. If it cannot be the professionals of the psychiatric institution that take that role as a guarantee of such a protection, it is difficult to imagine who, then, it could be. With this point of departure I acknowledge the choices of the team about which patients I could visit with them and which patients I could not.

Secondly, there is a point of a more analytical nature, and that is about how the patients’ voice is performed as something important to be able to participate in not only research, but also in the approach that the team is introducing, the Open Dialogue approach. In the Open Dialogue approach equality between people is by its executers thought to be ensured by letting all ‘voices’ be heard. This is often mentioned within the group of personnel, and I would have liked to pursue this issue of vulnerability contra voice further. However, due to the scope of the thesis this is one of the issues that remains just a potential.

Pols (2005) has written about the ‘patient perspective’ as a trend in health research methodology. She writes that the patient perspective is used in research as a tool to represent patients as knowing and participating subjects rather than as medical objects of knowledge. With this perspective Pols (2005) enlists two problems. Partly, the patient perspective requires that the patients have an understanding and perspective of themselves as an individual and the ability to formulate his or her own situation through language. This excludes patients that do not have any language. Partly, the idea of ‘voice’ as a representation of the world ignores that the world is also performative. That the world is performative connects to the discussion about the ambition to give voice to a collective might not be about repeating human actors words, but rather to make available the ‘voice’ of a whole range of actors, also the non-human.

However, some voices are absent in my material. For example the patients’ voices became invisible. None of the patient visits have explicitly been analysed because it was difficult to incorporate the patient perspective even if I felt that I took measures against creating tension or unease. The staff member usually introduced me to the patient and other colleagues, and I presented myself and told the patient that I could leave if he felt like being alone with the staff. Some patients asked me what I wanted to know and I
explained briefly that I was interested in the way the team worked and their efforts to change their practices. In spite of this, I do not know from the perspective of the patients whether they found that the introduction of the new working practices in the form of network meetings and different professional roles, reluctance towards psychopharmacology and so forth was a good idea. However, people who have experienced psychiatric treatment that I have met on different occasions are in favour of the approach and lobby to raise awareness around network approaches such as the Open Dialogue approach (www.sind.dk, www.NORSNET.org). On the other hand, what I could have analysed was how it was performed. How the visits with the patients were performed and how these reflected upon their initiatives. This, however, I also chose not to do because the intangibility of what the initiatives to change were about was even more intangible when being outside the team. As the reader will understand when reading the analyses, there is an explanation for this. Some of the ways that the team configured their innovative efforts were immobile. It meant that their ways of innovating had difficulties in travelling outside specially earmarked situations beyond where it took place, for example in the study group sessions and supervision sessions and in interviews with me.

As mentioned above in the continued negotiating process of accessing the field, it was important to make salient that the patient should be protected and the focus should be on the staff. Thus, I was observing and was mostly silent at the visits where my presence had been accepted by all parties, and took a rather passive position where I would answer questions if I was asked, but I would not initiate a conversation myself. This, of course, has of consequence that the patients ’voices’ are only remotely present through the stories of the staff and my observations that have been used for analysis.

**Collected material**

**Overview of types of data**

The field material consists of observations of the daily work of the team that I noted down in field notes. During the time I shadowed the team members we had informal talks. Interviews were conducted with all members of the team, apart from the secretary who does not visit patients and who does not participate in the development of the working routines and is, thus, not directly involved in the innovative efforts of the team. The material also consists of videos that the team has recorded for learning purposes. The team recorded their supervision sessions with an external psychologist and some of the sessions in the study group that was established every fortnight to discuss and practice the Open Dialogue approach. I also had access to a large amount of text that has informed the analyses but has only to a limited extent been subject to
analyses. This was the electronic patient records, patient assessment schemes such as the Global Assessment of Functioning Scale, patient satisfactory schemes, descriptions of the organisational setup etc.

**Observation**

Because the place where I collected my empirical material is placed 130km South from Copenhagen for practical reasons I had to economize on the time planned to spend shadowing the team members in their work. I found it important to follow the team members in their daily work precisely because I was interested in how they were performing their efforts to innovate their daily practices. These observations have, to a great extent, provided me with a knowledge that is used as background information. In order for me to understand what was special and unique about the way the team settled in at the study group sessions, where the past and the future got excluded, I also draw upon a knowledge about how the conduct of the morning conferences are performing a different temporality where decision brought into the future and responsibilities from the past are taken into account. Also, when selecting a theme such as the recruitment of patients for analysis and how it interacts with the team’s initiative this is connected to knowing how patients are recruited on the basis of diagnostics and knowing, through interviews and literature, that diagnostics can be controversial in the execution of the Open Dialogue approach. Therefore I am curious to know how the team deals with this potential tension between practices. Thus a lot of my observations are used as knowledge to influence the choices for analysis in the material. The information compiled through these observations enabled me to get a more comprehensive visual picture of the team members working routines. With this I became more aware of what was left out in my analysis and what was taken in.

**Me - the fieldworker**

When I was working in the field I was in a position of a newcomer, I did not speak the local language and I did not have the same experience as the people that I met. The purpose of the field worker’s presence is different from the rest of the group. Fieldworkers are usually temporarily present and do not intend to stay in the group permanently. As a fieldworker I became connected to the team not in order to become a member of the team but to understand and observe what their work was about. The position as a fieldworker is connected to our position in the group (Whyte, 1995). As my position is attached to different purposes and interests than the members of the group, the knowledge that I can acquire will, therefore, also be different. My purpose was not to treat patients in the same way as the staff. My purpose was to understand how the team wished to change their practices. One could say that we had a mutual interest in
developing knowledge about what the initiative to change the practices meant and how that could be done. Even though my purpose was different, it will never be a global knowledge or a view from nowhere (Haraway, 1991b). Rather, observation is based upon the fact that the subjective person is a prerequisite of new scientific knowledge (Hasse, 2002, p. 24). However, this does not mean that the researcher is interested in writing her own autobiography, but is interested in performing science that intervenes and is intervened by the group of personnel and concerned to raise interest that goes beyond that team's efforts.

**On the use of video**

Some of the observations were supported by videos of the study group sessions and some supervision sessions.

“Ethnographic field notes and interviews are useful, but the real-time production of social life happens faster than any note-taker could document, often quicker and with greater complexity than a human observer can consciously perceive, let alone memorize.” (Büscher, 2005)

When looking through the material gathered to start the selection process for analysis, I found it divided into two chunks: One that potentially could provide ‘good descriptions’ and one that could not. In both cases I had selected the material because something intrigued me about that specific element in my material. In one of the chunks, the nature of the material did not provide me with enough details to illustrate and describe thoroughly the details of the performance in the selected situation. In that case I decided either to not to use the example or to try to find new material that could fill in the gap where I found I lacked detail. In the other pile of material I have simply not been thorough enough in my description. I have made a ‘bad description’ that requires explanation (Latour, 2005, p.222). A good description is a description that does not require explanation as to how the actors are connected in a specific configuration for example. A bad description is, thus, the opposite, a description that requires explanation as to how the actors are connected. If I had made a bad description, I have not stayed ‘true’ to the object I wished to investigate and the investigation has become a mere means of pre-defined categorization. Videos have a double function: to give access to social life and to train the eye to search the detail; to stay true to the actor by a means of qualifying the initial emotional make up and to qualify my initial intuitions of what I thought I saw.

At first, however I could not let go of having to analyse specific categories and themes that were not very closely attached to the performances of the team. In the beginning I used a video-transcription programme called Transana and I made detailed discursive analytical maps. I invested a huge amount of work in transcribing videos, making key
word lists, connecting across video sequences and so forth. Everything that created a very interesting story about what was going on in the team. However, I found that my occupation with the material was still merely discursive and I ended up not using the programme but instead ran videos over and over again. I selected fragments, described it, and oscillated between transcript and video until I found my description was exhaustive. I started describing the sequence where I was surprised, or felt uneasy or puzzled. The description developed with increasing details and as long as I could not describe my emotional response, or what resulted in the surprise, I continued looking for the detail. For example, I did not know in the beginning of the analysis of multiple presences that what made me feel uneasy was the reinsertion of managerial responsibilities (Chapter 11). And the descriptive detail became important, especially in the analysis of silence. The glances, the pauses, the hand on the table were all details that helped me describe what was performed with, and through, the silence.

The use of video was convenient because it made me able to be present, without being physically present. (I only attended one supervision session that was video recorded). The recordings helped me to focus on interactions and revealed details that were difficult to memorize without that visualization.

**Conversations and interviews**

When interviewing the team members my ambition was to find out how Open Dialogue is performed. I held extended interviews of approximately 1-2 hours with nearly all the members of the team who drove out to see the patients (the secretary and the psychiatric worker who retired during my field work were not interviewed). I interviewed a few of them twice. I also interviewed the head manager of the county and tried, without success, to get an interview with the manager of the district.

**Overview of interviews**

Below is the list of personnel that I interviewed.

- Social- and health care worker
- Psychiatric worker
- Team leader, nurse
- Psychologist
- Psychiatrist
- Consultant psychiatrist
- Head of psychiatric department in the county (placed outside the team)

My interviews differ from the classical qualitative research interview, where it is the
informants ‘life worlds’ that is inquired about. Kvale (1997) writes about the qualitative research interview that it: “has of purpose to gather descriptions in order to interpret the meaning of described phenomena.” (p.19, my translation). However, the perspective of the life-worlds is criticized by Järvinen & Mik-Meyer (2005) for assuming a more or less stable life-world that is disclosed in the interview (p. 16). Instead of the team members ‘life-worlds’ I accentuated different things in the interviews which were mostly things that were detached from the staff member’s personal history, but focused rather on their perspective of the innovation process; historically and ideologically. For example I ask why they find the Open Dialogue approach important to be introduced (used especially in the analysis on ‘alternative dialogue’ chapter 7), and how they introduced the approach in the first instances in the team (used especially in the analysis on patient recruitment procedures where laughter triggered my attention to see a tension in the material). In that sense I use the interviews to explore the innovation process and ask the interviewee to elaborate on the answers to get more detail on the questions and topics that I, at the time, thought would be relevant in the analyses of the project. Rather than looking for a complete picture of the working life of the staff the interviews are, thus, focusing on themes directly dealing with the introduction of the Open Dialogue approach in the teams working routines.

When trying to grasp how the innovative efforts would be performed I often felt that I did not get a very explicit or clear answer in the interviews. The way to deal with this was through slowing down and listening intently. In retrospect I think that this is not something I knew to do ahead of the interviews. It was something I learned both in those interactions, but also through being present in the different situations where the staff would practice the Open Dialogue approach. In these situations I noticed that the rhythm of their conversation would be much slower and circular than what I experienced, for example, at the morning conferences where decisions of the working tasks of the day had to be decided. As a result of what I experience as slow and circular answers in the interviews I had to slow down my questions and listen (see page 110).

Why to use interviews in cases where the performances and activities are to be the centre of the analysis? Would the focus on observations not be more logical to have as core material in the analysis? Yes, observations would have been more logical in a performative and symmetrical analysis, however I have several reasons why interviews ended gaining a lot of space.

Firstly, when first starting the fieldwork my knowledge of the readings within the socio-material tradition was limited. Following an actor was, therefore, very human and only with time I became aware that the circle of chairs and the round of conversation were of importance in themselves, extracted from the meaning making of the humans.
Secondly, the readings that inspired me in the first methodological outset was extensively informed by a post-structuralist reading where meaning making and positioning in interviews are also regarded as performances (Sørensen, 1989). Performances in talk deal in this respect with how conversations are interactions where the participants acts in interrelation to each other (see also Amhøj, 2007; Kofoed, 2005; Søndergaard, 2000/1996). I am still of the opinion that talk is performative and construct the absence of diagnostic language in, for example, the analysis on alternative dialogue. This may be, but is not necessarily, contradicting the position that I developed with time through my inspiration from STS and the more material-oriented approaches such as ANT. The interviews, thus, did not simply confirm the informants’ subjective concern about their efforts to innovate their working practices. The interviews helped me to follow and identify particular ways of doing those efforts. What was performed in the interviews was, thus, not subscribing to a dichotomous understanding of, on the one hand, the staff members’ subjective experience and, on the other hand, the innovative ‘objective’ efforts or a concrete material practice of managing the Open Dialogue initiative. The interviews are, thus, not approached as a conversational analysis, but as a tool to become attentive to the practices of the team members. Further, paradoxes and multiplicity in interviews are not regarded as inconsistency in the staff members’ perspectives or positioning. With a performative approach paradoxes and multiplicity are not covering a real prior understanding or agenda. Rather, this multiplicity in the interviews is taken as continuing ontological work. Team members know that their practices are multiple, complex and possible to discuss. Likewise the reader will find interviewed situations in which an ideal of the Open Dialogue approach is performed, for example where equality and flattening of hierarchies are spoken of as important, and the reader will find situations with a flat hierarchical setup that is challenged because managerial responsibilities or the “psychiatric doctrine” is enrolled as important to the daily practices as well.

Thirdly, the situations were like the earmarked Open Dialogue situations (supervision sessions and study group sessions that have also been analysed) where the efforts to change their practices were the most salient. As I have explained, a lot of my observations simply did not contain the innovative efforts of the team. I gave three possible reasons. 1. That the initiative was still new and fragile and, therefore, not easy to transport out of the team. 2. That psychiatric practices in many of the meetings have long histories of existence and have, therefore, enrolled a lot of allies. Presenting and performing the Open Dialogue approach in those settings could, therefore, seem meaningless, when the Open Dialogue in these situations had many less allies. 3. Specific ways of performing the approach, like uniqueness, closedness and immobility made it difficult to negotiate and compromise with the approach outside of the team.
Now I have described the process of gaining the access to the field and the kind of activities I observed, in the following I will describe what tools I applied to gather the material.

**Method**

Method is about what I did with the meta-analytical resources at hand to obtain the material. This is what the following section is about.

**Shadowing**

The first method I will describe is how I followed the team members in their work. I followed most staff members of the team. The consultant psychiatrist, the psychologist and the psychiatrist, the team leader, the social worker, and the social and health care worker. I followed them around in most of their activities. When they wrote on their computer, when they attended the morning conference, when they had lunch, when they visited patients, had meetings with involved parties at the municipality etc. I did not observe/hear much of their conversations with patients on the phone and I did not experience how they conducted network meetings where several staff members and several relatives were invited for an Open Dialogue meeting\(^49\). The way to follow somebody around in this way in colloquial English is called “shadowing” but it is also explored as an ethnographic method by Czarniawska (2007). Shadowing, in her terms, is about following “selected people in their everyday occupations for a time” (Czarniawska, 2007, p. 17) and is, therefore, very suitable for an investigation of what is done. I noted things down when it was convenient and was not interrupting the interaction in the room. And I noted down on my return journey in the train. Often when visiting patients it was not convenient to take notes as I felt it made them insecure and I, therefore, waited until a later time or on my way back on the train. I used the time on the train to summarize or write extensively of my impressions of the day. If I had analytical ideas or questions along the way I wrote them with a different coloured pencil and did not pursue the question, but went back to the description of the situation. I noted down what people did and said, about what places looked like, and how it felt to me. I noted down my initial thoughts and questions. I noted down anything that puzzled me and I noted down if something surprised me or made me feel

\(^{49}\) These meetings would have been of great importance to participate in and I tried to negotiate the possibility of joining by directly asking several times. But not many of these meetings were in fact conducted during the time of the research. When they were held the staff members that participated used time to discuss and prepare for it in the group of personnel, but they told me that there were already a lot of people attending those meetings and it would put too much pressure on the patient to have me around as well.
angry, uneasy or empathetic with what I experienced. For example, when a post-it note was used to write on by someone instead of interrupting in a supervision session, I noted it down as something unusual to do. Or when I was portrayed as the “fly on the wall” which made me feel uneasy, I noted it down. I also noted down if the staff took off their shoes before going into a home or if they did not. I noted down the eye-movements of the patient, what he watched on the television and that he had bananas in his fruit bowl. A lot of these details, obviously, have not been selected for analysis. In the beginning and for a long while during the field work I did not know what I was looking for apart from knowing that the innovative efforts were difficult for me to see and therefore I broadened my scope of what I was noting down.

After my field work period I started to make a compilation of my observation notes and made thematic division of the observations into situations of the day: such as morning conference, visiting patients at home, visiting patients at hospital etc. However, I found out that in order to get an understanding of the team’s innovation efforts this method had two problems: 1. It included a lot of situations where these efforts were not visible at all. 2. This method was not sensitive enough to capture how intangible these efforts sometimes appeared to be. My luck was that the team had video recorded some of their supervision sessions and study group sessions and I had obtained permission to also use those for my research.

Moving conversations

An aspect of shadowing was done through moving conversations, as I have called them. Apart from formalized interviews that took place in the offices of the staff, in a consultation room or in a site outside the offices, I had informal conversations with the staff members especially in their cars on our way to visits in the country district.

These informal conversations were often on the move and this is a method inspired by Ingold and Lee’s “walk and talk” (Ingold & Lee, 2006). Walk and talk is conducted instead of face-to-face interviews. One takes a walk together. As one accompanies each other on such a walk and then shares the same visual images and experiences on the way, the interview relations become similar to that of a travelling companion (Ingold & Lee, 2006, p. 80). Also, Ingold and Lee are interested in phenomenological life-worlds and, therefore, their walk and talk idea is slightly transformed for my purpose. Like Sandbjerg, (2009) I do not have the expectation of a common understanding or horizon created on the basis of this method. Neither am I interested in understanding or finding out how this travel, in itself, is affecting the way of the innovation processes the team members try to introduce. Rather, what I was interested in was how they spoke about their practices in different ways than in the formalised interviews, how the spatial and
temporal setup of being on the move would also make up the practices differently in the team member’s talk. The moving conversations also made the performance of a different knowledge available simply because it did not connect to the recorder or the questions that were formulated by me in the formulated interviews.

The car provided one such unique space of moving conversation. The access to, and the production of, knowledge is configured through time and space on the move. One day I had a lift in the car with the team manager returning from a meeting. I noted in my field note book: “We talk a lot in the car. It seems like a special room for intimacy. It has not really succeeded in any other space with this staff member.” (24.April 2006). This was what gave me the idea of the moving conversation. The field made me aware that this was an important way to interact with the field and construct knowledge.

But my reflection of intimacy was showing that it was not only the fact of movement that made these informal conversations unique. The way our bodies would be facing away from each other (rather than face to face), together with reference to Freud and Jung, I think helped create a space of intimacy, But this argument is also helped by the description of the placement of the bodies in the little space: The car and being on the road going from somewhere to somewhere else does something to how it was possible to talk. The car is a small space. Our eyes and bodies are facing ahead and the driver has to concentrate on the traffic and steering the car. The fact that eyes do not meet makes the reading of body language more difficult, but may also, then, be of less importance because it is less salient how the adversary reacts towards any given information. Being in the car is physically distanced from the offices, the telephones, the computers and the colleagues that connect to the psychiatric organisation. Being distanced from those things reduces the necessity of having to focus on work obligations while talking. Thus the car is a special space that is making available the possibility of intimacy. Intimacy, in this respect, does not necessarily mean to talk about personal matters but to exchange views and share detailed information on professional issues. It is an intimacy that makes available the mutual intervention with each other because I, as a researcher, do not provide predefined questions or have expectations of answers and the team member can talk about a whole range of things that she or he feels important or relevant to share with me, the chosen topic will be related to me as a receiver of the information. So the topic of conversation is constructed through what we want to talk about with each other about rather than with an interview guide. This provides a possibility of surprise, because nothing is agreed in advance. This is counter to some interview situations where I, as a researcher, ask in order to obtain answers. The travel in the car and the movement away from other influential actors in their daily work (the computer, the desk, the monitoring of activities, the telephone, the office walls etc.) becomes important for what can be and is said.
In these informal moving conversations I obtained a lot of knowledge about what was going on in the organisation, how psychiatric services work, how the team members felt supported by the management. But also about more Open Dialogue related topics such as: “what is reflection” and “how does it change your way of being a psychiatric professional”. I have not used the knowledge from the moving conversations explicitly in the analyses. The knowledge gathered in those situations, on the other hand, has been important for me to understand the motivations and aspirations of the team and I think the intimacy also made the team workers become more comfortable with me.

**Slowing down to listen heterogenically**

Getting back to the vagueness and abstract nature of the answers in the interviews and in the informal conversations I tried at first to pursue the, to me, abstract and vague answers about how the Open Dialogue approach could be defined. An abstract or vague answer was, for example, when I asked what the important elements in the Open Dialogue approach were about and the staff would then answer that it was respect and listening. This may seem straight forward, but it was very difficult for me to understand exactly what was meant by these terms. So when trying to explain to me that the consequences of changing the team’s daily practices meant that the staff would ‘listen’, have a ‘dialogue’, or be ‘respectful’ towards the patient, I was still rather puzzled.

But it turned out that some important invisible work was at stake here. In the interviews the staff members actually performed the Open Dialogue approach without explicitly saying how, because it cannot be explained, it can only be performed. Therefore, when they talk about equality or listening in the interviews I found it difficult to use their words to explain what they meant, because they actually did listen, and I was made to listen due to the abstract and reflective answers.

I realized that I as an interviewer was trying to catch words that seem to have the possibility of being able to be interpreted in multiple ways. I was trying to purify the meaning of Open Dialogue in the interview. I connected the words: listening, dialogue, diagnosis, meeting, knowledge to an expectation of a stable and commonly agreed definition of what these terms mean and imply. However, what I learned through the listening was exactly the opposite. The listening produces a platform of negotiation of these terms and, therefore, makes them open for interpretation. Thus, interviewer and

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50 For a paper presented in Manchester, March 2008 on Resistance, Power and Discourse I used some field material from one of these moving conversations. It was about the emotional make up of envy constructed to provide a platform of resistance and uniqueness in the team.
interviewee are performing the central concepts of the Open Dialogue approach in the interview. The interview with the psychologist, for example, opens up with a question on what it means “to meet the patient where she is”. This is still the subject of the conversation 30 minutes into the interview. This negotiation is illustrated with the following fragment of the interview with the psychologist. Here, the psychologist resists the eagerness of the interviewer in trying to define what Open Dialogue is all about:

“I think the question is a bit inverted. There are some thoughts and some attitudinal approaches of different kinds that artificially get assembled and given the name Open Dialogue. So it becomes a bit opposite to ask about how Open Dialogue is defined, right, I think it starts with the thought (...) We are about to, still, trying to understand what these thoughts imply, and attitudinal approaches. It is about as you said in the beginning in great respect about equality and human contact.” (12.Sept.2006).

The psychologist is trying to explain that it is very difficult to respond to my purifying questions as he sees the definition of Open Dialogue as artificial and only possible to pinpoint after many years of trials and experience with the set of thoughts that constitute the motivation to change their practices. Together with the attempts of purifying Open Dialogue in the interviews a specific rhythm, where pauses and long reflections on the meaning of a specific word is taking place, is also performed.

In that sense the performance of the Open Dialogue approach was about how we (interviewer and interviewee) together would also practice the ‘listening’, the ‘dialogue’ and the ‘respectfulness’, in the interviews. And the fact of not knowing in advance what these concepts contain would force us to slow down the pace of questioning and answering and listen.

When the psychologist listens, it also means that most questions are answered in a circular way. The answers are nicely woven together and connected. It is not a matter of disclosing different aspects of the Open Dialogue approach. For example, the psychologist would get back to the themes of conversation and link them to each other: Listening is connected to equality that is connected to the meeting with the patient that is connected to being in opposition to being diagnostic and so forth. It is nearly impossible to detach one answer from another. This, on the one hand, makes it very difficult to describe what Open Dialogue is all about, because it is about everything at the same time. However that is exactly the central point. Open Dialogue is resisting definition in terms that can be defined through the stabilisation of categories.

“This is why I problematize language. Because the moment I try to define (Open Dialogue, or elements in Open Dialogue) and engage in an agreement of that definition contradictions and oppositions will appear.” (psychologist interview 12.sept08)”
It, thus, requires different tools to describe the performance of the approach in a different way than by looking for singular and categorical answers and that is another reason for me to use tools from STS and ANT, namely symmetry and performance. This is the reason why listening is not only a matter of words, but also timing, space, emotions, things and invisible work. Thus the term heterogenic listening.

Symmetry and performance add to the listening the need that I must pay attention to multiple voices, not only in the sense of sound, but in the sense of what is making a difference in this particular situation. This heterogenic listening made me notice the glances of the eyes, the silences, whether or not the body language was calm, but also the circle of chairs, the present temporality, the round of conversation, and the way I became affected by the field. I will elaborate these in the following section.

**Tools of selection**

I have now described how I gathered the material. In the following I will elaborate on how I selected from all this gathered material. Here I draw on the meta-theoretical premises of performance and symmetry, and describe how I went into the field and then, retrospectively, back to my material with an ambition of being a caretaking heterogenic listener.

These ambitions are informed by the readings on symmetry and performance and together with the semiotic-material definition of action it makes it rather open as to what can be included in the analysis. It has to make a difference. It has to make a difference as to how we can understand and configure the innovative efforts of the team. It also has to be representative of those efforts. But not in a generalised quantitative way. As has been argued in the introduction with the example of an allergy to onions a very small example can potentially have great impact. The standardized programme on how to produce burgers could not encounter the allergy to onions. We would not know the insensitivities of strong programmes like the production of burgers or the development of penicillin or patient recruitment systems if our analysis was not sensitive to the ‘silent’ or ‘invisible’ work that goes on in the process. Making a difference is connected to the subtle performances of the team and how these performances define what the innovative efforts are about. Thus, silent and invisible work are performances that are intangible, that are difficult to categorize, that have not raised political interest, but in spite of this the performances give important insights on how we can understand practices and innovation processes. To catch such performances I have developed methodological tools that are sensitive to subtleties:
Surprise and interactive emotional make up.

The empirical situations that are drawn upon in each of the analytical chapters are synthesised from three particular kinds of settings: The study group meetings, the supervision with an external supervisor and in conversations and formalized interviews with me. As I will explain, the situations were selected through a detailed selection process that involved connecting fieldwork, time, history and sensitivity. I will present each element in the following paragraphs.

**Temporality of the material**

The material, the stories and explanations and the emotions connected to the field are both attached to specific events in linear time but also spread across a time. This became especially salient after returning to the project twice following longer periods of absence. This seems to have put the question about the criteria of linearity and temporal relevance into perspective. The question arose of whether the collected material still had its relevance in relation to whether the novelty of my field material had worn off. I answered that it is possible to learn general things about innovation processes taking a point of departure in the specificity of the case study. The relevance of the material that has been included in the thesis is not taken from its temporal linearity or ‘newness’ but from the analytical questions.

The text of the dissertation is creating a specific temporality. But this text also consists of many layers of temporality through theoretical and thematic references back to different periods, and created in different contexts. The text configures a specific temporality through its descriptions of connections across linear time of events in the field. The descriptive text connects events that are temporarily spread and then connected anew in a present (in both senses of the term, present physically on paper and present in time). To fold time is a process of configuring a text and to be part of the practice I investigate. As such I am inspired by Serres’ topological folding of time51 and let the material be temporarily folded and constituted in the analytical description of

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51 Serres uses the fold in a topological manner. This is a principle of dissemination, regularity and distance between entities in configurations. He includes time in the term and argues for a symmetrically and flat temporality (rather than a linear or circular). The term folding of time is, among others, developed by Deleuze (1988/1993). He is inspired by Foucault’s use of the term that uses it to destabilize the dichotomy “inside” and “outside” a given order. The fold’s inner side becomes its outer side at another place in another temporality; the division between the two is dissolved when the fold is moving, like the question of what belongs to a given order is made relevant anew. (Notes from the PhD course "analysing fluids", Feb. 08)
the empirical material.

“What are things contemporary? Consider a late-model car. It is a disparate aggregate of scientific and technical solutions dating from different periods. One can date it component by component: this part was invented at the turn of the century, another ten years ago, and Carnot’s cycle is almost two hundred years old. Not to mention that the wheel dates back to neolithic times. The ensemble is only contemporary by assemblage, by its design, its finish, sometimes only by the slickness of the advertising surrounding it.” (Serres, 1995, p. 45).

I transport an event out of its temporal linearity and connect it to an analytical configuration. Serres says about time that the interesting thing is not to see how to move back and forth on a given axis of time, but to investigate what it means to be contemporary. Analytically I therefore approach my material in a temporal “flat” manner. This means that the linear moment where I observe an interesting situation or have interviewed somebody I connect to other times. The connections that are configured afterwards are configuring an intervention between me and the field and are connected to how I justify the selection of the analysed material. The fragment of the material does not have a linear temporal importance, but gets an importance through the analytical description and gains relevance and topicality through that description. For example, my composition of the description of the study group session (p.151ff) is a condensation of several study group sessions across time. What gives the picture of how a study group session would be run is a result of this condensation. In the folding of time also lies a selection process. The variances in the study group sessions have been excluded by me in order to be able to say “this is how it is usually run”.

But this is not a precise argument as to why an ‘ancient’ body of material is still relevant today. The folding of time also has to do with the fact that local connections and relations between things and people simultaneously transport links to global trails (Latour, 1999b). Scale is the actor’s own achievement (Callon & Latour, 1981; Latour, 2005, p. 184ff).

“As Boltansky and Thévenot have shown, if there is one thing you cannot do in the actor’s stead it is to decide where they stand on a scale going from small to big, because at every turn of their many attempts at justifying their behaviour they may suddenly mobilize the whole of humanity, France, capitalism, and reason while, a minute later, they might settle for a local compromise (Latour, 2005, pp. 184-185).

Thus, we should not take the zoom effect for granted. Framing things into some context is what actors constantly do. However, it is this framing activity, the very activity of contextualizing that should be brought to the foreground, and that cannot be done as
long as the zoom effect is taken for granted. Size and zoom should not be confused with connectedness (Latour, 2005, p.187). My analyses are analyses of local practices. They are analyses of tiny and fragile details of working routines and arguments of why these should be different. However, as you will see, these details connect with actors that are way beyond what happens in the team. Universal human values, for example, or human equality or evidence based medicine, to mention a few. Therefore I do not address scale in my thesis. I do not address whether local practices are more or less important or influential than big actors. And, likewise, I do not address the temporal relevance of how the field and I have intervened with each other and what analyses have been written as an effect of that.

As has been written in the introduction, the innovative efforts of the team never became stabilized and gained a foothold, they disappeared. Reasons for this cannot be found in the categories or in a structural analysis, because then we would not see anything (such as the process of looking for singular answers in the beginning of my field work). The beginning of a process is often intangible (Latour, 1996a). This is why detail becomes so much more important. Not only because the detail, for example, a specific silence or way of settling into the room are the only allies that make us understand the beginning efforts of a process of change. But also because details are also part of the situations that the team has to tackle and keep together and these situations seem at times so fragile and likely to fall apart.

The team’s efforts are not only a matter of changing something exterior in their daily practices. At times they fight against themselves, for example, when the re-introduction of managerial responsibilities becomes an obstacle to the pure and collective space that they also wish to create (chapter 11). This fragility makes the local practices important too. The rise and fall of the instantaneousness in the situations, the description of these local practices are an acknowledgement of the specificity.

**Historical trails of reference**

Although my meta-theoretical argument for analysing new practices is based on a symmetric ambition, certain objects, things and technologies will appear to be foregrounded in each chapter, for example diagnostics, evidence based practice, a circle of chairs, time, the way to conduct a round of conversation, silence and laughter. These choices are effects of theoretical but also historical references.

The historical argument is that specific objects and technologies have been the subject of extensive attention ever since the institutionalization of mental health care and mental health care services has taken place (Foucault, 2003/1962, 1971/2005; Rose,
Therefore, specific things and governmental technologies have been chosen as important to understand the performances in the team. The chosen objects and governmental technologies, for example the diagnosis, the patient list, and the table carry heavy and finely-meshed connections to other times and other places. This means that they have a history where, on the one hand, their application and meaning has in recurrent ways connected with other entities in the world that these relations have come to seem stabilized and natural and, therefore, correct (Turkle, 2007, p. 311); a so-called black box⁵² (Latour & Woolgar, 1986/1979). These are, at the same time, also technologies that have given rise to a lot of attention. Their survivability and influence can be explained with a relationistic approach, especially in the West, through these finely meshed connections to other times, places and practices. A lot of researchers have criticized the use of diagnosis and its role in the monitoring practices in the neo-liberal structuring of the health care system (e.g. Clarke & et al., 2003; Rose, 2007) and the patient list used at the morning conferences could be said to be an example of this, and the table and chair formation has been extensively discussed as an artefact that organises spatial becomings (Elgaard Jensen, 2001; Sørensen, 2005).

Due to the widespread presence and influence of these specific objects and technologies, the aspiration to innovate mental health care logically has also been directed to deconstruct exactly those objects and technologies. An ANT description of innovation processes is also, therefore, to do with deconstructing black boxed practices and artefacts by giving voice especially to the connections that they have.

However, a historical selection does not, in itself, justify the selection of the empirical material or the object for analysis. But the selection of empirical material for analysis also depends on something else besides the controversies in the past. In the following section I will get back to the selection tools of surprise and interactive emotional make up.

**Surprise⁵³**

The point in the investigation of complex practices is not to end up with dualities and to

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⁵² The way facts about knowledge and objects are coming into being is illustrated with the term “black box” which has its roots in the study of scientific facts. Latour uses the term as a synonym for the scientific finding that is taken for granted, as if it was disconnected from its original set up and context. He found out that scientific practice develops through phases of insecurity, disagreements, errors and hesitations, but that it later establishes itself as secure, undeniable and closed, for example in the output of scientific articles. All the work behind the scientific finding disappears behind the fact. The facts are what appears as the black box (Latour, 1987; Latour & Woolgar, 1986/1979).

⁵³ These thoughts have developed during a PhD course on fluid things at Copenhagen Business School 28. Feb. 08 with Maja Horst and Mike Mikael.
show the advantages and disadvantages but to show that something can be different. Law (2004, p. 9) suggests that one should let oneself be surprised, which dissolves our striving towards security and certainty. Letting oneself be surprised is connected to the point of being a caretaking researcher and allowing the project to become something different from what I would expect with my stereotypical expectations and with a docile research approach. The feature of surprise is, therefore, the key to make something becoming meaningful and scientifically relevant. This, however, does not mean that the surprise remains a surprise. As researchers we will never have the last word. Our informants complicate things for us and our texts and words are always only temporarily fixed and are in process.

When was I surprised? To take an example from the analyses, I was surprised when the team leader laughed at my linking of patient recruitment procedures and the organisation of Open Dialogue network meetings, which will be the topic of analysis in Chapter 13. I was also surprised when the psychologist declined the expectations of his colleagues’ call through eye glances to come up with an answer in the supervision session, which is the subject of analysis in chapter 14. Why did I get surprised in those instances? On a general level because I expected something else. I expected in the first case that this linkage between the patient recruitment procedures and the organisation of network meetings was logical as I could not imagine how to organise these meetings differently, being well aware that the patient recruitment procedures were organised from central quarters and out of the hands of the team. It may be that this was the most logical thing to suggest, but the reaction, the laughter and, subsequently, my surprise told me that here was something unusual going on. In the analysis I argue why this is so. In the case of the psychologist declining the expectations to answer what should be discussed in the session from his colleagues, I was surprised because I did not have the imagination to think how he could do it otherwise with the expertise he had.

The field taught me that there are a lot of other possibilities to act and perform practices than you, as a single researcher, can imagine. Letting oneself become surprised, therefore, opens up the possibility of letting the field intervene with one’s expectations and presumptions. As such the use of surprise then helps to bridge the discrepancy between the researcher’s presumptions and the ability of the field to behave along lines that are incoherent, inconsistent, intangible and do not fit categories.

54 Hastrup (1992) uses the term amazement that in my reading cover a similar approach to the field. Amazement, however, is a slightly stronger word that is to me not sensitive to the subtleties I sometimes experiences in the material, so I have used the one from Law (2004).
When I became surprised I treated the incident as I did in the rest of my work with my material. I started to describe it. I described what happened rather than what made me surprised. As such it is a point of departure, but not a justification for the analysis. In most cases the way I was surprised is not visible in the analysis, because it is primary a tool for me to detect where in the field I found that things made an interesting and relevant difference and, thus, an interesting topic for analysis. One exception is the above mentioned analysis, where laughter is the point of departure of analysis. The reason that this example stands out is because it was so explicit. In the other cases it is a mixture and a whole range of things that can be said to be a collection of empirical material, theoretical readings, surprise and an emotional make up that I will explore in the next section.

There were cases where it was difficult to be surprised. That was when what I observed corresponded to my stereotypical perception of how things should be. Inherent in surprise is that it contains something new, or a new combination of old things. Not everything in the field is new to me. It is, for example, not new to me that staff members fill in electronic patient records after visiting patients, it is not a surprise to me that they meet for morning conferences every morning, it is not a surprise to me that the patients are treated mainly with psychopharmacological medicine. However, these things in new combinations would have been surprising, for example if the morning conference was held in an Open Dialogue way through the teams’ reflection on things. Since I had already been in the psychiatric field for a couple of years before conducting my field work, this knowledge which once, potentially, could have been surprising to me was no longer so. This was simply because I was aware that the above kind of practice is so widespread in governmentally funded psychiatric care that not organising the psychiatric services accordingly would be surprising. The advantage of not being surprised by everything is that there were some elements in the field that I did not notice as being important to take into account. It became a principle of ordering what was important and what was not important to investigate. However, the disadvantage could also be that I have overlooked elements worth investigating because I was not surprised or affected by them, and so they were not taken into account as being important. However, like every other systematic method, something is left out and something is taken in. But I added another tool to make me sensitive to the important material for analysis in the field. This, as I will explain below, is the interactive emotional make up.

**Interactive emotional makeup**

In line with Despret’s (2004) and Stengers’ (1997) focus on the interest and the caretaker role as qualifying scientific contributions, emotions have been an important
guiding tool for the ability to sense this fragility and subtleness in the team’s work. As Latour says: “An object that is merely technological is a utopia, as remote as the world of Erewhon.” (Latour, 1996a). He refers to the importance of injecting a bit of “emotion and poetry into austere subjects” of investigation (ibid). One way, among others, to analyse normalities and codes of appropriateness and inappropriateness has been suggested by Søndergaard (2005) as rendering oneself especially sensitive towards aspects that awaken hesitation, laughter or disgust (p.257). One could say that the way I use “surprise” described in the above section is similar to this. It is my own personal experiences and presumptions that are connected to what I have observed and heard that makes me react as surprised. However, the interactive emotional make up broadens this a little. Instead of looking for normalities or appropriateness in that sense; I look for what is making a difference. It may sound a bit programmatic but making a difference is what potentially transforms things. It means that making a difference is when things and people intervene with each other. What I am looking at is, thus, how I get affected by my intervention with the team. For me emotions and intuition have been of great importance and a useful methodological tool of research to sort out and explore interesting connections between actors in the empirical material for analysis.

“Was I obliged to leave reality behind in order to inject a bit of emotion and poetry into austere subjects? On the contrary, I wanted to come close enough to reality so that scientific worlds could become once again what they had been: possible worlds in conflict that move and shape one another.”(Latour, 1996a, p. IX).

Latour (1996a), Despre (2004) and Stengers (1997) and a whole body of feminist researchers (e.g. Butler, 2005; Hemmings, 2005; McKenzie, 2001; Sedgwick, 2003) have been occupied with mixing up the ancient settlement between knowledge and passions in favour of considering what ties things together as explicit politics (Stengers, 1997). As I have written in the chapter on analytical resources, the shape of a configuration is created by connections between actors. Connections that make differences. To make a difference is an activity where something or somebody changes something and give it new shape. When attending to non-human actors it might be a bit misleading to talk about emotions in this respect. However, the point is that in the crafting of the text and in the interaction in the field I become part of the configurations and I try to make that explicit through the concept of the interactional emotional make up. It is about how the field intervenes with the researcher and the researcher.

55 Erewhon is the name of a novel by Samuel Butler, published anonymously in GB in 1872. The title is also the name of a country. In the novel, it is not revealed in which part of the world Erewhon is, but it is clear that it is a fictional country. Erewhon spelled backwards is ‘nowhere’.
intervenes with the field. Thus, my errand is not to talk about emotions in the connections between actors in the field, for example, the emotional make up of the relation between the team personnel and the circle of chairs, but between the actors in the field and me as a researcher. The way my attention has been directed towards the material has been influenced by my emotional make up in relation to the field. An emotion does not, in itself, justify an interpretation. I will, therefore, not justify any analysis by referring to a sensed emotion. Emotions in this reading are performed and constructed (Despret, 2004b; Latour, 2004a). The term ‘make up’ is signifying this. I further wish to stress that this make up is happening in an interaction between actors and, therefore, I add the term ‘interactional’. Basically, how one gets affected by the team can be used as a selection of field material where the field and the object of study intervene with each other. When something made me anything but indifferent, for example being annoyed, angry, uneasy, happy or wondering, I read this as an effect of a negotiation process between me and the field. It is a negotiation process of me adding expectations, questions and presumptions, to what Open Dialogue and the innovative efforts were about and this would meet the performances that did not match necessarily those expectations, questions and presumptions or did so in positive ways (for example when a patient came to visit the social and health care worker to tell her about his happy new life). I, as a researcher, would be enrolled in what would happen in the field, and my attention was triggered to ask further questions about that incident or situation. As with the performative effects that will be described in the analyses, the emotional make ups have local specificity. When feeling annoyed I, therefore, argue that it is unlikely that I would feel something different exactly because I am configured in relation to the situation to feel this way. However, this does not mean that the emotional make ups could not be different. They are constructs that carry connections to experiences, histories, and expectations compiled from places and times elsewhere (as any other actor also carries connections to other places and times). A researcher with other experiences, histories, expectations might feel angry and the description of the incident of what constructed her as angry would connect to other actors. However, the more detailed the description the more precise also the description of the emotional make up.

As has been indicated, the access to the field was not only smooth and pleasant, but also at times uncomfortable and annoying. But uneasy relationships are not

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56 In retrospect there is an overweight of emotional make ups that connote tension and something negative: like annoyance, nervousness and anger. This is something I only became aware of in retrospect and the reason for this is due to the local performances. However, I would find it interesting to look specifically at positive emotional make ups to see what kind of configurations they are effects of. For example, it could be interesting to investigate what kind of configurations produce happiness, joy, and desire?
unproductive. Rather than only seeking happy, friendly, or close collaborations with the field, we might also ask how positions and power relations are negotiated and contested in uncomfortable research relationships and what possibilities emerge from engaging in frustrating, seemingly non-collaborative practices (Moje, 2000, pp. 25-26). This reminds me that it is not only smooth emotions that teach us something about performances in the team, and even without a primary focus on power, it teaches us something about what is performed and how things are performed. For example, at a supervision session (p.67) the consultant psychiatrist presented me to the external supervisor and explained that my presence had been agreed by the whole group of personnel. The supervisor asked what my role should be during the session and with a smile the consultant psychiatrist answered that I was “a fly on the wall”. The supervisor asked me to stay in the circle around the table and come with input and reflections at the end of the session. I felt uneasy and marginalised by the reflection of the consultant psychiatrist. It was a discomfort that I sensed again in other situations where my presence and the purpose of the project were questioned. At first I was wondering what kind of power relation there was going on; how I was positioned as “being a fly on the wall”. I was formally allowed to be present. Everybody in the team had agreed to participate in the project I was thus allowed with my body, I was allowed to observe, but not necessarily to participate. This created at times an uneasy or complicated research relationship.

With time I returned to this feeling of unease or being comfortable and tried to take the focus away from how the field intervened with me, but rather how I intervened with the field. The fact that I was physically present at their supervision sessions made me part of what was going on (see also the paragraph on being a fieldworker p.102ff). I was included in the performances of how their practices would be configured. The way I intervened was an exhibition of the fact that they were attempting something new. That was my reason for being there. I had explained to them that I wanted to understand and explore how they innovated their practices. When I was present at the supervision session it, therefore, meant that something new and innovative must go on in those sessions. My expectations interfered with how they were present in the room and added to the fact that their initiative was new and not yet stabilized. In addition the fact that the themes of conversation are rather personal in those sessions potentially also created a sense of exposure, threat and fragility. So I see my unease as an effect of what kind of emotional make up was produced in the room in that situation: The newness, the instability, the fear of exposure, and the team’s sense of insecurity and fragility. It was performed as something that had to be protected from strangers and, therefore, necessarily produced me as an intruder or a stranger, since the integrity of what was going on in the group was performed as something that had to be protected.

Another example where I used interactional emotional make up was when my sense of
feeling comfortable was used in the selection of the material on the circle of chairs. When watching the video of the study group session, I did not, to my surprise, feel exposure; I felt a sense of security and comfort. I wanted to understand why that was so and started to describe a study group session. The result of this can be read in the analysis ‘intensive dialogue’ chapter 10.

My sense of being annoyed was used for the selection of material on the analysis of universality. I became annoyed with the head manager for making the initiative of the team banal, for making it something common and already in existence. However, that was only my initial justification for selecting the material in that analysis. As it turned out through the description and the analytical work with that interview what was performed there was much more complex. The reason for this can be read in the analysis on ‘universal dialogue’ chapter 8. This analysis in particular shows that emotional make ups are something that both can be an entrance to a material and an output of a performance or a configuration. I have used it as a methodological tool to select material and, therefore, as an entrance to the material. Along with the analytical work the emotional make ups sometimes change and that could also have been subject to analysis. However that has not been my focus.

Thus, this involvement in, and attachment to, the field is not stable. Emotional make ups move and are transformed across time and space. The instantaneous delight of finding an important connection in one’s material moves with time, with attachment to other actors and knowledge and disappears easily. The temporary stabilization of the relevance of the examples that was initially connected to an emotion has been developed through the attachment of descriptions, references and analysis to these instances. This means that my initial sensations when described and investigated in relation to the situation in the field, sometimes evaporated and, thus, did not gain enough importance for me to carry further. Others changed but were transformed into something else through the analytical work. Something I would call an academic engagement and creativity. This is the academic crafting that goes on in all academic work. The work of circulating references as (Latour, 1999a) calls it. It is the work of keeping track, tracing back and making evident. This is done by accumulating similar empirical situations either in one’s own material or in that of others, the work of referring to analytical concepts (such as, in my case, symmetry and performance), and by building up arguments through describing in details what connections I see in the material.
Summing up

This chapter has described how the analytical premises of symmetry and performance will be approached in the analyses. I suggested different criteria of scientific quality when working with a constructionist scientific approach. These were to raise heterogenic interest, meaning to mutually intervene in the relation between the scientist and the object of study; to raise interest to a research community; and to include heterogeneity in the analyses.

The chapter also explored how the access to the field was not a progressive linear attainment but an ongoing renegotiation process. Due to this the methodology was adjusted and made the presence of the patients’ voices peripheral. It described how I gathered the material through observations, informal talks and interviews and how I selected or put aside the relevance of meetings where the performance of Open Dialogue was absent. In the section on methods I described what I did to gather the material and I described my use of the concept of shadowing and moving conversation, slowing down and heterogenic listening. Shadowing is a concept developed to illustrate how I followed the staff around in their daily practices. Moving conversation is a way of shadowing when we were travelling together. These conversations were constructed in ways that produced intimacy. Slowing down and heterogenic listening were developed as tools to work against the eagerness to draw conclusions or to find singular answers. Further, when describing what material I choose toanalyse, I explained the tools “surprise” and “interactional emotional make up”. Use of surprise as a methodological tool helped me to confront stereotypical presumptions and it helped me to listen heterogenically and made available that things could be different than expected. I see it as a tool that opens up the field for multiplicity rather than a methodological tool that closes it down for singularity. I then explained the tools that helped me select the material for analysis. I explain how I treat the material in a temporarily flat manner and that some objects that have historically been given attention have also been foregrounded in my thesis. The term of interactional emotional makeup is used to justify how affect is also part of every performance in scientific work. In this respect I describe examples of how the field and I intervened with each other through interactional emotional make ups. It is described as a methodological tool for selecting the material for analysis.
Part II - Dialogues

The overall purpose of the analytical chapters is to answer the research question of how the efforts of the team are configured in their daily working practices and what we can learn about innovative efforts through these configurations. The meta-theoretical assumptions are that configurations are constructed through heterogenic and sometimes incoherent performances. Due to my focus being on performances and not on categories, the choice of empirical material for analysis is based on work situations where the efforts of the team stand out and make the innovation processes salient, they are not based on particular directory categories (gender, age, power etc.). This is in order to show that what occurs is of primary importance to the understanding of the innovation processes rather than intending to fragment a new practice into categories. This first part of the analytical chapters of the thesis I call ‘dialogues’. The innovative efforts are in these chapters composed as different dialogues that refer directly to how ‘dialogue’ in the treatment approach can be understood and made real, and, thus, make it clear how the approach cannot be grasped as one singular thing: the alternative, the universal, the closed and the intensive dialogue show the first four different ways in which the Open Dialogue approach is performed. Further, the chapters in this part of the thesis all have in common either uncompromising, exclusive or closedness effects. The different dialogues presented are multiple. What will be the effect of these local performances and how one can talk about innovative efforts in this light will be described in the following pages.
7. Alternative dialogue

Introduction to cutting the connections

The introductory description in chapter 4 of how Open Dialogue complies with recent reforms and tendencies within healthcare gives the impression that there is a point of departure of shared interests between a modern mental health care organisation and the Open Dialogue approach. However, the following analysis illustrates that one way Open Dialogue is configured is rather opposite to that impression. It becomes an alternative to the medical world view. This chapter offers a discussion of how that is done through the introduction of the term “cutting connections”. The empirical material I use to discuss this opposition is mainly rhetorical. Thus, from rhetorical performances deduced from interviews with staff members about the topic of diagnostics, this chapter explores how the efforts of the team are configuring the innovation processes as an alternative. It explores ways in which the configuration of Open Dialogue is based on cutting connections to diagnostics that align with other practices in the psychiatric organisation, but at the same time Open Dialogue feeds upon exactly what it cuts itself away from, namely diagnostics. At the end of the chapter I raise the question of how the sustainability of innovation efforts can be understood when, on the one hand, the fact of taking distance and contrasts to the outer world establishes a platform of purified (undisturbed) performance and, on the other hand, this distancing and contrasting renders the innovative efforts invisible to the components in the psychiatric organisation that align with diagnostics.

Mental health ‘forms’ black boxed

One of the tendencies in health care in general and mental health care more specifically which was mentioned in the introduction to Open Dialogue in chapter 4 is the extended use of standardized monitoring methods and the focus on clinical evidence when validating health care. This tendency connects to the daily practices of the outreach team through the circulation of forms, within and outside of the team, that carries with it this purpose of monitoring, standardizing and qualifying treatment and work activities. With form one should, therefore, not understand ‘shape’ but rather ‘formulas’. Thus, in the daily practices of the outreach team there are many different forms that patients are asked to fill out, such as different kinds of questionnaires on, for example, the social functioning level of the patient (Global assessment of functioning - GAF), the national questionnaire for development of indicators of schizophrenia (NIP), the patient satisfaction questionnaire, and the electronic patient record (EPR) which is a continual assessment of the patient and a management monitoring system of the
activities in the supervising team. In addition, there are forms indirectly involving the patient, for example the staff members’ written assessments and conclusions from feedbacks to questionnaires about improving care or how best to approach patients. These forms, as mentioned, are part of the daily practices of the team. Following these forms around in the outreach team and beyond, one could get a very detailed description of how the daily working practices would be performed. However this would not give a description of the efforts of the team to innovate their working practices. The reason for this is precisely what this chapter is about. Open Dialogue is performed along different lines than these forms. This chapter explores how Open Dialogue is configured as an alternative. If only forms were followed we would, therefore, not gain sight of Open Dialogue. In such a description the efforts of the team would not be visible at all, they would only be absences. It means that, simultaneously, having a daily practice where forms are of great importance, forms are also, at the same time, performed as not being part of Open Dialogue. Now this needs an explanation.

Forms are obviously more than just plain documents; rather, forms are configured with decisions, diagnostic language, and professional hierarchies and, as such, they reflect specific moral, political and social choices. In these terms forms from the medical practices, together with forms from any other practice, are governmental technologies that have disciplining effects (Dean, 1999; Foucault, 1979/1973) with the aim of keeping track and collecting evidence (Latour, 1999a). Importantly, these forms reflect choices of standardization and define solutions to problems that contradict the Open Dialogue ideal.

In the chapter introducing the case study (chapter 4) it was described that monitoring and standardizing practices are conducted through the application of forms (for example patient lists, electronic patient record, questionnaires of different sorts etc.). They are applied to keep reference and are circulated from team, to management, to policy level and back. In the excerpt below forms are formulated in explicit terms as contrasting with the ideal of Open Dialogue treatment:

“[It is the existing psychiatry] that has made a whole lot of forms about what it is that they (the patients red.) have to register, follow and do to get this treatment. So it is possible to argue, that the patients have to function so well that they are expected to be capable of managing and having the energy to fill out all these eternal forms that have to be filled out and made. This is where I think that with Open Dialogue there are not that many requirements (for patients red.). (Interview with staff, July 2006)
This member of staff both criticises the ‘forms’ and suggests Open Dialogue as a more convenient alternative for patients who do not have the ‘energy’ or capability of dealing with the ‘requirements’ of the forms.\textsuperscript{57} My analytical focus, however, is not the specific ‘forms’ itself, such as the use of questionnaires, GAF, NIP or EPR; more precisely, I will reflect on how ‘forms’ are rendered into important black boxes but are, nevertheless, important in the configuration of Open Dialogue as an alternative.

I interpret this first interview fragment as contrasting different health care paradigms, with forms on one side and, on the other side, formulation of a treatment approach as something where there are few requirements and where there is a lack of energy. This connection between filling out forms and the requirement of having energy to do so is also supported elsewhere in other studies where the self-reported experience of staff say their time is used to register and monitor activities in their work, which they feel takes too much time away from their essential activities of care (Mol, 2008; Rankin & Campbell, 2006). Others have pointed out that these activities are of more managerial importance rather than clinical (Dodier, 1998). In the above excerpt this connection between the energy-taking activity of filling out forms for personnel is transferred to how patients must feel when having to fill out forms.

Forms in this analysis, thus, become a generalized term that black boxes all the complexity that is inherent in the use of questionnaires, monitoring and standardizing activities in mental health care. In this analysis forms have obtained black boxed status because it is configured as such in the empirical material used in this particular analysis\textsuperscript{58}. This means that when team members, for example, talk about diagnostics or the medical world view it is often discussed as reductionist and, therefore, objectifying the patients for example. When they fill out Global Functioning Scales (GAF) together in the team they would talk about the scale as something that does not have a therapeutic purpose but as something that is reducing the complexity of how to perceive the abilities of the patient. When arguing that the team is black boxing mental health forms this is what is meant. That in the daily routines of the team the complexity of these technologies are reduced to be reductionistic, objectifying and without (or only

\textsuperscript{57} An interesting analysis could also be made about how the subjectification of the patients is taking place in the configurations of Open Dialogue. In this case the patient is performed as somebody without energy to fill out forms for example. In other configurations the patient is subjectified as somebody that has a voice of his own and should be heard in all decisions concerning treatment. The subjectifications of the patients are relevant in all practice configurations. However due to the scope of the thesis these have not been included.

\textsuperscript{58} This does not mean that forms are always black boxed or othered. However a central quality of the ‘alternative’ dialogue configuration is that it is. Thus, this is also the argument for cutting my description where the forms are not questioned or challenged, so to speak. (See also the previous note concerning the focus on practice configuration rather than on the translative abilities of specific actors).
little) therapeutic purpose. To describe how black boxing is done in greater detail, in
the following section I will introduce the analytical term ‘cutting connections’ which is

**Cutting ‘forms’ from the alternative dialogue**

The purpose of contrasting what is belonging to a black box and what is outside of it, is
to cut the connection and exclude ‘forms’ from Open Dialogue treatment practice.
‘Cutting’ is a term inspired by Derrida (1992 in Strathern, 1996) and is a metaphor for
the way one phenomenon stops the flow of others. Strathern uses the metaphor to
discuss the analytical challenge of how to interpret objects of reflection. It is formulated
as a criticism against the unlimited network metaphor that shapes the ontological
premises of how especially classic-ANT researchers shape the world. The network
metaphor describes an assemblage of heterogeneous elements (Callon, 1986; Latour,
1999b). They are heterogeneous and ascribe to the principle of symmetry and are,
therefore, different in kind and size. The position of an actor in a network is not defined
by its predefined ontological premises. Rather, its ontology is defined by how an actor
in a network is related in a network. From this follows also that distance and proximity
are relative. For example you can stand in a telephone booth and be more distant from
the person in the booth next to you than from your mother whom you are talking to on
the phone but who is miles away (Latour, 1996b). It also follows from the network
metaphor that as soon as relations change, and actors stop providing their work to keep
the network together, the network starts to dissolve (Sørensen, 2005, p. 61ff)\[59\]. In
principle the network in the network metaphor is unlimited and can extend itself
forever.

Following the critical voices towards the network metaphor Strathern argues that, for it
to be of any use, it is essential for something to be held stable in order to define its
configuration. Cutting in relation to the efforts of the team also has the effect of holding
something stable but with a slightly different purpose than the analytical one. Here it is
more practical. It is a way of establishing a configuration in which the composition of
‘alternative’ gets its existence by separating from something else. Cutting connections,
in this respect, is a way to establish clear borders between what is within the
configuration (i.e. what can be defined as Open Dialogue treatment) and what is

\[59\] The network metaphor has been criticised from various points (for example Star, 1991 for being managerial (see
introduction of the thesis); Haraway 1997 for creating a ‘Gods eye’; and (Lee & Brown, 1994) for pointing at the colonial
character of the network metaphor. It leaves no room for otherness and allows for nothing to stand outside the network.
Everything is integrated. (see also Sørensen, 2005 p. 70ff for further critical references)
outside of it. It is an attempt of purifying where certain values and behaviour are kept at a distance to facilitate or make available the situatedness in the Open Dialogue performance. Cutting connections, however, also establishes conditions of ambivalence. Open Dialogue as an ‘alternative’ to existing practices is both depending upon, but also counter to the very same existing practices. Thus, when I continue to operate with a distinction between cutting connections and innovative configurations that establish clear demarcated borders and divisions, it is because some configurations do not have cutting connections as a primary quality. Rather, I argue that the analytical concept of cutting connection is especially useful when the practice configuration creates a distinct otherness by which to define itself. Thus this chapter has been given the title “alternative dialogue”.60

**Forms and diagnostics generalized**

The reason to why I explicitly link forms and diagnostics in this analysis is because it is performed with similar generalizing effects in the empirical material. The following observation is compiled from all the interviews conducted in this research and from the many observations of how the staff members comment on the use of scales for clinical purposes (GAF & NIP), diagnostics or monitoring forms. Staff members make a generalization about what forms do within health care. This generalization is also prevalent in relation to diagnostics. This performance of forms and diagnostics is to do with what the staff members explain is representing a specific objectifying and reductionist medical world view. The generalization is effective in the team to construct their innovative efforts as an alternative to this view, however it does not mean that forms are performed as objectifying and reductionist everywhere in the psychiatric services. Here, I wish to remind the reader of the meta-theoretical premise in ANT that an actor is always a material-semiotic definition. It means that its characteristics are made real in the relational setup it is performed in. Therefore, forms and diagnostics do certain things in, for example, the interview excerpts included in this analysis where they perform something that is reductionist, objectifying the patient, and not producing an equal relationship between staff and patient. Elsewhere they perform something that requires energy for the patient to fill out, they perform something that takes time from the personnel, and they are performed as something that is redundant to the care the staff is providing. Thus, through the efforts of the team forms such as questionnaires, scales and statistical measures are performed in ways that, in general,

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60 Even though the other configurations in this analytical section are still qualitatively distinct and demarcated (and therefore termed ‘pure’), they produce different things than othering, i.e. internal platform of performance, intensitivity, and collectivity.
give forms and diagnostics the purpose of identifying and classifying a problem that is predetermined according to specific indicators. But the team members are not alone in performing forms as categorizing and reductionistic in mental health care. For example Rose (2003) suggests that the American diagnostic system originally was not developed for a clinical purpose, but for a statistical purpose and which has the effect of making the reduction and classification of answers more prevalent. Several studies also suggest that managerial measures, statistics and clinical measures in practice intermingle and connect (Dodier, 1998; Mol, 2008; Rankin & Campbell, 2006; Rose, 2003). Thus, some of the team’s performances, for example those that establish the Open Dialogue as an alternative to the medical world view, and research have produced forms as a configuration that has the reduction of probability and risk as effects. In short, the fact that identification, classification, reduction of risk and reduction of possible knowledge claims has become both an effect of performances in the team, but does also have historical connections, especially in health care.

Further, Schmidt (1999) argues that health, in line with the rising individualization of society, has become a personal matter. This way of rendering something personal is of central importance to the concepts of chance and risk, because as Bruvik argues (2004), they belong to two different regimes: Chance belongs to the regime of the personal, while risk belongs to the scientific regime (Heinskou, 2007). Forms that reduce risk are, therefore, in this type of performance actors that produce singular knowledge claims belonging to a clinical scientific regime. Singular knowledge claims are claims that are preliminary stabilized and seemingly factual in that it has reduced a tremendous amount of complexity into either one or very few statements. It is slightly different from the definition of a black-box as one can imagine black boxes making complexity and multiple knowledge claims appear stable and a matter of fact. The singular knowledge claims I have defined as black boxes only contain a few or a single statement of truth and do not allow for greater variability. In the performances of the innovative efforts of the outreach team the diagnostic system is constituted as producing singular knowledge claims.

61 Taking a ‘chance’ refers according to Heinskou, 2007 (with reference to Smith) to an “existential life perspective” contrary to a "professional death perspective". We do not necessarily commit an existential risk when we take a chance (Schmidt 1999:269-271 in Heinskou, 2007). The fact that we do not commit an existential risk by challenging or disregarding the forms that reduce risk is in Schmidt (in Heinskou 2007) and Heinskou (Heinskou, 2007) terms, thus, exactly because it belongs to a professional scientific regime, and not to an existential state. However, with my symmetrical point of departure I am reluctant to agree with this claim. Potentially both risk and chance pose existential challenges.
The diagnostic form configures the alternative

The following extracts from the interview with the psychologist show different aspects of cutting the connections to the diagnostic system. The analysis explores how the process of cutting connections to the diagnostic system is creating a well delimited alternative to the existing working practices.

At this stage in the interview, I am asking the psychologist what conditions are necessary to be able to institutionalise Open Dialogue within the existing organisation. He expresses that a different set of ideas and attitudes are the prerequisite for developing a more structural change. I pursue the question and ask what that implies in more concrete terms. This extract and the following ones show different elements about how we can understand the efforts of the team as configured as an alternative.

Psychologist: “Equality [is] that vi are born on equal terms, that we go to the same day care, that we have the same emotional reactions and material needs and what else it might be. That is what is common to all of us. This is universal in human life. And then there are things that we do not have in common. The classifying, diagnosing medical model has a tendency to eradicate what we have in common in favour of what is different. This is happening in the prescriptions of all sociological models. Are you a murderer or you are a person that has committed homicide? There are different life conditions connected to being the one or the other person. Your possibility of development, your life conditions, your relations to people around you, conditions for your self-understanding, your psychological, spiritual conditions are changed whether you are a murderer or a person that has committed homicide. It is different life conditions, on all levels. And it is the same for a person that is categorized as schizophrenic or that in your life have met a mental illness that probably will have consequences for your life. But this doesn’t change that you are a person with a life...”

Interviewer: “So equality is connected to the experience of the other as a whole human being?”

Psychologist: “Equality should hopefully support ones experiences of the other as a whole human being. Equality is not an experience; it is a fact, that the other is a whole human being. It is an acceptance, one that is pervaded with everything else, also the fact that I as a professional relate to the other. It is not a question of my experience, it is there the equality. [...] [The experience] is not enough.” (Interview with Psychologist 12.Sept.2006)

Helping another person should not be based on a medical ‘prescriptive’ model (the diagnostic system) but should be based on human equality. To say that the medical model is ‘denouncing’ is a way to black box the form of the diagnostic system, i.e. the medical model is based on a medical world view and the diagnostic system is the form used to help other people in that world view. Throughout the interview with the
psychologist he elaborates that human equality is not a construction or a subjective experience; it is a fundamental acceptance of the other person as a human being. When arguing that human equality is not a construction or a subjective experience he establishes a dichotomy between what makes people equal and what differentiates people. What is connected to equality is ‘human life’ as a “fact”. In this excerpt he especially draws on common emotional and biological characteristics. What differentiates people is psychiatric expert knowledge (‘the classifying, diagnostic model’). The psychologist argues that if psychiatric staff members only take into account diagnostic measures, and thereby being able to define the problem of the patients in advance, he would: “deny that [human] equality. Then I would say that you are actually different from me.” (12.Sept 06).

Open Dialogue is, thus, in this configuration, about forwarding what people have in common and about equality. Throughout the interview with the psychologist Open Dialogue is configured through contrasting it with the previously mentioned forms that are institutionalised in the existing psychiatric practice. To configure Open Dialogue in opposition to forms such as the diagnostic system is an establishment of a connection to the tendency of extended standardization and, at the same time, a way of monitoring use in mental health care in general. Through black boxing this tendency, it makes it possible to fix the diagnostic system as reductive, and to see that the existing approach to patients is ruled and controlled by causal elements that do not allow the voice of the patient to have any say in the treatment.

This fixing of the diagnostic system as reductionist is a double movement. It makes it possible for Open Dialogue to define itself as both an alternative and as something new, whilst at the same time in this configuration it is also dependent upon the very existence of such a reductionist black box. Without the reduction Open Dialogue would not have any argument to exist because the definition of what it could offer the mental health organisation would be invisible. Through the configuration of an alternative also comes along a visibility of what the innovation is consisting of: Namely, as will be explored below “a radical, different approach”.

The psychologist: “[Open Dialogue treatment] is seen as radical in many places, not only in psychiatry, but not least in psychiatry, that has a tradition of being very hierarchically built on a medical model, where it has been attempted to define a diagnostic system that is covering and descriptive, and where there is a correspondence between a diagnosis and a treatment, mainly medical. It has been tradition, and that is what most of the psychiatry is built on. In that respect, Open Dialogue is a radical, different approach.” (Interview with psychologist, 27. July 2006)

The alternative configuration here depends upon explicitly excluding the diagnostic system from what the team tries to innovate. Configuring as an alternative implies
cutting connections to actors that classify or reduce knowledge claims, and this means that the innovative efforts of the team and diagnosis in this type of configuration do not intermingle, do not merge into each other and do not have any common, agreed basis on which to define good treatment. On the one hand, this opposition is black boxing diagnostic measures which makes it impossible to challenge or question what is configured as reductive, such as a form that favours differences between people rather than what is held in common, that predefines problems and, further, generalizes that this is what most psychiatry is ‘built on’. On the other hand, the innovative efforts of the team are configured as promoting equality, taking into account the whole human being and being a ‘radical, different approach’.

The alternative configuration of the efforts of the team is here, thus, a configuration that is explicitly excluding certain aspects that are prevalent in the daily practices of the team: The diagnostic form for example. Existing medical scientific standards are explicitly excluded from the ‘belongingness’ of the ordering that is spoken about here – the Open Dialogue.

Explicit exclusion is different to the concept of manifest absence (Law, 2004) that signifies that something is necessary in order to be able to grasp a specific ordering, but that thing is not actually present in that ordering. When something is manifest absent it is still taking part in that particular configuration, but it is not expressed. For example in the principles described in the introductory chapter, several manifest absences can be identified. ‘Expert position’ for example is inherent in the understanding of the principle of ‘dialogue’. In the description of this principle one understands that in an ideal understanding of a dialogue, nobody has priority above others to give definite answers. But explicit exclusion is when things are named. For example, here diagnosis is explained to be excluded because it categorizes patients. Furthermore the explicit exclusion covers a definition of self as a group/practice through the focus of ‘them/they’ (the exclusion of the Other), while the term ‘manifest absence’ is covering a definition of self as a practice through the focus of ‘we’. In elaboration this means that there are two different ways to cut connections and to define the efforts of the team as an alternative to existing practices. The explicitness is when the psychologist refers to the diagnostic system as reductionist in the sense that it does not encounter the person but only the patient (the symptoms). Open Dialogue is established as an alternative because it has the ability to be equal, meet the whole human being and so forth. But Open Dialogue is only an alternative exactly because it is fed by the existence of
diagnostics (the Other).  

However, the team is aware of this paradox, on the one hand, of having to rely on the way patients are recruited in the psychiatric system (through the diagnostic system, in the sense that in order to get affiliated with the team you need a diagnosis) and, on the other hand, the innovative efforts of the team have to do with promoting equality in the treatment approach. This is paradoxical because diagnosis is configured as classifications, reducing risk and differentiating, whilst equality is configured as human sameness (focusing on what we have in common). With these configurations it seems, on the one hand, difficult to imagine the team’s innovative efforts being stabilized (unless they can be convincing enough to change the recruitment system) and on the other hand, it is difficult to avoid the innovative efforts disappearing when this apparent non-adaptability is configured the way it is.

To summarize, the efforts of the team are here configured through the cutting of connections to the forms applied in their daily practices. They do this by black boxing them as reductionist where patient becomes objectified and treated as unequal. But in the efforts of the team it is not only a matter of cutting of. They attempt to mobilise actors to their innovative efforts. The innovation processes are about adding something. To the alternative configuration (apart from equality as mentioned above) is added namely “listening” and “a set of thoughts”. The alternative configuration, thus, adds other qualities to maintain its alternativeness.

As the next elaboration will show, the alternative configuration is not only a matter of cutting connections to the standardizing, differentiating ‘forms’. In the following paragraphs it will be explored how other qualities are added to the alternative configuration, qualities that not only direct the way of differentiating the efforts of the team explicitly from the medical world view by cutting connections, but also direct how to perform ‘listening’ and how to approach Open Dialogue as something that is not possible to pinpoint as a method but is rather a “set of thoughts”.

62 An illustrative example of how to configure Open Dialogue through present absences will be shown in other analyses, for example the analysis of multiple presences in the next analytical section, where present absences such as managerial responsibilities make a difference in the performance of Open Dialogue, not by naming them, but by performing them.

63 A paradox is a statement or group of statements that leads to a contradiction or a situation which defies intuition; or, it can be an apparent contradiction that actually expresses a non-dual truth (cf. Koan, Catuskoti). Typically, the statements in question do not really imply the contradiction, the puzzling result is not really a contradiction, or the premises themselves are not all really true or cannot all be true together. The word paradox is often used interchangeably with contradiction. Often, mistakenly, it is used to describe situations that are ironic.(www.Wikipedia.org)
Validating the alternative to the medical world view

The psychologist: “If I have to meet the patient, then I have to meet the person. Or else then I don’t meet the patient, if I haven’t met the person also.”
Interview with psychologist (12. Sept. 2006)

The term diagnostic avoidance means that the team of personnel in general does not use diagnostic language or refer to diagnostic symptoms when describing the patient or the problems of the patient within settings where they overtly practice and discuss the Open Dialogue approach, and where they are not primarily concerned with fulfilling their jobs as defined by the psychiatric organisation. In settings that are earmarked for Open Dialogue, such as the study group and in interviews with me, Open Dialogue staff members refrain from using diagnostic rhetoric about the patients. In these situations the diagnostic system is not only explicitly absent but also manifest absent (Law, 2004).64 When something is manifest absent, it signifies that it is necessary in order to be able to grasp a specific configuration, but that thing is not actually present in that configuration.

This has two effects. One is that the diagnosis is back-grounded, so that it does not govern how treatment is discussed. The other effect is that the team ascribes other definitions to diagnosis than those that are valid in the DSM IV or ICD 10 (which is WHO’s international classification system of illnesses that has been used in Denmark since 1995). For example the diagnosis “psychotic” would be described by Open Dialogue practitioners as an experience of a crisis that has not yet been given words (Interview with psychologist, Sept. 06 and Seikkula, 2002/2000).

Innovating mental health care, then, in this alternative configuration is about creating a space where diagnostics can be excluded or at least manifest absent. Study group

64 A similar term the blank figure is a developed by (Hetherington & Nick, 2000) to describe actors that contain the double characteristic of, on the one hand, being tamed and defined where rules determine their use (what I refer to as black boxed) and, at the same time, these blank figures are performed as invisible and difficult to grasp due to their fluidity (Hetherington & Nick, 2000, pp. 176-177). This coupling of black boxing and invisibility proposed in the concept of the blank figure helps us to understand why forms, at one at the same time, are very salient and often drawn upon to configure the Open Dialogue approach as an alternative, and at the same time is very difficult to know its actual performance, because it is rendered invisible in that configuration. The reason why I settle for the term manifest absence is due to the fact that I do not follow particular actors in their different configurations (this would, for example be an analysis of how forms have different configurative effect across different situations like the morning conference, in the patients home etc.) but rather I look for how the practice itself is configured in multiple ways connecting to different actors (for example laughter, silence, circle of chairs, forms). The reason why the term manifest absence is better adapted for this is that the meaning of its term can be used within one single configuration at the time. I find that the term blank figure only gets its rightful use across several configurations.
sessions and the supervision sessions are such spaces. One effect of cutting connections in Open Dialogue as an alternative is establishing spaces where the diagnostic system only has limited or no access. But establishing a pure space is not only about excluding, for example forms, it is also about including specific ways of doing health care in ‘alternative’ ways. What is included in order to produce the purified alternative is about ‘listening’ and ‘a set of thoughts’.

“to ‘listen’ implies that I do not insist on getting any presumed thoughts through that I would take into the conversation and that I would use to deny the experience of the patient. (...) The moment my experience is made more valid than yours (the patient’s ed.), then I stopped listening.” (Psychologist, 12.sept.2006)

The psychologist explains that the team tries to look out for situations where the patient can express something that the psychologist can listen to. ‘Listening’ appears to be a core principle and aspiration in this alternative configuration. So I approach what it means to ‘listen’ to find out how it is a way to add to this configuration apart from its ability to cut the connection to the ‘diagnostic number’. I ask the psychologist, what it means to ‘listen’ (interview 12.Sept 06). He is contrasting the fact of ‘listening’ to methods found in old psychiatry teaching books where it is taught its function is to correct, adjust, patients’ understanding of reality.65 The psychologist is using this as a contrast to qualify and add arguments to how Open Dialogue is “a radically different approach”. Because listening gives access to the lived life of the patients, by adding listening as an actor in this alternative configuration it results in converting diagnostic measures to fiction and the ability to listen and meet the whole human being is treated as reality66. We may ask why this is so? When extrapolating from the interview excerpts, listening is seen to be open to other aspects of the patients’ lives than just to the diagnostic symptoms. Not doing so is explicitly excluded here, because it does not include the ‘person’ in crisis (what the psychologist implies when saying ‘person’ is the whole human being, experiences, social network, personal resources as in contrast to a patient being made up of symptoms only). The Open Dialogue approach, thus, is not only a question of treating symptoms but of treating relations that are connected to developing a new common language through listening and connecting to the social life of the patient. The diagnostic measures have already been described as configured as reductive, but that reduction is not necessarily fiction. However, what has also been described is that equality is a fact not an experience. And what we have just seen is that

65 Here again is an example of black boxing. The complexity of existing psychiatric practices is reduced.
66 I thank my supervisor Estrid Sørensen for drawing my attention to this important aspect of the construction of reality and fiction as part of the alternative configuration of Open Dialogue.
the performance of equality is dependent upon listening. Thus, the reason why I construct the fiction/reality divide in the performance of this alternative configuration is that in the above quotations the access to equality is performed through the listening. On the other hand, equality is performed as not being accessible through diagnostics. Thus, the use of diagnostics can only provide a limited or even distorted picture of the needs of the patient, thus the choice of the word: ‘fiction’.

**In the alternative configuration classifications are still taking place**

Therefore ‘listening’ is added as a central actor to the alternative configuration. Listening is not only an addition but is also constructed in opposition to the reductively configured diagnostics. In the example below diagnosis is absent, and the efforts of the team are still defined in contrast to what has previously been referred to by the psychologist in the team as the reductionist characteristics of the diagnostic system. But what I would like to explore further in this analysis is how the efforts of the team in this alternative configuration might have similar classification effects as those they configure for the diagnostic system. Open Dialogue in this example cannot be narrowed down as a ‘method’ (that is standardizing and categorizing) but rather it is ‘a set of thoughts’:

> “Open Dialogue is in that respect not a method that can be taught and then introduced. But it depends on a set of thoughts and a specific way to position oneself in relation to both working partners and patients that require a much broader development towards the reflective.” (Interview with psychologist, Sept. 2006).

The psychologist is in opposition to Open Dialogue as a *method*67, he suggests that Open Dialogue is not primarily instrumental68. Open Dialogue is not a method that can be taught and then implemented. To the psychologist it is more complex. It is a world view, a way of reflection. It requires reflection and “a set of thoughts and a specific way that one position oneself in relation to both working partners and patients.” The

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67 Interestingly the head of the psychiatric department in the whole district is also in opposition to Open Dialogue as a method, but for different reasons. To him Open Dialogue is not yet evidence based according to randomised clinical experimental criteria. (interview with head of psychiatric department, Oct., 2006)

68 In the empirical material of next chapter ‘universal dialogue’, Open Dialogue is also configured as instrumental. However the configuration has different effects. In that analysis Open Dialogue is configured as universal rather than unique. Thus, this is an example of how a specific actor (here ‘method’) can have different effects in different configurations.
argument in this excerpt that Open Dialogue is not a method is, again, illustrating a way to cut connections to medical ideals in the field of mental health. It is a way to distance oneself from explanatory frames where causal effects and standardized answers are used. In Open Dialogue, one does not know the result or the means to the end result in advance.

However, both existing psychiatric practices and Open Dialogue use classification methods. In both cases illnesses are defined. In that sense this configuration also connects to what Moser (2007) has identified, that both clinical and alternative practices within health care work along similar lines of systematising their practices. In the case of the diagnostic system DSM, illnesses are defined through identification of symptoms. In the case of the Open Dialogue approach, illnesses are also predetermined, maybe in a less categorical way, but nevertheless they are seen, for example, as a ‘crisis’. The efforts of the team are thus again configured as an alternative in a very specific way. In this case the same fundamental method of systematising is applied in both types of configurations (the medical and in the efforts of the team). Open Dialogue includes more elements and complexity when providing treatment, however, it seems that it is still, fundamentally, a categorizing method that is applied. For example, who defines whether a patient who claims to be having a ‘crisis’ is allowed treatment, or how do you categorize who is entitled to get help and who is not? Ideally speaking Open Dialogue refers to a crisis as a trauma that has not yet found words to express it (Seikkula, 2002/2000). This is also a type of categorization, although along different ontological lines than the ones provided for through the diagnostic system. In short, in terms of defining who their patients are, it is difficult to argue that Open Dialogue is an ‘anti-method’

\[69\] However I think that the differences between methods of diagnostics and the Open Dialogue approach of ‘listening’ some Open Dialogue performers (for example the team members in present case) would wish were greater. The fact that people like me, managers and surroundings ask what Open Dialogue is about; make them try to define it in operationalized ways. And is as such an effect of the intervention between the questioner and the questioned. Defining psychosis in some way is a product of that demand of answers. Radically speaking the Open Dialogue approach could operate without such a categorization model and is therefore in theory actually an ‘anti-method’.

**Summing up – the composition of an alternative dialogue**

The purpose of this chapter has been to show how the efforts of the team in mainly rhetorical settings are configured as an alternative. This is done through the black boxing and exclusion of forms from existing practices and, more specifically, through...
cutting connections to the diagnostic system. Through the interviews with the psychologist it has been shown how cutting connections to the medical world view makes it possible simultaneously to add different values such as; equality, listening and a set of thoughts to the alternative. But it has also shown that, on the one hand, this alternative is interdependent upon the medical world view and, on the other hand, through the way this configuration is performed (through cutting connections) it renders Open Dialogue’s existence invisible outside the team and outside the participants that align with its configuration. This is precisely because, as alternative, it is configured along fundamentally different ontological lines.

The extracts above have shown how the efforts of the team and the configuration of diagnostics intersect. It has been shown that diagnostics as a therapeutic value is peripheral; whilst it cannot be disregarded as an administrative tool since we know the diagnostic number is essential to get patients referred to the team. It has also been shown that staff do have opinions about the value of diagnostics, but they see it is an ambivalent tool of use because, although it is a key to recruitment of patients it is also in opposition to the ideals of Open Dialogue – that in its configuration as alternative it becomes a treatment approach that counts itself as not predefining the definitions of, or providing the answer to, a psychological crisis.

This ambivalence can be formulated in the following way: On the one hand, performing the innovative efforts of the team is an attempt to dismiss or disregard categorizations that are done through the diagnostic system. On the other hand, the diagnostic system is the key to getting patients affiliated to the team. The diagnostic system is, thus, a key component in psychiatric care. It is a meeting point, a so-called obligatory point of passage (Bowker & Star, 1999), something that all actors will want to relate to, that partly makes it possible for the existing practices to include Open Dialogue, and partly makes it possible for Open Dialogue to survive in psychiatric care.

**Conclusion - Invisibility**

The performance of the alternative dialogue in this chapter is established through cutting connections. But cutting connections does not only have the effect of establishing something unique and protected, it may also have invisibility as an effect. Inside the team it created very strong alliances through configuring the diagnostic system as reductive and categorizing, whereas equality, as it is configured here, is a fact. However, in the examples given in this chapter there seems to be no connections made through the forms that constitute the relations between the outreach team, the management and the remaining psychiatric organisation. Therefore in spite of the strong alliances within the team Open Dialogue may also render itself invisible to the
rest of the organisation. As a result, cutting connections, as we have seen, seems to create ambivalence towards the efforts of the team’s ability to survive. Latour argues, the strength and stability of a network, a measure of its length (or delimiting a network), is defined by the greater number of powerful ‘allies’ or technological mediators drawn into the network (Callon & Latour, 1981; Latour, 1996c; Svenningsen, 2003, p.57). This means that a theoretical and practical explanation of the disappearance of Open Dialogue could be explained by this way of cutting connections. The existing practices, which rely on a medical world view and managerial, monitoring forms, were not able to align with this specific performance of the efforts of the team and vice versa, and therefore they were not able to recognize each other. It creates ambivalence when having to find a balance between establishing oneself as new and innovative (and unique) and, at the same time, connect with existing practices and values (compromising).

The ambivalence is further amplified because the configuration of Open Dialogue in relation to diagnostics is simultaneously conditioning its very existence as an ‘alternative’ treatment practice. Without diagnostics there would not be any ‘counter-diagnostics’.

Finally, in these examples the focus has been on the rhetorical performance around the diagnostic measures. In other words, the focus has been, primarily, on how staff members have spoken about Open Dialogue in relation to diagnostics. There was a specific reason for this. Namely, the quality of this particular configuration was exactly to make forms redundant and, therefore, absent to Open Dialogue. The way diagnostics is rendered redundant in this analysis is of qualitative importance to how we can understand what kind of Open Dialogue is practiced.

But configurations of the efforts of the team are not only performed as opinions and attitudes. They are also performed through presences in the daily working patterns of the team. But before exploring those presences we will remain a little bit with how the Open Dialogue approach is defined and performed outside the team.
8. **Universal dialogue**

*Introduction*

This chapter shows how Open Dialogue is fragmented into *universal values and non-applicable elements*. This story supplements what we heard in the previous chapter – that the configuration as 'alternative' might make the efforts of the staff to make Open Dialogue susceptible to invisibility. This chapter will demonstrate a double movement of both fragmenting the Open Dialogue approach into: 1. Applicable elements that are adaptable to a medical world view and psychiatric practices such as Open dialogue’s values and 2. Non-applicable elements such as problematizing the Open Dialogue approach as evidence based. This double movement not only produces invisibility but, in fact, also produces *visibility* of the elements in the Open Dialogue approach that are performed as adaptable.

Thus, the relationship between Open Dialogue and more conventional psychiatric practices can be performed in many different ways. This chapter will show how Open Dialogue in the case study is not always performed as the “unique alternative”. We will see demonstrated, how the cutting of connections to the medical world view can be carried out in ways which opens the possibility for easy integration and capability between the alternative (Open Dialogue) and the existing practice. It discusses how cutting connections creates an *interchangeable platform of performance of practices* that both produce singular knowledge claims, but also makes innovation processes possible.

As in the chapter on the performance of the ‘alternative’ configuration, in this chapter the performance of Open Dialogue, from its outset, also is in alliance with recent reforms and tendencies within healthcare that were described in the chapter introducing the case study(chapter 4). Here it also gives the impression that there is a point of departure of shared interests in innovating mental health care practices through the introduction of the Open Dialogue approach. However, the following analysis draws on a situation outside the team, namely an interview with the head manager of the psychiatric organisation in the county. This analysis explores ways in which the specific way that the head manager talks about Open Dialogue is based on cutting connections not to the medical world view but rather to certain aspects of Open Dialogue that contrasts with the medical world view. In this analysis we, therefore, see how a fragmented and universal configuration makes it possible for the Open Dialogue approach to get mobilized into the existing practice.
A first fragmentation of the Open Dialogue approach is related to how the head manager explains that the Open Dialogue approach is not evidence based. The head manager is a psychiatrist by training and, at the time of the data collection, was head of the psychiatric department in the county. As has been mentioned in the introduction of the case study, the manager has encouraged the formulation of the project for this thesis and has shown interest in finding out what qualities the Open Dialogue approach could provide for the mental health care treatment, patients and relatives. As in the other interviews, I asked the manager what would be necessary to be done in order to make a change in the mental health care practices that involved the Open Dialogue approach. The head manager starts talking about specific elements that could easily be transferred to existing practices, namely the psychotherapeutic dialogue. However, he also adds here that this is a type of treatment that is not evidence based. The manager answers:

“I have the impression that at least to some Open Dialogue is a very psychodynamic or psychoanalytic approach. It is an approach that is not an evidence-based method, which has the greatest acceptance in our days. [...] well, there are other methods, namely the cognitive methods that have far more impact and scientific support.” (Interview with head manager, October 2006)

Responding to my question of whether the Open Dialogue approach can be implemented into the psychiatric organisation, the psychiatric manager stresses the importance of evidence-based practice. Clinical evidence is a term that is widely used in the Western health sector (Jensen, 2004). “Evidence based” is thus a term prevalent in the health sector. The principle that one can provide evidence for effective treatment, which is what evidence is here equivalent to, is developed within the field of clinical medicine to assure that patients get the treatment that is most likely to be successful. Within clinical medical terminology evidence means to identify statistically measurable causal effects from standardized treatment methods. The criteria of success have roots in a medical world view that can be dated back to the 18th century where it was the medical (doctoral) objectifying glance on the body that made possible the identification of symptoms of illness, for example the diagnostic system (Foucault, 2003/1962). It is a framework of reference with roots in clinical medicine. Research methods where personal experience and expert judgements are used have the least value in this respect, because the criterion of evidence in clinical medicine is to identify statistically measurable causal effects of standardized methods of treatment (Rod, 2009). It has been criticised as something that is taken for granted as a valuable tool in measuring ‘good treatment’ (Juul Jensen, 2004) and for rendering the human the object of outer control and surveillance (Foucault, 2003/1962). The above quote from the head manager applies the medical criterion of clinical evidence and suggests that it is a
weakness in terms of recognizing Open Dialogue as a psychiatric treatment approach (rather than a set of values).

One can say that the evidence based standards perform the criteria on how knowledge within the clinical practice is accumulated through forms and technologies, while the medical world view creates the premises for the content of the knowledge accumulated, meaning what kind of knowledge is to be accumulated. The introduction of ideals of evidence based practice result in standardization, and monitoring of the activities of the personnel, of the medical use of the social functioning level (GAF) of patients, of the amount of hospitalization time under which jurisdiction patients are treated (with or without coercion, what treatment they receive, or have received and so forth). The Open Dialogue approach as described in contrast to clinical evidence adds to parts of the public debate where especially medical practitioners and psychiatrists have discussed the disadvantages of the approach due to the fact that it is not clinically evidence based (e.g. see also medical practitioners and doctors debate in Danish on www.dagensmedicin.dk). When the Open Dialogue approach is criticized for not being evidence based by, for example the manager, it is often with a reference to a concept of evidence, where best evidence is based on randomised, double blinded experiments. Within this terminology personal experience or expert judgements are considered to have less value, because they do not have statistically measurable causal effects of standardized treatment methods as in clinical medicine70. But the medical world view and the criteria of evidence are in contrast to many of the principles of Open Dialogue treatment71. The principle of dialogue and the principle tolerating insecurity are two such examples. These principles stress the importance of not defining symptoms in advance, they stress the importance of not reducing the complexity of the patients problems as a first treatment solution, but rather to explore them. The medical world view does the opposite, it reduces probability of symptoms, and it seeks to reduce complexity in patients psychiatric problems through providing answers about how to treat them (for example through medication or other clinically evidence based methods). This is the institutional history that the manager is part of and is drawing upon.

70 This argument is inspired by a presentation given at the yearly conference organised by the Danish Association of Science and Technology studies, May 2007 by Morten Hulvej Jørgensen (today his last name is Rod).
71 This does not mean that today’s psychiatry in general is solely based on criteria of clinical evidence as the one described, neither is it based solely on an objectifying worldview. As with Open Dialogue, traditional psychiatry is not a static delimited practice. Several movements have influenced and confronted the clinical evidence and objectifying view in the existing practice, for example as early as the 1890s there was an anti-psychiatric movement beginning from the documents of the psychiatric patient Amalie Skram (Møllerhøj, 2008). Later the psychodynamic approaches and anti-psychiatric movement in the 70s challenged the traditional approach (Laing, 2001/1960). The so-called traditional psychiatry as a pure object is also performed through historical and socio-material configurations.
In the extract with the manager\textsuperscript{72} above there is a manifest absent reference. Choices of new methods of treatment (for example Open Dialogue) should be taken on the basis of best available evidence for the effect of different treatments. The manifest absent reference has earlier been explained to be a reference that is necessary for a certain configuration to be performed but is not explicitly present (Law, 2004). It signifies in this case that clinical evidence is necessary in order to be able to grasp choices of new treatment approaches. Thus, in this configuration clinical evidence is performed as a prerequisite to be able to understand the new treatment approach as a possible actor of innovation. However, there does, in fact, exist research findings based on the same evidence based methods as the ones the manager refers to (Seikkula, Alakare & Aaltonen 2000; 2001a; 2001b). But in spite of this the Open Dialogue approach is, in the above interview extract, cut from being adaptable with clinical evidence. The Open Dialogue approach is not in alliance with the research already made.

On the basis of arguments of evidence or lack of evidence, the manager treats the question of implementing Open Dialogue as a rational organisational issue. But he does that through fragmenting the Open Dialogue approach to elements that are not adaptable to clinical evidence. We see this cutting of connections between Open Dialogue and clinical evidence is repeated further on in the same passage when the manager establishes a connection between the psychoanalytical approach and Open Dialogue. The connection is established through the commonality of them not being evidence based. But the point with this example is not to test the argument of whether the Open Dialogue approach is in fact evidence based or not. Rather the point is to show what Open Dialogue is made to be in this extract. When the head manager is fragmenting the Open Dialogue approach, certain fragments become adaptable in existing practices, others do not. The reason why proving facts is not of primary relevance here is to be found in the following citation of Mol (2002) where she explains her approach to science as an empirical philosophy:

“\textquote{It is possible to refrain from understanding objects as the central points of focus of different people’s perspectives. It is possible to understand them instead as things manipulated in practices. If we do this - if instead of bracketing the practices in which objects are handled we foreground them - this has far-reaching effects. Reality multiplies...Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement.}” (Mol 2002: 4-5)

\textsuperscript{72} This example may portray the manager as one sided in his opinion about Open Dialogue. It is a core ambition in the theoretical approach of the thesis that positions neither practices nor people to be perceived as stable and coherent. Their make up depends on the situation. Likewise the manager has, as mentioned, also supported the initiation of the present project without making any proviso of its methods.
Being able to follow the practice performances of this “remarkable achievement” does not give me, as a researcher, any critical edge in the classical sense of being able to tell what is wrong, and what, consequently, ought to be done about it. But with an STS and ANT re-description as Bruun Jensen (2004) puts it, the point of finding out what is wrong and, consequently, what ought to be done about it becomes less important because as soon as the performances are re-described, practices and social worlds, their inhabitants and their relationships start to look different. So it is not a matter of wrong and right when the Open Dialogue approach is cut from connecting with clinical evidence. It is a matter of what consequences it has when the manager fragments the approach the way he does.

On a practical level the manager performs a fragmented Open Dialogue where there is an explicit exclusion of clinical evidence that is an important actor in psychiatric treatments. This means that clinical evidence is not part of this particular configuration. The fact that clinical evidence is absent, it has of effect that it cannot be recognized as a potential treatment approach of innovating health care because clinical evidence is performed as a prerequisite. Rather it is as an ideology, as an idea of conversation, as an attitude etc. as we will see in the following section.

**Universality and fluidity**

As we shall see in the following extract, Open Dialogue is also in the same interview performed in a way that is *not* counteracting clinical evidence. This is the second fragmentation. The manager says the Open Dialogue approach (in this excerpt it is called the Lapland model due to its geographical place of origin) is a treatment from which one can pick and choose elements.

“But with such new things I think that there is a tendency that one takes exactly what attracts one most by the Lapland model, and then it is what one uses. And then there may be other things that at first do not appeal so much that one will put less weight on. And here I think that the Lapland model is not quite: “It is exactly like this and this one has to do”. In general, you see the Lapland model is more an ideological way to work than it is an instrumental method. It is more attitudes and approaches to the work and to how the conversation is, and to what psychiatry is and to what the patients are and the relatives. It is my impression that the model is a bit loose.” (Interview with psychiatric manager, October 2006)

Through this interview extract the Open Dialogue approach is performed both as a treatment approach that does not align with clinical evidence based practices, which is its manifest absent, and as something that is more a form of working rather than an actual treatment approach. When the head manager says that the approach is “a bit loose”, it implies that it is not clear how to define it according to clinically evidence
terms. This point adds to the previous one where Open Dialogue was performed as an
approach that does not meet the standards of clinical evidence. Here it is further
performed as an approach that is rather vague, and more a matter of ideology and
attitudes than content of treatment. But in spite of the fact that the absence of clinical
evidence and the presence of looseness may make us think that this approach in this
configuration cannot innovate mental health care, there is another crucial sentence in
the above extract: “I think that there is a tendency that one takes exactly what attracts one
most by the Lapland model, and then it is what one uses.”

With this sentence the approach is fragmented into elements of usability and non-
usability. This second fragmentation of the Open Dialogue makes it possible to be an
innovative approach after all.

This might at first sound like a paradox, however it will become clearer in the following
excerpt. In this excerpt the foregrounding of usable and compatible things illustrates a
different performance of the Open Dialogue approach than the previous one. Its
“ideological way to work”, its “attitudes and approaches to the work” and “the way the
conversation is” are principles of the Open Dialogue approach that, somehow, seem to
be able to add value to a clinical (evidence based) treatment. What seems to be implied
here is that it does not threaten clinical evidence but provides clinical evidence with a
form of how to perform it in valuable ways. At the same time these elements configure
Open Dialogue as “a bit loose”. Also, in relation to the description of the clinical
evidence based principles presented above, this excerpt suggests that elements from the
Open Dialogue approach that perform “anti-diagnosis”, “anti-standardization”, “anti-
psychopharmacology” (see the description of the Open Dialogue principles in chapter
4) are dismantled and the eventual adaptability with the medical scientific standards is
achieved, because of its looseness. The looseness is that which makes what Open
Dialogue ‘is’ fluid. It means that it can be defined in general terms and is, therefore,
easily adaptable. In this case it becomes easily adaptable to existing practices in
psychiatric care, because the ‘loose’ definition of what Open Dialogue is does not put
any uncompromising restrictions on how it should be applied.

To speak of something as fluid connects to an analytical concept developed by Elgaard
Jensen (2001); Laet & Mol (2000); Law & Mol (1998); Law & Singleton (2005); Mol &
Law (1994) and Sørensen (2005). In comparison to the Open Dialogue as “a bit loose”
fluidity can be related to a Zimbabwean Bush Pump described by Laet & Mol (2000). In
the same way as the Open Dialogue approach is performed here, the Zimbabwean bush
pump, has the ability of being composed of adaptable pieces, so that it continuously
changes shape. What is characteristic of the bush pump is that each component of the
pump is not, in itself, necessary to make it work. Each component can be replaced by
other components and some components can be removed altogether. In addition, the
pump sometimes has the purpose of providing clean water, sometimes to be a status
symbol in the creation of Zimbabwe as a nation. The point of the Zimbabwean pump according to Laet and Mol, (2000) is that its configuration varies with the different situations that the pumps get performed in relation to. The success of the pump, it is further argued, is its ability to change shape.

Hence, the point is here that the 'looseness' of the Open Dialogue approach exactly makes the Open Dialogue adaptable, however, it is adaptable in particular respects. The looseness is not aligning with clinical evidence or the content of mental health care. However attitudes and ideology are adaptable to the form of mental health care. The performance of Open Dialogue as 'loose' based on attitudes and ideology connects it with the historical development within mental health care in general, and links, on the one hand, with the development of the anti-psychiatric movement, and, on the other hand, to the development of managerial strategies and patient and relatives wishes of increased patient emancipation within health care.

**Universal values are added**

In the following section the head manager adds another twist to the fragmentation of the Open Dialogue approach. What we will see is how the loose elements in Open Dialogue are, in fact, adaptable to the existing psychiatric practices because they are valued by many people. This is what I come to refer to as: “universal values are added”.

When something is defined as fluid, it is actually rather difficult to fix, and it is difficult to stabilize as something specific. In this case it adds a very interesting ability to the Open Dialogue approach. I suggest, through the citation below, that the head manager connects the attitudinal properties of the Open Dialogue approach with universal values. This connection links with an interest in a suggested common good of the psychiatric services in general. We are to think of the usable elements in Open Dialogue as universal, and, therefore, not a specific property of Open Dialogue.

“Well, I am saying that those elements in question,- I guess that is why it appeals to many people and users and relatives - are good, and are strived for in the normal psychiatry...well, most elements.” (Interview with psychiatric head manager, October 2006)

“Users and relatives say that Open Dialogue satisfies some of the wishes they have concerning being more equally treated, that they are listened to more, their relatives are included to a greater extent and they are included to a greater extent themselves, and that they are allowed to decide more and it is more that their wishes are in focus than the wishes of the system etc. ...issues that do not have much to do with a psycho-analytical approach. But I think that all who would like to improve psychiatry would like to implement it.”
Open Dialogue values are performed as ‘quality treatment’ because “all who would like to improve psychiatry would like to implement it”. The fact that patient involvement, attentiveness, equal treatment and so on are created as common universal values makes them disconnected from being an inherent property of Open Dialogue. When Open Dialogue is performed as common, its ownership disperses, float around and can be attached to any practice. This is similar to the example of the silences that will be explored in chapter 14. Equality, the wish to be listened to and inclusion are detached from belonging to a specific practice and can, therefore, also be connected to any practice. No matter its configuration. The link established between Open Dialogue and universal values here makes it possible to introduce certain elements of the Open Dialogue approach into a practice that rests on a medical world view. And there is a reason why this can be important to do. In the interview the head manager listens to patients’ and their relatives’ wishes of becoming more included in the decisions taken in the treatment. The head manager finds that Open Dialogue in some ways is a means to improve patient emancipation. By adding ‘looseness’ to the Open Dialogue approach it is possible to connect to both managerial strategies, clinical evidence, patient NGOs and politicians that promote patient emancipatory demands.

**Implications of fluidity and universality**

In the first excerpt, the performance of the Open Dialogue approach conflicts with clinical evidence and, thus, a medical world view and in those terms does not align with governmen tally funded psychiatric practices. In the second excerpt, the properties of Open Dialogue are translated to elements of universal value. Translating Open Dialogue to universal values has several effects, both organisationally and on a managerial level. On an organisational level, Open Dialogue can be the remedy to comply with public demands and align with recent reforms in the field (see also the introduction to the case study, chapter 4). With these performances of the Open Dialogue approach it is possible to align with patient emancipation, which is of strategic organisational value but not necessarily therapeutic value. On a managerial level, the commonness of Open Dialogue makes it adaptable to the existing system. This fragmentation of Open Dialogue makes it possible both to align with public demands and medical scientific standards, because the structures in that way are not required to be changed.

The performances of the Open Dialogue approach in these extracts are both performed as fragmented and fluid.

The excerpts have shown that that Open Dialogue is fragmented because in certain
ways it is not medically evident. This was seen in separating the Open Dialogue approach from clinical evidence and through the expression of “one takes from it what one can use”. In this performance it is possible to take elements from Open Dialogue and still call it Open Dialogue.

At the same time the ‘looseness’ of Open Dialogue makes it possible to transform and adapt itself and makes the connections to other configurations. When it is loose Open Dialogue is configured as something that is difficult to define, but this, at the same time, makes it able to adjust and transform itself. Thus, being loose means that it is adaptable to both the execution of the medical world view (by its universal values) and patient emancipation. On the other hand, dialogue and network treatment are performed as elements that can easily be absorbed into the existing structures of the organisation. It is adaptable, but it does not cause an organisational revolution.

When Open Dialogue is performed as universal values it connects to existing practices, but it also, again, raises the question of visibility. However, the question of visibility is here different from the question of visibility to be discussed later in chapter 9 on ‘closed dialogue’. There, as we shall see, the efforts of the team to innovate their working practices closes their performances in on themselves, and, therefore, the innovation is unable to travel and connect outside the team. In this present chapter, however, the universality that gets added to the Open Dialogue approach raises the question of whether Open Dialogue remains recognizable as a particular or unique approach. Universal values are collective. Open Dialogue is, thus, not the owner of these values. Open Dialogue is, therefore, also in danger of not being recognized as a particular approach that cannot be displaced by something else. The Open Dialogue approach is here performed as a shell, without its own contents – an empty signifier so to speak (Lacan, 1968). It is performed as having attitudinal value but not instrumental value. Open Dialogue ‘attitudes’ connect to the patient emancipation. Instrumentality connects to clinical evidence. Moreover, the fact that the Open Dialogue approach is not performed as an integrated whole, makes it possible to avoid substantial changes of organisational structure, because the performance of the Open Dialogue approach as an integrated whole would either require its acceptance or its rejection. Since the looseness of the Open Dialogue approach aligns with universal values and patient emancipatory ideas, the performance of the Open Dialogue approach as loose makes available both an acknowledgement of the approach for its values and attitudes, and on the other hand, avoids costly education of personnel.
Conclusion – adaptability is both good and bad in innovation processes

The present chapter has shown that the effect of cutting connections is not only creating a uniqueness or exclusiveness as in the case in the previous analysis where distancing to diagnostics rendered the equality performed in Open Dialogue unique. This distancing is also causing erosion of the uniqueness. A unique performance of Open Dialogue establishes a platform of free space where the performance of the Open Dialogue approach is purified from connecting to actors outside that space. When making Open Dialogue a matter of universal values - albeit not evidence based ones – it makes it possible to accept the approach in the organisation. However it also, in addition, takes away its quality of a special treatment approach that, potentially, makes the innovative efforts of the team invisible as something fundamentally unique or new.

Further, one might also ask why the Open Dialogue approach is not simply acknowledged and recognized as a valuable alternative to the medical world view? It is difficult to say. One suggestion, also connecting with Latour’s writing of the pasteurization of France, would be that the alliances against accepting Open Dialogue as evidence based are too many (pharmaceutics, medical practitioners, alliances between marked interests, politics and singular knowledge claims). Another more fundamental suggestion is that it would create the demand of a variation of mental health services that at the present time are counter the existing ones, which creates work on a restructuring process, training and financial resources. A third suggestion is that when Open Dialogue is constructed as universal values it is harmless and, therefore, acceptable, but that does not mean that it is recognized as a clinical medical treatment approach.

In conclusion the fragmentation of Open Dialogue in the interview with the head manager produces at least two effects. 1. To maintain an alliance with the medical world view prevalent in the existing psychiatric practices. Clinical evidence is, in that sense, necessary for new treatment approaches to be recognized. 2. Fragmenting Open Dialogue to having elements that are of universal value also makes it possible within the organisation. However, this second fragmentation also has of possible effect that the uniqueness of Open Dialogue dilutes and, therefore, potentially, renders it invisible as an innovative approach. The point is that if Open Dialogue is comparable with everything else, there is nothing new about it.
9. Closed dialogue

The two previous analyses have been concerned with showing how the Open Dialogue approach is coming into being through different ways of cutting connections. The term cutting connections was an analytical tool to explain how the performances of the team on the one hand created an exclusive and alternative configuration that took distance from the medical world view and, on the other hand, created it as a practice that was not evidence based. The following analysis is an elaboration of that theoretical contribution. I will now expand the rhetorical illustrative examples from interviews with the psychologist and the county manager to more complex empirical examples from the practices of the team. Cutting connections are here configured through a specific temporality when performing Open Dialogue. In the analysis we will see how the Open Dialogue approach is performed through the creation and sustaining of a specific temporality, which is a particular present, without any reference to a past or to a future. The analysis is based on observations from study group meetings that produce the most salient composition of a temporality that is configured as a present, without reference to the past or the future. Temporality in the innovative efforts of the team is not mundane. Rather, a lot of effort is necessary to compose the quality of the very specific temporality when trying to innovate the practices of the team. At the end of this chapter I will discuss how this type of configuration is creating a type of knowledge that, in many ways, seems mutable in the present space that it is created in, but has difficulties travelling across practices that do not align with its form. This is what produces it as closed. It is closed in on itself.

Temporality composed through cutting connections

To meet in an Open Dialogue study group setting is already temporarily configured. (The format and habitual procedures are further described in chapter 10). What will be explored in the following section is that this temporal configuration is performed through a specific temporal rhythm.

Describing the study group session

The meeting room is on first floor of the office building and is arranged for the study group sessions with chairs in a circle and there is no table in the middle. Having a hot drink during meetings is important and staff members usually bring their mugs of coffee or a bottle of water. This is about the only accessory they bring along with them that, in some ways, take part in the session. For example a paper describing a patient may be briefly included, but papers very
seldom participate in the study group meetings. Mobile phones, calendars, post-it notes and pens are tried to be kept out of the room.

Staff members usually arrive more or less together, sometimes waiting for one of their colleagues having to finish off some work in one of the offices downstairs.

Three principal types of conversations are performed in the study group sessions. The first is when an invitation is given for two members of personnel to talk together while the rest of the group listens; the second is the initiation of discussions where the rest of the group reflects on what the two members have discussed; finally, ‘rounds’ are types of dialogue where each staff member talks in turn and they can comment upon what has been discussed or say that they do not have anything to add.

Usually a study group session is opened with an ‘opening round’. In the first five minutes or so each member of personnel ‘settles in’ and comes with an input about what they have been thinking lately, how their weekend has been, what has been of importance to them in their work and so forth. The talk is usually rather informal. This introductory informal talk is followed by a silence. There is no written down agenda guiding the discussion of the day. It means that deciding how to use the two hours is something that is decided in the room. And it is not something decided necessarily either by the team manager, or by the consultant psychiatrist (who has formal responsibility for treatment).

Other types of ‘rounds’ can be called the ‘reflection round’ and the ‘ending round’. The ‘reflection round’ is often initiated by the psychologist after having discussed a topic and there has been silence for a while. The psychologist is not formally or explicitly allocated the role of summing up. But he has been employed due to his knowledge and experience in systemic therapy where group processes and meetings are used. This may be a reason why it is him summing up these study group meetings.

In the rounds usually nobody judges what has been said in the session nor do they make suggestions or offer solutions or propose future actions. In the rounds the staff members comment upon and talk about the topic just spoken about most often in fairly abstract terms.

The ‘ending round’ is a similar round of conversation where each staff member again reflects and comments, mostly upon the overall content of the day’s meeting. The psychologist often sums up after the ending round before the closure of the meeting. He is also using abstract terms like ‘reflection’,

73 This is a material setup that the team has established for practicing Open Dialogue. One can say that materialities are aligned to facilitate the ideals of Open Dialogue making available to the team members to align their own input with this material setup. However most of these elements are also ideal absences held at the network meetings with patients and their social networks. It means that whenever a network meeting is actually taking place with a patient and her social networks the material set up would more or less be established the same way. Although a central object would often be present namely the table. The material difference between inter personnel contact versus personnel and patient contact is interesting. However, this is a point of analysis that will not be taken further in this context.
‘meeting’, ‘dialogue’ and neither he nor others make decisions about future actions or what should be taken out of the room.

During the discussion and in between the shifts in conversation there are silences often lasting more than 10 seconds. These silences are often connected with gazes around the room, low voices, no interruptions, no diagnostic language and adjustments of bodies in the circle of chairs.

This description is giving the reader a sense of how the study group meetings are usually run. This description illustrates the timing, the spatial setup and the accessories that participate in those meetings. It is visualized with the picture below.

(Snapshot of study group session, Oct. 2005) Once a paper participated in the study group session. It was a situation where the social and health care worker and the psychologist had previously discussed a patient they would like to discuss in the session. Very quickly the paper with the description of this specific patient became redundant (moved from the lap, to the hand when starting to speak to behind the back, and finally to the floor). The movement of the paper with the description of the patient is an example of how a connection to other times, places and discourses was eradicated during the study group conversation. The focus in the conversation was on the relation between staff and patient, neither on the symptoms nor the pathological picture in general.

In the description of the study group setting here and in the introductory chapter of the case chp. 4) linear time is both made present and absent. It is present through the synchronisation of all staff members’ calendars which makes the meeting possible. All staff members have blocked in alternate Mondays and present themselves in the study group.

The regular recurrence of the study group session is expected to avoid the usual hectic and highly contingent practices outside the room. Calendars and other tools manifest connections to, and reminders of, other obligations, and they can be excluded exactly because of this recurrence. For instance the calendars synchronized to the same dates,
with the same interval, blocking out the same amount of time for each meeting. It requires reliance upon the venerable Western tradition that stresses the regular recurrence of meetings on the same day every fortnight, rather than on irregular meeting times (Latour, 1997). Inside the room there is a mixture of attending to the temporal framework of the meeting (two hour sessions with a break midway) and not attending to the temporal framework of the meeting by focusing on being present and not referring to past and future (see below on how the personnel ‘settles in’). On the one hand the temporal framework of the meeting is salient due to, for example, the attention to the big clock hanging out of sight of the camera. It is sometimes attended to in order to make a collective decision about how to prioritize the content of the remaining time of a session, or it indicates when it is suitable to have a midway break. These presences of linear time are connected to the outer organisation (calendars organize the avoidance of double booking working tasks), the clock makes sure that staff members are not late for working tasks after the study group meetings, and so forth. In that sense time in the study group sessions is still connected to the outside world.

However something else is happening with time in the study group sessions. Certain types of temporality are excluded. The temporality of the clock is put aside and a different rhythm, the one I will elaborate on in the coming lines, is performed when the group searches for conversation topics, since written down agendas or patient lists are not governing the topic of conversation. The decision about what to talk about in a given session is organised through a different temporality than the temporality made available by the clock. Rather, Open Dialogue is configured through the ways people ‘settle in’ before starting the meeting and through the long silences that occur on a regular basis during these study group settings. This, to some extent, aligns with the way Latour phrases time:

““time” is not something that is in the “mind” or that is “thought” by a mind but something rooted in a long material and technical practice of record-keeping, itself embedded in institutions and local histories.” (Latour, 1997, pp. 172-173).

Reading Latour, time is thus not something that can be detached from daily practices. Our sense of time must be understood in relation to the study group case and its absence of agendas, the setup of chairs that make certain types of conversation possible and precludes others etc. This theoretical reference helps us understand how time is a way of connecting something present to something absent. Something present (the clock on the wall) connects to work obligations outside the room, for example. But the way I theorize time is adding to this conceptualization. When I analyse the study group session, there are elements of objective linear (the accumulative timing of the calendar) and circular time (the repetition of the study group session) measurements that are
performed through the “long material and technical practice of record-keeping” but this is not all.

Because measurements of time are a commonplace of social life, sociologists have tended to ignore the significance of temporality as a feature of social organisations. Time has simply been considered as mundane and, therefore, invisible or irrelevant for analysis in social studies. But temporality is significant to practices and social organisation because it structures our lives. However, the way temporality is approached might be even further explored. In this thesis temporality is not only a structural, linear or circular thing or something that distributes power relations (as shown, for example, in analyses of Foucault (1979), in his section on docile bodies, or Zerubavel (2006), but something that qualitatively produces subjectivities and composes behavioural modes (Shove, 2009, p. 30).

Temporality is, thus, in this reading something that helps construct “a sense of social time [that] is made and re-made according to social practices” (May & Thrift, 2001, p. 5). Performed time, alias socially practiced time, also constructs the ways the staff members come into being as staff members, when to speak or not, when to decide or not, when to argue or not and is connected to the construction of the present, the past and the future. And the timing produced the how to be present in this temporality. This can be compared to a Luhmanian (1990) supported argument on how systems are referring to themselves. When a system is referring to itself, Luhmann calls it ‘autopoietic’. It means that it creates itself and everything that it consists of:

“Everything that is used as a unit by the system is produced by the system itself. This applies to elements, processes, boundaries, and other structures and, last but not least, to the unity of the system itself. Autopoietic systems, then, are sovereign with respect to the constitution of identities and differences. They of course, do not create a material world of their own. […] what-ever they use as identity and differences are of their own making.”(Luhmann, 1990, p. 3).

Similarly to Luhmann’s description of the ‘autopoietic’ system the specific performances of temporality in the team define clear demarcated borders to what is a

74 An analysis of temporality is highly relevant when trying to explore how practices are performed and what kind of presences are made available (Latour, 1997; May & Thrift, 2001; Shove, Trentmann, & Wilk, 2009). In spite of that acknowledgement time and temporality have only been drawn attention to, to a limited extent in the analysis of practices in health care. Zerubavel (1979) however, is one such example.
different temporality outside this temporal configuration. It is yet another way of cutting connections. The temporal performances are adding a mode of being to what would not otherwise be possible.\textsuperscript{75} Thus, the compositions of temporality take a specific shape in the innovative efforts of the outreach team. I will show that the ways to erase the past and the future are made by attempting to cut the temporal connections to outside the room\textsuperscript{76}.

\textbf{Cutting connections to the past}

Decisions about what is to be spoken of in the particular study group session are not brought into the group through an agenda, or a patient list, or decisions from the last session. When starting the study group sessions an ‘opening round’ is initiated and each member of personnel settles in. This is done through leaving the toils of the weekend (the past) behind and is a way for members of the group to prepare for the present session. Leaving the toils of the weekend behind is a term that covers how the staff ‘settles in’ in the session. It happens through expressions like: “I’m fresh and ready” (psychologist), or “It is Monday so I just sit here and see what comes around” (social worker), “I have been worrying about my medical examinations and I have a terrible headache, but being here just now feels like a relief” (psychiatric worker). Leaving the toils of the weekend behind, thus, means that they are left behind when starting the group session. The opening round helps the past to be left behind and this is a way to get ready for being present in the present temporality. The past is in that sense erased. Thus, specific types of being in the world are constructed through the exclusion of the past.

\textbf{Cutting connections to the future}

The present temporality is also composed through cutting connections to the future. With a slight analytical detour to one of our greatest phenomenologists, Walter Benjamin, 'the Jetztzeit’ (the now-time) or what I call the present presence is in his terminology a moment without history, a moment outside of time. The present is disengaged from history’s causality, and from history’s dictate: today’s actions are no longer predetermined by earlier events (Benjamin, 1994).\textsuperscript{77}

\textsuperscript{75} I owe the development of this elaboration of temporality in a Luhmanian reading to Dr. Will Medd.
\textsuperscript{76} Cutting connections (Strathern, 1996) is explored in the previous analysis.
\textsuperscript{77} I thank Marie Bruvik Heinskou for inspiring this similarity in my analysis.
Similarly to Benjamin’s now-time, the staff members are doing just that, for example, by not carrying any decision out of the room, by not having any agenda of the day, by not discussing how to take (future) action on things. When ending a session, the psychologist usually suggests an ending round where everybody reflects on the themes of the day and he usually sums up, not necessarily by reflecting on what has specifically been said, nor suggesting what should be learned, but by sharing his own reflections with the group. Nothing is written down at the end of the session. Neither decisions nor any appointments are made.

So my argument is that the making of the present through the exclusion of the past and the future that connects to the outer organisation, is what is also making presence, in a specific way, possible inside the study group session. In line with this argument Serres (1995) is offering a symmetrical conceptualization of time that is useful, where he argues for its fluidity (Serres 1995, p.45). The reader has already been presented with this quote in the methodology chapter 6, p. 113. Here it is used as an analytical tool:

“What are things contemporary? Consider a late-model car. It is a disparate aggregate of scientific and technical solutions dating from different periods. One can date it component by component: this part was invented at the turn of the century, another ten years ago, and Carnot’s cycle is almost two hundred years old. Not to mention that the wheel dates back to neolithic times. The ensemble is only contemporary by assemblage, by its design, its finish, sometimes only by the slickness of the advertising surrounding it.” (My emphasis, Serres, 1995, p. 45).

With reference to the “late-model car” Serres illustrates his understanding of time as a multiple process. Events and objects are a composition of many different times. When something can be performed as belonging to the present or to the instant, it is about how different times are configured in a specific situation or event. When something is ‘contemporary’ it implies that a specific composition of the present is performed. Jespersen (2007) presents an interesting analysis, inspired by Serres, of how socio-material entities in the general practitioner’s practice make multiple conceptualizations of time available inside the doctors’ consultation room. Serres himself applies the principle of generalized symmetry to the extent of time. That means that chains of association can be brought back and forth in time with no limitations (Serres 1995). One could also talk about this type of time in my material. What is similar in the approach of Serres (1995), Jespersen (2007) and this analysis is that time is suggested to be considered as a multiple and situated process. In that line of argument I would

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78 I thank Astrid Jespersen (2007) for the elaboration on this quote.
look for how associations between different times are created in the study group
d session. Following Serres (1995) I could look at the study group session as a specific
temporal configuration that connects actors that were previously distant. However, that
is not what has been done in this analysis. That would involve a methodological take on
the actors to discuss and describe their origins and to place them in connection with the
event of the study group session. But my ambition is not historical in that sense. It is
not the multiple composition of time in a single event. Rather, I would like to rephrase
Jespersen’s (2007) insight about how things become contemporary, in order to
understand what specific kind of temporality as practice is performed in the team. It is
a temporality that defines the staff members through a practice in the present. Thus it
does not become the temporality in itself that is of interest in this analysis but rather
what it produces.

The heterogenic present

The present is configured through both a temporal and also a material composition.
‘Settling in’, the circle of chairs, the conversation ‘rounds’, the mugs of coffee or tea that
can be attended to in order to make a pause, are all both temporal and materially
composed and seem to be what is added and aligned with what may be called the
‘present’ of the study group sessions. At the same time diagnostics, expert positions,
patient lists, agendas etc. that are likewise both temporally and materially composed,
are left out of this configuration of Open Dialogue practice. These excluded entities
carry a historical trajectory of narrowing down knowledge claims. It produces singular
knowledge claims as argued, for example, on p. 129ff and p. 86ff. Singular knowledge
claiming materials are questionnaires, diagnostic measures, written down agendas,
hierarchical positions that are all materials and governing technologies whose purpose
is to, first, come up with an answer to a problem and, second, to exclude right from
wrong answers79. Traditionally singular knowledge claims that are claims of knowledge
that provide only one or few answers, are prevalent in research traditions within
natural sciences and clinical evidence based methods where randomised trials and
probability of outcomes are supposed to narrow down the possibility of answers (as the
previous analysis also indicates). Their purpose is to narrow down the probability of
doubt and risk in order to be able to take decisions on how to act accordingly.
Configurations within these traditions are ways of producing knowledge that are
narrowing possibility and multiplicity of answers to what is right and wrong. This

79 The point of ‘singular knowledge claims’ has also been explored in the chapter on “alternative dialogue” where
diagnosis was explained to be configured to produce homogenous, singular facts.
means that defining what is right and wrong, and taking decisions, are based on narrowing down possibilities rather than opening them up. The ‘present presence’ configuration of Open Dialogue study group sessions encompasses just the opposite. In other words, it is a temporality that opens up the possibility of multiple knowledge claims because they are made possible in the present (temporal) configuration of the efforts of the team in the study group sessions. Multiple knowledge claims open up the possibility of interpretation and allows for the multiplicity of answers as to what is right and wrong. Multiple knowledge claims is a type of knowledge where the multiplicity of answers is regarded as the right one, so to speak. Being present in the presence is therefore also closely connected to the performance of Open Dialogue as an ‘alternative’ practice. This is because when creating something as alternative it is also normative in the sense that it excludes something else from being part of that alternative. In the present presence singularity is what is excluded, because the staff, when settling in, make themselves ready to contribute to the collective and be present as a collective.

Conclusion – a self-referring configuration

What happens in the study group is that a temporality of its own is configured. It is a temporality that seems fundamentally different to temporality in existing mental health care practices in two ways. Firstly, it cuts connections to what is outside of itself, and also to the outer organisation. Secondly, it produces a temporality that orientates the definition of what Open Dialogue is inwards. Contrary to the first analytical chapter where Open Dialogue was performed as an alternative and in contrast to (and therefore depending on) the outer organisation and the medical world view, the temporality performed in this chapter configures the innovative efforts of the team as a specific way in which to conduct conversations that focuses on a temporal present. The innovative efforts of the team are, in this respect, defined in relation to the team itself, rather than to something outside of the team. In this sense, the team is configured as a closed circle without references or alliances outside the study group. This is contrasting the ways of conducting conversations which produce knowledge that can move across time and space, so-called immutable mobiles (Latour, 1987). This is a type of knowledge that is configured around, for example, diagnostics and clinical questionnaires. These are made to travel without changing their shape. However, through closing in the efforts of the team in an isolated present temporality, the efforts of the team configures mutable

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80 The performance of multiple knowledge claims will be explored in the chapter on collectivity. Briefly, multiple knowledge claims are configurations of knowledge practices that are supported by configurations that produce collectivity.
immobiles, that is, knowledge that changes (is never fixed), but that has difficulties travelling to practices that do not align with its form. Mutable immobility is the subject of the next chapter that is further explored through the spatial setup of the study group session in the outreach team.
10. **Intensive dialogue**

From the previous readings in this text, one gets the impression that there are certain aspects of mental health care that are important in the performance of Open Dialogue, whilst others are excluded. When taking a distance from diagnostics and the medical world view is added to the performance of a present temporality it seems that the initiatives of change in the team are impermeable to the outside world. This chapter extends the analysis of how innovations are about creating a unique space that adds to this isolation from the world. It aims to show that the performance of a nearly naked room produces mutable immobility that also has intensity as an effect. Mutable immobility and intensity are both concepts that explain aspects of how the performances are happening without connecting to certain actors that are prevalent in mental health care practices outside the room. Intensity is in this context to be understood in an STS reading (Latour, 1997). It is socio-material and, as such, intensity can have many effects. I show three effects in the chapter: 1. Intensity is the socio-technological production of how participants should feel, which is also termed emotional make-ups (Despret, 2004b). 2. Intensity is the hard work of keeping mental health technologies out of what is defining what is happening inside the room. 3. Intensity is the effort of foregrounding bodily interaction.

**Performing space**

Extending the temporal configuration presented in the previous chapter, the mutable immobility is not only about temporality, it is also about space. Spaces are also configurations and have performative effects. The efforts of the team are, thus, also configured in space:

“Space, here, should not be understood as a primordial given, an a priori of thought or a straightforward matter of topography. Psychology is involved in the invention of spaces, in the opening up of certain fields for thought and action...” (Rose, 1998, p. 91).

What Rose (1998) is here referring to is how the discipline of psychology is also performing specific spaces that have a disciplining and opening up effect on the people involved in this psychological space. The innovative efforts of the team can be considered in a similar fashion. Similarly (however not with a primary focus on humans, but rather on knowledge production), I will show what kind of effects this particular spatial figuration is performing and will, thus, in this analysis pose the question: “what kind of knowledge is performed through the circle of chairs of the study group session?” The overall argument is that the connections between what is present and what is absent around the circle of chairs offer a particular configuration of
the efforts of the team. I wish to develop this point by reconstructing one empirical sequence; more precisely, I analyse the physical set up in the study group room.

Is a circle of chairs providing trust and security?

As mentioned in the study group description in the chapter 9 on ‘closed dialogue’ the chairs are always placed in a circle. The staff members mostly sit relaxed with their backs against the chair, their hands on their lap, often with their legs crossed. When talking, arms and hands are gesticulating and sometimes placed behind the back of the chair. There is an absence of a table, an absence of calendars, and (most often) the absence of papers. This is, in general terms, the usual bodily and physical setup that the team has established for practicing the Open Dialogue approach. The way bodies are present and the exclusions of specific medical forms are adding to the ideals of Open Dialogue, where predefined decisions and guidelines of the content of conversation are to be avoided, and where the way to be a professional is to be performed through human interaction (and therefore calls for a body language that is open, inviting and ready to listen).

Think of the circle in relation to a triangle or a square. If people sit in a triangle or a square the hierarchical order of speech would be made clear by the form, because bodies and distances between bodies direct the way of both listening and the direction of gaze. The distance between people established by different forms of seating facilitates or negates different types of participation (e.g. Foucault, 1979/1973; Juelskjær, 2007; Sørensen, 2005). Does the circle call for human interaction and the establishment of equality and thus trust and security? We have been taught, for example, through the development of psychology in liberal societies (Rose, 1998, pp. 13-18), that the ‘specialists’ role in shaping the ways human beings have come to experience themselves is connected to a whole range of tools, materials and technologies. Another more Protestant religious reading of the room would be where the absence of furniture and things are thought to liberate the soul and make the connection to God more direct and intimate (Law & Mol, 1998). In line with this thinking Jung and the later Freud developed the idea of ‘free associations’, where patients were placed on a couch facing away from the therapist in order to talk about what comes into their minds by a word of stimulus without being distracted by the therapist (Koester & Frandsen, 1997). One could say that the social interaction in those

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81 See the description of the study group session p.151ff. (See further the text below the picture describing the presence of the paper).
settings is thought to facilitate the pureness of the soul. The idea of the pureness of the soul is inherited from the idea that the soul is most pure when it is not disturbed by technologies and things (Douglas, 1984, 1966, 1997). So in this reading, the coupling of a presence (the circle) and an absence (the table) can be seen to foreground human interaction and to be an attempt to perform purity of the soul. This is adding to the argument about the equality between the bodies in the room because they are seemingly stripped of things and technologies that provide a differentiating status.

But in spite of the inspiration to read the room in a certain way that is given by the above readings, I would like to add a point of relativity. When Elgaard Jensen (2001) describes a reception counter in a centre for social work, he says that at first glance it induces the feeling of welcome and trust, but when later noticing the bolts on the floor affixing the counter, it induces the feeling of possible situations of conflict. The surprise that the closer look at the reception counter induces is informed by readings of STS and ANT literature (e.g. Elgaard Jensen, 2001; Latour, 1996c, 2005). This means that the reception counter and its symbolic meaning cannot be defined a priori. Therefore, relying especially on the performative turn, that signifies an emphasis towards the multiplicity of how practices and objects come into being, in fact we will not know immediately that this spatial setup has an a priori effect of disciplining, nor to trust and security or to feelings of conflict or purity of soul. Things and words do not in themselves constitute meaning and action. They have to be understood in chains of relations within a configuration. This means that each entity, by itself or per definition, does not induce a particular behavioural pattern or create a specific production of facts. These are effects of the performances. I, therefore, need to take a closer look at what happens in the circle of chairs. It is not enough to speculate.

But let us rest with the presumptions for a brief moment. I will follow the first impression of Elgaard Jensen (2001) who saw the reception counter as inducing trust and security and use this impression as a methodological handle to preliminary fix the absence of a table as if it was aligned to support pureness of the soul, inter-human communication and equality. At first we will look at how the reception counter is inscribing the perceptions and feelings of trust and security.

So now I will take the reader through the description of the how people settle into the circle of chairs in the study group session to see what happens with the first impression

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82 To preliminary fix the reception counter means that it could be performed in different ways in different relational set-ups, as can the diagnostic language, the chairs in circles and the absence of written down agendas in my team of personnel. “As if” is here used as an analytical tool to explore a certain configuration.
Performing a circle of chairs

Studying the video clips of the study group I notice that before beginning to talk, people move around a little, move their chairs or shift places if there is an imbalance in the circle (it appears to be possible to have one, but usually not two, empty chairs in the circle). Because of the moving around I get the sense that the completion of the circular form is important. Bodies, as it were, prepare themselves to fit into it. The placement of chairs in a circle makes bodies face the middle of the circle without facing any specific person. The circle appears to make any start or finish of speech random because there is no chair appointed to e.g. a chairperson who would lead. However, each individual is exposed. One cannot hide behind a table. All movements are visible. There is no place to hide. Every movement and respiratory difficulty becomes visible to the others in the room, and is either safe to share because the room feels secure, or unsafe to share because the room is like the panopticon of the open room (Foucault, 1979/1973) which means that nobody can ever escape the glance of their colleagues and the knowledge of this produces discipline and self-control.

However the group settles quickly in the session once adjusted in the round. The body language is more or less the same the whole way around the circle: Open chest, hands on the lap, most legs crossed, back against the chair. Calm eye movements. On the face of it, everything seems to contribute to an atmosphere that is calm and inspired with equality, except that at the same time the atmosphere in the room is intense. I will return to this intensity below.

The placement of chairs in a circle, together with the absence of the table and the calm body language, seems to be making the levelling of speech possible. The availability of speech that is not guided by a hierarchical levelling, meaning that one specific person takes the lead, is also supported by the fact that neither the team manager nor the responsible consultant psychiatrist are directing who should speak when, and about what, as is found in chaired meetings with specified written agendas.

83 During a joint session with Marli Huijer in EASST in Rotterdam 2008, she drew my attention to Hannah Arendt “the human condition” (Arendt, 1998) and suggested to analyse the presence of the table as an entity that unites people in a civilized way (rather than suggesting its distancing and hierarchical effect as I presume in the beginning of the paragraph). Drawing on Arendt the symbolism of the table is human civilization. This discussion made me think of a central point of analysis in the article “on interobjectivity” of (Latour, 1996c). His article suggests that communities of chimpanzees and human do not differ in sophisticated social relations but rather in the tools, artefacts and technologies that supports the community. An argument could then be that the absence of the table in fact is not dissolving expert roles or hierarchies but rather, on the contrary, potentially making inter-human contact cruder.
Thus, we have the presences: the circle of chairs, the listening bodies in the circle, the circulation of conversation, and all the absences: patient lists, agendas, tables, calendars, mobile phones, questionnaires to fill out and so forth. This configuration also assists in not determining the nature of the discussions. It allows the discussions to circle around such topics as the definition and purpose of Open Dialogue principles, (such as ‘respect’ and ‘dialogue’) and it allows anyone to decide upon the focus of the day. The team tries to refrain from making judgements or from giving direct advice to each other in these sessions. For example, this means that when a colleague would express that she feels a relation with a patient difficult, the other team members would not suggest to her what to do, but rather reflect upon what her story makes her think about. The absence of tables, the non-judgemental and non-decisive conversational form, the body language that is listening and ‘open’ make a composition of participation that foregrounds human interaction.

All these described materialities and forms of interaction in the study group constitute a purified, meaning ideal, pre-scribed form of the Open Dialogue setting. The absence of hierarchical trails, where the provision of singular answers are prominent, (that could be configured through written down agendas, the consultant psychiatrist taking decisions, reference to diagnostic symptoms and so forth) and the presence of interpersonal contact facilitate a configuration of the efforts of the team as an equal configuration. This means that each actor (both in terms of different types and within each group of actors) has equally as much or as little opportunity to take part in the discussion of how to define the innovative efforts. This description of how the people settle in with the circle of chairs is supporting the initial impression of how the circle of chairs is making the levelling of hierarchical communication possible.

Summing up, this chain of interaction, of making certain things absent and certain things present: - the humans- and the chairs— in the nearly naked room -, leaves a particular intensity in the room which I will come to next.

The effects of the circle of chairs

Through the circle of chairs which directs the bodies towards each other, through the

84 This is a first hand impression. When going more into detail of course a lot can be said about who is speaking a lot, who is not speaking, how decisions are taken and so forth. For now we try to go with the preliminary impression.
levelling of speech and the facilitation of the non-directedness of the conversation of
the meeting, and by the alignment of all these entities together, the performance of a
primarily human configuration takes place - but it is a configuration that is mediated
through a spatial setup, the circle of chairs and is, therefore, also heterogeneous.

Here, I would like to make a connection to Latour (1993/1991) and his notion of
purification. In spite of the fact that we know that the world consists of a myriad of
things that intermingle and relate in multiple ways, we keep on craving for categorical
and stabilized definitions. We simply insist on splitting the world into dichotomies
‘circulating references’ in *Pandora’s hope* (Latour, 1999a) and in his book *we have never
been modern* (Latour, 2006/1991). Why is this of interest to a circle of chairs?

It is of interest because what we have seen here in this analytical chapter is exactly what
Latour describes, i.e. it is a performance of an attempt at dividing the world. The circle
of chairs is an element in the efforts of the team to make their innovation processes
recognized as performing pureness of the soul and equality. What the circle of chairs
performs as present and absent is exactly this, a dichotomist division of the world. The
spatial setup is configuring identifiable ontological lines - different from what is
configured, for example, by the diagnostic forms or the National Indicators Project in
the existing practices.

Latour (1993/1991) offers with his book *We have never been modern* a philosophical
manifesto that deals with understanding the empirically-founded ANT studies. He
explains that we still split the world into dichotomies because we still believe in the
Kantian notion of exclusively defining an object that is closed in on itself and that is
separable from the relations around it (see also the description of the Kantian notion on
p. 78ff). It builds on the notion that this putative object ‘out there’ is not possible to
define in exclusive terms outside relations with others. Latour argues that modernity is
often defined as humanism, either with a reference to the invention of the human or to
its death. But this reference to humanism is, in itself, modern because it is
asymmetrical (prioritizing the human). As he further writes, the invention of the
human has, at the same time, invented something non-human: the things, the animals
and God. Modernity originates in the simultaneous creation of the three; the human,
the non-human and God, followed by the obliteration of this simultaneity (that is due to
our Kantian heritage), whilst underneath hybrids are continuing to multiply exactly due
to this separation (Latour, 1993/1991, Chapter on the Modern constitution).

Through the description of the modern constitution Latour explains that purification is
one side of a dual movement of how things are coming to be understood in the world.
The circle of chairs can be said to facilitate a purification attempt towards configuring
the efforts of the team so that their efforts are not polluted by singular knowledge claims and standardizations from diagnostics, NIP or monitoring requirements. But this purification is not homogenous in spite of the fact that it foregrounds humans and inter-human relations, the pureness of the soul and equality.

I develop the term purified heterogeneity as an elaboration of the argument of Latour (1993/1991) that purification processes are necessarily separating the human from the non-human, or humans from material or spatial setups. In the performance of Open Dialogue a separation process is indeed taking place. There is an exclusion of certain types of forms (patient lists, diagnostics, and questionnaires), technologies, tables, hierarchical expert roles etc., but, counter to Latour’s purification argument, what remains in the room is neither singular nor homogeneous. This is where the argument of intensity comes in. Intensity, Latour (1997) argues, is heightened when there is an imbalance between the spatial, temporal and acting parameters in a configuration. The reason why I suggest that the efforts of the team, through the circle of chairs, are configured in a purified heterogenic attempt is due to this point of intensity.

**Extending mutable immobility to the ‘circle of chairs’**

What happens in the chain of connections in the room when staff members settle in on a circle of chairs? What happens in the circle of chairs is mutable but not mobile. Mutable immobility is connected to the establishment of an Open Dialogue that is not only emptied of the transferability of form and content, but also emptied of the types of forms that narrow down knowledge claims. In other words, I found that the ways of performing the efforts of the team was not only mutable immobile in a specific temporality but also in a specific spatial setup. It means that the efforts of the team are changing and are adaptable but only within a distinct temporality and spatial setup.

This interpretation also adds to my reading through the different types of empirical materials. For example in the interviews, the staff added the importance of general ethical values that are distanced from psychiatric expertise. The importance of being human before being professional is emphasized (interview with social and health care worker, July 2006). We saw this in the first analysis where ‘listening’ and a ‘set of thoughts’ were established as a contrast to diagnostics (interview with psychologist, Sept.06). Also important is the avoidance of predefining decisions and using medical forms in Open Dialogue and this avoidance involves being non-judgemental and entails the sharing of a new language (Video of supervision session 4. Aug 2006). One expression that synthesises this is taken from the literature:
Humanity, shared experience, and present temporality are components that make up the mutable immobility. Mutable immobility here is knowledge that has the ability of being created and transformed in the space of the study group sessions – in connection with the circle of chairs, but it does not travel out of the room, and as such does not leave traces beyond the space that it has been created in. Taking this further, I will argue that the mutable immobility is creating specific effects of intensity. Intensity is the topic of the next section.

**Intensity**

Firstly, intensity comes in many forms and is configured, like everything else, through different configurations. One performance of intensity can be seen in the movies’ use of techniques. In movies, intensity is established through the use of sophisticated techniques of camera angles (facial close-ups), special stage lighting (darkness), and music. We only briefly see intensity of that kind in the study group sessions: At one point the staff discuss in an opening round the darkness of the room and compare it with an external therapeutic house, where there is a very nice and welcoming atmosphere with lit candles and a cosy light, as they say. Using the movie techniques does not cut connections to any group of actors, but rather, on the contrary, they align with a reference to specific kinds of emotions among the audience: sense of danger, insecurity, fear etc. This is an intensity that can be defined as a heterogenic performance that produces certain types of emotions and exclude others.

Secondly, another type of intensity is intensity within the outreach team’s study group as something produced as an effect of the “apparent, albeit imperfect” exclusion of technologies from the medical world view\(^{85}\). This type of intensity is produced by an exclusion process of hierarchies, medical questionnaires, diagnostics, agendas, patient list and patient records. But these medical technologies are part of the team’s working practices and therefore very present in most of their working day. The fact that these medical technologies were, figuratively speaking, just outside the door of the study group room, make the effort to keep them outside even more difficult and, therefore,

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\(^{85}\) The discussion of different types of intensities has been developed through discussions with Estrid Sørensen in supervision and with Signe Vikkelø at a seminar on materialities and education (26th of March 2009, Danish University of Education).
intense. This type of intensity can be defined as a heterogenic performance that needs to assemble a lot of allies in order to maintain its shape as pure. The reason for this is because actors potentially challenge its shape. Figuratively speaking, it means that when a specific practice or social technology is threatened to be taken over by another programme or social technology it is put on alert. Intensity is, then, all the work and effort mobilised to keep the competing social technology or programme outside the door.

The intensity produced in this text is different from the example given of the intensity produced in movies that wants us to feel certain things through the use of the dim light or the facial close-ups of a person being scared or slow or fast music etc. The effect of the circle of chairs is the production of specific emotions, so qualitatively in effect it is like the movies (meaning that intensity in general produces specific emotions). But the difference lies somewhere else. It lies in the means. The spatial setup is not intentionally producing specific kinds of emotions. Emotions are produced but they are not controlled by the technology or the circle of chairs. We cannot know what kinds of emotions are produced in the circle of chairs, as we can know that fear is produced with the close-ups in the movie of faces that are scared. Here, the intense effect of the spatial setup through a circle of chairs does not predetermine which emotions are to be produced.

The circle of chairs is thus a type of ‘counter-technology’. It is a spatial set up with the purpose of excluding the technologies that may be comparable to the ones used in the movies. Its purpose is to avoid any predefined methods of measurements or judgement. It is stripped of the kind of technologies that are narrowing down knowledge claims. In line with the discussion about keeping medical technologies ‘waiting outside the door’, the circle of chairs, indeed, produces an intensity that has an effect of cutting connections to certain types of actors, but not only those outside the room, or its external shape so to speak. One can say that it is the product of both cutting connections to medical world references and producing a present within the room, but it is also an effect of the specific alignments between the different actors in the room. Thus, in this case it is an intensity that is an effect of a purification process, where the core argument is to configure the efforts of the team without techniques, although through a spatial setup that is making equality and ‘soul’ available in its internal ordering. This type of intensity can be defined as a heterogenic performance that needs to assemble a lot of allies in order to maintain its shape as pure and distanced from actors that can disturb this purity, not only in relation to external orderings but also in relation to internal orderings. This means that inside the room things can also disturb the performance of an ideal Open Dialogue. This is why the table is taken away.

Thirdly, despite the fact that the configuration of a practice will always be already
human and already non-human in the sense that one can never separate the one from the other (Latour, 1993/1991), one can talk, however, about how a certain composition foregrounds a certain type of actor to appear as having more importance than other actors. The intensities in the room are results of different socio-material configurations, and in this example a particular intensity develops in the chain of interaction between the humans and the circle of chairs and the nearly naked room. The circle of chairs displaces agency from the chairs to the bodies, and make the bodies work to perform equality through circulating speech and open body language. It is hard work to preserve a purified configuration, not only because there are competing technologies but also because this performance accentuated the human interaction and this is only supported by, and not distributed to other things and technologies. This is how I interpret the third reason for intensity in the room. The configuration is accentuating one type of actor, namely the human bodies, but in a configuration that is solely defined by what is present in the room without reference to decisions before or after, without reference to hierarchical positions, without reference to patient lists and so forth.

**Conclusion of the performance of the purified circle of chairs**

This analysis has pointed to how the efforts of the team, through the spatial setup exemplified through the circle of chairs, are not only a matter of a shared human experience. I have shown how the innovative efforts of the team can be seen as a mutable immobility that has *intensity* as effect. In that sense, the circle of chairs makes available what I have argued to be a *shared heterogenic purification attempt*.

What is excluded in this spatial set up is the governing technologies that narrow down knowledge claims, such as diagnostics, hierarchical positions and standardizations. These technologies frame what can be controlled and what is not, of who has the right to decide and who has not. They produce predictability and security and thereby, as argued elsewhere, the reduction of risk. On the contrary, in the purified circle of chairs equality is making available any input from the team members. Their input in this spatial setup is not foreseeable and cannot be controlled. This, in principle, makes it impossible to predict what types of knowledge claims will be produced in the circle of chairs. The circle of chairs does not invite for transportation of knowledge out of the room or for stabilization of those knowledge claims beyond the particular study group session (nothing is written down on paper, no decisions are taken). The knowledge that is produced in this room might, therefore, be immobile, but not necessarily. This type of configuration is creating a type of knowledge that seems mutable in the present space that it is created in, because it is collectively created anew at every session. However it has difficulties travelling across practices. What is created is created here
and now and with the help of the spatial setup is an intensive bodily interaction. But this knowledge is difficult to transport out of the study group sessions, because the staff members can only refer to the present and are not to judge or come with advice of future behaviour or adjustments in the relations with the patients, for example. The knowledge that is created is created in the room and remains in the room as a shared experience. What is transportable is the form of the sessions (spatial setup, the way of settling in, rounds of conversations etc.) not the knowledge that is performed in the sessions.

In terms of innovating mental health care with Open Dialogue this analysis could raise two issues of discussion: 1. A circle of chairs produce specific things. Here it is intended to produce, among other things, a collective decision making process. It is intended to exclude diagnostics and hierarchies. If one wishes to support this kind of approach in mental health care, one might consider how the knowledge that is then produced in this room gets to travel beyond the group of personnel that practice this collective decision making process. 2. Further, one also may want to discuss whether the production of intensity is something particular to the Open Dialogue approach or to other mental health care approaches that are low-technological and, if so, what kind of concerns does it bring to mental health care when through that intensity control and predictability of knowledge claims and emotional make ups disappear?

The Open Dialogue approach has a principle of enduring insecurity and the circle of chairs also seems to support that principle. The next section is about what happens when the purity of the circle of chairs is challenged. It is about what happens when the ideal of the Open Dialogue is interrupted.
Part III - Negotiations

The second analytical part of the thesis I have called ‘negotiations’, and it is composed of four chapters that each show different types of effort that do not have exclusiveness or isolation as effect, but rather, show struggles that have different types of compromises as effect. In these chapters I write about tensions, adding together and fragmentations of the innovative efforts. They are all efforts that explicitly relate to the surrounding practices. The last chapter in this third part of the thesis is on silent work. The chapter is placed here because a negotiation of expectations of the insertion of expert knowledge is taking place. However, these expectations are declined by the silence and as such, in spite of the negotiation, there is no compromise made.
11. Multiple presences

Introduction

In the previous chapter I described an attempt of purification within the study group through the arrangement of entities exemplified by the ‘round’, i.e. a specific order of chairs and seating positions and the absence of table, absence of written down agendas and forms of conversations etc. However, calling it “attempt” has a reason. With an STS-approach health care as configured here, is neither solely materially configured, because things are nothing in themselves even though they are provided agency, nor solely socially configured, because people are nothing in themselves, even though provided agency. In this reading we heard there was, therefore, nothing anti-hierarchical about the circle of chairs as such.

In this chapter, we will continue to investigate the implications of this. The ideal of anti-hierarchy is, therefore, even through the support of the circle of chairs, and the collective decision making process etc. an ideal construction and is hard to maintain assembled in practice. Purifications – like the above description of the circle of chairs - are often challenged and when that happens, hybridization processes occur (Latour, 1993/1991). Hybridization is the complex process of making an object or a practice something it was not originally meant to be. It is the consequence of an object’s entanglement with diverse practices, structures, other objects and so forth.

In this chapter, I will begin to show how Open Dialogue becomes hybridized as it becomes mixed with hierarchical stereotypic governmental technologies and embedded in the specific study group encountered. We will see how as a result it becomes fluid who has the right to define the agenda, who has the right to participate as a manager, and who has the right to give advice to fellow colleagues. In other words the outcome of this heterogeneous chain of connections creates hybridity where variability in participation possibilities is performed. In this analysis the focus is on how the mixing of the efforts of the team in existing organisational procedures is taken further.

It is very difficult to isolate any object or matter. This is the reason to why an attempt of purification and stabilization is hard to maintain. The moment a practice or an object is involved or handled in the world other objects, practices, times and places connect to it, challenge it and negotiate with it. Both Callon and Latour (1981) and Strathern (1991) have developed notions to explain how objects and scales are something that are difficult to stabilize and define a priori. They suggest that stabilizing is difficult to keep in place because these always ‘leak’ (Callon & Latour, 1981) or are ‘fractal’ (Strathern, 1991). Of course these two terms are not identical, but the point is here to show how,
when something leaks, it means that seemingly stabilized objects and practices always connect to time and places somewhere else. The following analysis is about how something is difficult to keep stable as a singular thing. The circle of chairs, thus, is not just performing intensity or human collectivity. This purified performance is challenged when the circle of chairs also connects to other things.

The empirical case I would like to draw upon is an incident where a ‘round’ has been suggested. Again, everybody is invited in turn to associate on what has been said. A ‘round’ in this context means that participants in the circle are not to come with judgements or opinions on what should be decided on a given topic. This is important to notice since this seemingly easy task is still open to a variety of participation possibilities.

**Disrupting the ‘round’**

The following fragments are taken from the second half of the study group session after a break. The entire team is present in the room. When settling in after the break, the psychologist starts the video-recording again and the psychiatric worker makes a little joke saying: “part two”, as if they were acting in a movie. The psychiatric worker continues talking. The psychiatric worker has, previous to the excerpt below, proposed that he presents the team’s work with the Open Dialogue approach at the school of social and health care workers, where the team is recruiting interns. His argument for doing this is to make the students more aware of what kind of work they would be undertaking when joining the team as interns. He says that he is nervous about presenting their Open Dialogue methods in front of students:

The team leader addresses the psychiatric worker’s nervousness: “Think about that you have participated in this study group for a year now and come to think about the word ‘interviewer’. That is also an expression of movement [from your approach to things before to your approach to things now]. I doubt that you will be asked questions (at the school ed.) that you cannot answer.”(study group video, 12. Dec. 2005)

Then there is a shift in the form of the conversation in the study group. The psychologist raises attention to the remaining time. There is fifteen minutes left. He suggests a final ‘round’. The round starts with the social worker. The social worker talks and ‘settles in’: **“it is Monday morning. That is not my strong side”**. The social worker continues talking about something (not concretely identified) that inspired her and made her think. She then asks which way the round is going and looks at the psychiatric worker sitting next to her. He refrains from talking, because as he says: **“I have already spoken”**. The person sitting next to the psychiatric worker is the visiting nurse. She also reflects on her own way of participating in the group: **“I don’t know**
what I have got out of it (the first part of the session ed.), because I know with myself that I reflect quite a lot. I might also be to blame for the conversation being rather fluttering.”

Importantly for my analysis, neither the social worker nor the nurse addresses the specific nervousness expressed previously by the psychiatric worker. In alignment with the flattening of hierarchy in the Open Dialogue approach, they associate their input to their personal state of mind and to how they have experienced the session. The following segment illustrates how the consultant psychiatrist and the team leader respond to the nervousness of the psychiatric worker.

The consultant psychiatrist comments: “the more one is familiar with it, the less one can keep it out [from ones habits and way of thinking]. There will be a time where you cannot refrain yourself from telling about it (your experiences with Open Dialogue treatment ed.).”

The psychiatric worker responds: “I know the school has something about us in writing (written information about the services of the team, a so-called service declaration ed.), but that is not the same as being given the opportunity to explain who we are.”

The team leader comments: “Well, I feel like taking up the thread, where you told about going to the school for social and health care workers [are to present our work].”

Then she draws in a reference to a book she has read and that she experienced as very difficult to understand.

She says: “when it came out, nobody understood it!”

She continues and explains that she read the book again at the weekend, and this time she got the feeling that she finally understood its meaning.

She continues: “I felt I didn’t have to look up every second word in the dictionary.”

This reading experience she compares with the learning process about introducing Open Dialogue treatment in the team.

She explains: “exactly this process...one can be alienated and then on a certain moment, where one has worked on it for a while one can get lights dawnd on you. We are at different stages in the process. I don’t think there is a right or a wrong way to do Open Dialogue” (study group, 12. Dec. 06).
The team leader\textsuperscript{86} takes up a specific thread in what has been previously said during the previous conversation. She chooses to address the nervousness of the psychiatric worker, and, importantly, subtly breaks with the material and conversational forms that are to secure the ideal performance of Open Dialogue, namely the ideal of the absence of judgments and advice that reproduce hierarchical positions. The team leader comments and judges (which is calling upon her capacity and duty as a leader), rather than aligning with the ‘rules’ of the round by associating (which is making the role of collective participation available). The team leader takes up a manifest absent (Law & Mol, 2003) thread by enrolling her position as a manager. She does that not only by addressing the psychiatric worker’s nervousness specifically, but also by referring to her own process of learning. She allies his individual problem with her experiences and, as such, makes this problem a collective problem, which can be taken care of in the group. She creates a point of identification to the group. She displaces the form of the round in the way she navigates between taking a voice as participant member and as manager. On the one hand, the ‘round’ gives her legitimate time to speak both as a manager and as a learning participant. At the same time she transgresses the regional borders (Law & Singleton, 2005; Mol & Law, 1994) of how Open Dialogue is configured through the round. The regional borders are here what can be explained as the attempt to purify and stabilise how the efforts of the team are to produce a non-hierarchical and collective configuration. The reference to other times and places is possible because the spatial set up and the round in themselves contains the possibility of ‘free association’ in the sense that it invites any participants to associate about anything (also managerial input) from any point in the circle. So there is a paradox in the constellation of the ‘round’, because it both makes all voices available in a non-hierarchical and collective way, and gives free reign to managerial and directory input. The performance of Open Dialogue treatment becomes more hybrid. On the one hand, the effect of the ‘round’ is that it facilitates the flattening of hierarchies. On the other hand, it also allows stereotypical management strategies of judgment and guidance of employees. This is illustrated by the team manager consoling her employee. She is soothing the psychiatric worker by telling him that being nervous is not an individual problem, but a collective feeling hereby understood to be acceptable. Further, she explains that there is no right and wrong in Open Dialogue explaining to the psychiatric worker that he cannot do anything wrong.

How do these comments align with the aim of dissolving expert positions contained in

\textsuperscript{86} The consultant psychiatrist also addresses the nervousness of the psychiatric worker and one could also argue that his input is challenging the purity of Open Dialogue being non-advisory and non-hierarchical. However the point with the team leader is strengthened because she is challenging the purity of the round facilitating collectivity that in the first description supported the dissolution of hierarchy.
the Open Dialogue approach? They are not in themselves wrong, but in the configuration with ideals of Open Dialogue treatment they are in conflict. First, the manager is taking up her expert position as a manager. Second, she is giving answers in order to soothe the psychiatric worker. Her answers are part of a managerial governing strategy for making her employee comfortable with what he has volunteered to do, namely presenting the team’s work to the students.

The analysed sequences show that configuration processes around new pure practices are not only linear courses of events. Neither are they situations that can be stabilized. Thus, the ‘round’ and the circle of chairs both perform variability in practice and makes practise possible. This means that the efforts of the team to innovate their working practices are not always performed, isolated from, or connected to the surroundings (for example managerial responsibilities), but is woven into them. In effect, this configuration is also about creation of fluidity (Law & Singleton, 2005) like the example of universal dialogue was (p. 145ff). Similarly, fluidity is a process where one can talk about the stabilized borders defining an object or a practice as porous and leaking because boundaries between inside references to Open Dialogue treatment ideals about collectivity and non-hierarchy and outside references to managerial responsibilities are blurred (Elgaard Jensen, 2004; Law & Singleton, 2005; Mol & Law, 1994). These movements are characterized by the fact that socio-material configurations are not always aligned in the same direction to produce stabilized ideals. If that was the case, we could talk about maintenance of a regional ordering with clear borders and where differences within borders are suppressed (Elgaard Jensen, 2004, p. 79) – what I have called a purification attempt. Purification attempts are attempts of making socio-material entities directed towards constructing an Open Dialogue treatment approach that is not ‘polluted’. In this context being polluted, then, is when something challenges the ideal of the Open Dialogue approach as they are performed in the practices of the team.

**Conclusion – Inserting managerial responsibilities**

When the round and the circle of chairs are also making available managerial responsibilities, it is disrupting the intensities of the round described in the previous chapter. It disrupts the kind of intensity that is produced by an effort of keeping out competing technologies and that type of intensity that foregrounds certain types of actors. The intensity is dissolved because non-hierarchical ideals are mixed with hierarchical technologies. This performance has effects on the professional participation possibilities and the purified ideal of a configuration that is stripped of technologies that perform singularity and hierarchy, is destabilized. The performative effects that are crafted in this setup suggest the creation of participation possibilities
that both fit with the ideal, and at the same time, include professionalism from outside the study group room, namely management responsibilities. This is possible because both human collectivity and management responsibility are made available in the conversational form of the round.

However, the empirical material also seems to indicate here that the ambition to innovate a mental health care with no hierarchies and no governmental technologies is very difficult to achieve in practice. The spatial setup of chairs in a circle and the conversational principle of ‘rounds’ may structure and stabilize relationships in certain directions thereby creating the effect of a space to perform Open Dialogue without hierarchies. But it is not possible to maintain a rigid regional regime of ordering where borders between inside practice and outside practice are preserved, because technologies from the daily practices of the team intervene this.

This suggests that even with the ambitions of producing a space and a new working practice where hierarchical positions are put on hold, and collectivity is the supported way in decision makings, it is important to create new technologies of governance. This is not necessarily to discipline individual behavioural strategies, but to control and keep out competing technologies of governance that challenge the internal fluidity and collectivity.

So far, in the analysis of reconstructing how the hierarchical positions are reinserted in the performance of Open Dialogue treatment, I highlighted the processual quality of the spatial set-up. I have shown that effects of spatial setups can change according to associations that are invested or taken up. Moreover, I showed that new patterns of governance must be developed when successfully working with a performance of Open Dialogue that excludes hierarchical positions.

This vagueness has as a consequence that spatial setups and conversational forms, at one and the same time, make available both the flattening of hierarchies and the reproduction of hierarchies. However, this does not necessarily have to be a contradiction. As we shall see in the in the next chapter a team member succeeds in mastering both a purified ideal of Open Dialogue by associating in the ‘right way’ in the study group setting but, at the same time, acknowledges stereotypical hierarchical positions. As such the next chapter is an example of how ideals from different practices can be added together without producing tension.
12. Adding together the psychiatric doctrine and humaneness

So far, in the analysis of reconstructing how the hierarchical positions are reinserted in the performance of Open Dialogue treatment practices, I have highlighted how socio-material setups are performative. I have shown that socio-material setups can change according to the associations that are taken up by participants. Moreover, I also showed that new patterns of governance must be developed when successfully working with Open Dialogue since who has the ability to define the agenda, who has the ability to participate as a manager, and who has the ability to give advice to fellow colleagues becomes harder to define in spaces where governmental technologies and agendas are left outside the room. As we have seen, this vagueness means that physical setups and conversational forms make possible both the flattening and the reproduction of hierarchies. However, as this chapter will show, this does not necessarily have to be a contradiction.

This analysis is of a very subtle, but sophisticated handling of the negotiation of a professional identity in the performance of new practices. On the one hand, we will see an example of how one can participate when aligning with the socio-material setup of Open Dialogue. At the same time, we will see that stereotypical trails of hierarchical behaviour are present and acknowledged, but then gently renegotiated. The chapter offers an analysis of a configuration that is not antagonistic and tensional. It is not about clashes or divisions between ideals. Rather it is configured through a mixture of humaneness and psychiatric doctrine co-existing and added together. This configuration is made possible by borrowing from the credibility of the medical world view.

Open Dialogue borrowing from the medical world view

I will discuss here how the concern of innovating mental health care practices is not only about the performance of antagonistic relations and exclusion processes to everything that already exists, but it is also about mobilising positive relations. In that sense this analysis draws parallels to the analysis on universality (chapter 8). In that chapter the adaptability of the innovation was created by making it commonly owned. However, what was also raised as a question was that this universality also created a risk of the innovative initiative disappearing because it could, potentially, loose its uniqueness and therefore become difficult to see as something different from, or contributing in special valuable ways to existing practices. In this chapter, it seems that
the uniqueness of the innovative efforts is maintained. Open Dialogue does seem to be different, and is an innovation, a new way of performing. At the same time the medical world view is acknowledged as important. The description is based upon an interview with the social and healthcare worker. In the excerpt below she says that from her own experiences and in the way that she perceives herself as a psychiatric professional it is possible to connect both the psychiatric doctrine and the ways of thinking that are compatible with Open Dialogue principles.

When I ask the personnel to describe the important differences in Open Dialogue approach compared to their previous working practices, it is a frequent response that being human has priority over being an expert in psychiatric doctrine and diagnostic knowledge (most staff have explicitly spoken about that in the interviews). In the extract below I ask how this is possible knowing that the psychiatric doctrine can be oppositional and controversial to Open Dialogue ideals. Becoming a professional is spoken of as an oscillation between the humanity of Open Dialogue and psychiatric technical knowledge.

“I think, that there is great professionalism connected to it, because one is still to reflect from one’s professionalism and one’s humanity, being a human. I don’t think that just anybody could come in from the street and do Open Dialogue, because the only criteria would be to be human. I am still of the opinion that professionalism...the actual doctrine of psychiatry - the typical illnesses - one needs to have. One needs to know about psychiatric nursing in one or the other way, because it is part of a greater whole... Well, Open Dialogue is a layer on top...a part of the context. But at the same time it's also a world view, a fundamental outlook, an approach to other people…”

(Interview with social and health care worker, July 2006)

This excerpt is about the doctrine of psychiatry, and the medical world view that the doctrine of psychiatry is based upon. The medical world view connects and aligns with standardised forms, diagnostics, clinical evidence and, as we shall see later, patient recruitment procedures (in chapter 13). This excerpt resonates with the other analyses in the thesis, for example when talking about diagnostics and medical world view in chapter 7 or about clinical evidence and universal values in chapter 8. What does this frequency show? It shows that the medical world view is present in various ways in the team. It also shows that the team is preoccupied with how to position itself and its innovative efforts in relation precisely to the medical world view. And of course it shows an understanding that making something new and innovative must be based on differentiating from something old.

But lastly, we will see, it also shows that the process of innovation that is done in relation to something else is done in multiple ways. For example, we saw previously in
the analysis of the alternative configuration that clinical evidence was Othered from the performance of the efforts of the team. The exclusion of clinical evidence in that configuration helped to perform the efforts of the team as an alternative to existing practices and to clinical evidence. We have also seen in the analysis where the head manager of the psychiatric services in the county was interviewed, that the performance of clinical evidence was reversed. Clinical evidence was performed as the particularity that was necessary for a treatment approach to be able to innovate mental health care. In the extract above something rather different is performed. The psychiatric doctrine is not necessary in order to innovate. However, it cannot be discarded, because “one needs to know about the typical illnesses”. Therefore the psychiatric doctrine and diagnostic knowledge are necessary in a different sense.

This seems to be central to the specific ways that Open Dialogue is getting configured in the outreach team. Humaneness (provided by the Open Dialogue approach in this excerpt) and the doctrine of psychiatry are connected to perform psychiatric professionalism in practice for the practitioners. In spite of the fact that Open Dialogue is performed as universally human, professional identity and ways to provide good care happen through reference to the ‘doctrine of psychiatry’. This oscillation between universal humanity and psychiatric professionalism that refers to a medical world view make it possible for the Open Dialogue approach and Open Dialogue practitioners to borrow from the legitimatizing diagnostic system and from its qualification of truth. It seems to be the case that the team aligns with the diagnostic system not only because of practicalities (as in the example of the organisation of network meetings that we shall examine in the next chapter) but also because the medical world view has credibility through the building up of alliances to different interest parties, (in a similar way to Pasteur (Latour, 1993/1984). This does not mean that it cannot be contradicted or that it is not vulnerable since all connections can be questioned and mobilized in different ways (Callon, 1986). The medical world view might appear as stable and unquestionable, because it has collected many allies. But if I refer back to Singleton and Stars’ contributions in the introduction about incoherent and silent work, I think I would like to raise an additional point here. Innovation is not only about strong actors making themselves visible, which was Singleton’s (2005) and Stars’ (1991) contribution. But neither is it, necessarily, about tension or the manifestation of contradictions. This means that one can imagine strong invisible and silent actors that perform important innovative practices as well in ways that do not necessarily manifest conflict. In fact the daily working practices are often invisible to, for example, management or the political level unless they are carefully investigated and inscribed in different kinds of monitoring technologies that make those activities visible. And these activities are not necessarily in opposition to the monitoring technologies. But, for example, the small gestures, acknowledgements and assurances are necessary in the contact with the patients. These actors are strong, because they are the ones that make
a difference to whether the contact can be established in the first place. However these actors are not necessarily traceable. As we will see in the last analytical chapter of the thesis silence also is an important actor to understand how the outreach team’s practices can be different. Silence is a strong actor because it is through silence that the ways professionals are together and the ways they take decisions in mental health care potentially are changed. Silence is invisible work. It is not traceable but in spite of this it is very important. But let us return to the point about the possibility of innovations that are not necessarily contradictory. The next section will explore that argument further.

**Do innovations necessitate contradictions?**

Let us return to the interview extract, this time following in more detail how the relationship between universal *humanity* and professional psychiatric knowledge is performed. Do psychiatric doctrine and knowledge about illnesses necessarily contradict humaneness in Open Dialogue? It does in some configurations. But not here. The efforts to innovate here is not a matter of excluding the medical world view. It is a “layer on top”. In analytical terms this can be said to be an example of making present and connecting things that, in principle, do not belong to Open Dialogue. The staff member talking in the excerpt is enrolling the ‘doctrine of psychiatry’ into her view on how to become an appropriate professional. However, in this example the psychiatric teachings (and the medical world view) are not made invalid. On the contrary, it is acknowledged as an important ordering (and necessary) principle and the social and health care worker suggests an important mixture of different approaches is needed to make good care available. In this respect what has become valid and true for the medical doctrine becomes adaptable to Open Dialogue.

With reference to Mol (2002) there are performances that are *mutually exclusive* in space, time or both of these. For example, in the first analysis on the alternative configuration the uniqueness of Open Dialogue depended upon the non-adaptability and the exclusion of the medical world view. There are also performances where incompatibilities are simply *kept apart*. This is where different versions of the working practices of the outreach team simply do not go together nor do they overlap. We have already seen that with the closed configuration of present time in the study group sessions. But there are also performances where differences are effaced by being *added together*. In some senses the psychiatric doctrine and humaneness are added together to provide good treatment and professionalism. Reading Law (2004, p.75) I would ask what counts as an improvement in treatment when humaneness and the psychiatric doctrine are added together? According to the psychiatric doctrine an improvement could be that patients are without symptoms such as hallucinations, which then counts
as one reality. Performing humaneness as an improvement in treatment might be that a dialogue between the patient and the professional has been established. This is also a construction of reality. But these two added together could that then be that both diagnostic symptoms have gone and dialogue established? Potentially the social and health care worker adds together humanity and knowledge about the psychiatric illnesses into a third reality, one that provides a platform of diagnostics and dialogue.

**Extension rather than cutting connections**

Psychiatric professionalism, that to a great extent is still founded on the principles taught in the medical world view, seems to have been part of the hinterland (Law, 2004) of the personnel for so long and with extensive alliances and socio-material connections that its foundation has become black boxed, and in this way, is a means of legitimizing and reality-providing for what can, and should, be defined as good treatment practice. The term hinterland relates to the question that there is always an external reality that precedes our reports. To this question Law (2004) responds that it depends:

"Reality and the statements that correspond to it are produced together in the disciplinary and laboratory apparatuses of inscription. But in specific circumstances (and we are all, and all the time, in specific circumstances), there is always also a large hinterland of inscription devices and practices already in production. This means that an equally large hinterland of statements, and realities that relate to those statements, are already being made. There is a backdrop of realities that cannot be wished away." (Law, 2004, p. 31).

In the interview excerpt we only get to hear about a small fragment of that reality that is composed. But there are connections that have the ability to travel far beyond that little tiny fragment. Some performances do not travel far, as Law (2004) says, and depends upon the ability to connect to actors outside the room or outside the expressed phrase. For example, in chapter 9 where past and present are excluded when staff members settle into the study group session only the present is performed, and a temporality that is only performed in the present has difficulties in travelling because it does not connect to references or materialities that would make it able to get transported out of the room. In contrast, the social and health care worker draws on a doctrine that has far reaching alliances and connections, far beyond the present and this interview

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87 The expansion and status of the diagnostic system for defining all treatment and inclusion or exclusion of patients in the psychiatric system can, in theory be described as a black box. But with inspiration from (Dodier, 1998) also the diagnostic system can be unstable and is possible to fragment.
What happens here in this excerpt is a reference that draws on an extensive knowledge about a presumption of what the psychiatric doctrine produces, here and elsewhere. The staff member says: “the actual doctrine of psychiatry - the typical illnesses - one needs to have. One needs to know about psychiatric nursing in one or the other way, because it is part of a greater whole...” The psychiatric nursing and doctrine are giving the staff member a point of reference. It is something that appears as stable and standardized. In this excerpt it is important to have this point of reference to a “greater whole” rather than linking with the exclusivity and uniqueness of the Open Dialogue approach (also see chapter 7). Performing the efforts of the team as a mixture between psychiatric teachings as a “greater whole” and ideal humanistic principles of Open Dialogue in this way takes away some of the uniqueness of Open Dialogue. This performance makes the becoming of a psychiatric professional rely upon multiple configurations, just as we saw in the spatial setup where collectivity and non-hierarchy were challenged. The frame of reference is still the psychiatric illnesses which are commonly understood and defined within the existing psychiatry.

In the excerpt the staff member defines Open Dialogue as a “layer on top”. It is rather unclear what is to be understood by this term. A layer on top could be about having working practices that are instrumental, objectifying and diagnostic, and adding the principles of Open Dialogue about equality and humaneness to this. However it is not clear how this is actually performed in their daily working practices. In theory this layer on top creates a platform where it is still possible for the personnel to refer to diagnostic criteria, and, thus, to connect to practices outside the team.

When the staff members keep a connection with diagnostics and a psychiatric doctrine it gives them confidence and security and an easy way to handle a foundation of identification. However, this foundation of identification mostly functions as a foundation of orientation (i.e. Søndergaard’s argument on the strategies of positioning of young academics in academia (2000/1996). Points of identification that function as a foundation of orientation, pragmatically means that diagnostics as a “layer on top” works as an important tool to know about how the psychiatric system works and what the requirements are to be recognized in that system. However, the reason why it may be formulated as a “layer on top” is exactly due to the fact that it is not necessarily something that the social- and health care worker identifies with, but it is an acknowledgement of the fact that this is the foundation of the system. When the psychiatric doctrine is formulated as a “layer on top” it suggests that the Open Dialogue approach and existing psychiatry are performed as having different paradigmatic origins, but that these are not necessarily in conflict but can work as tools of orientation.
When Open Dialogue is performed through oscillations between the existing psychiatric doctrine and with humanity, the question of how to orient oneself as professional arises. It is possible to function as a psychiatric professional and also as an Open Dialogue professional. It is possible to speak of the personnel stepping in and out of psychiatric diagnostic categories and humaneness with the effect that, in this example, the personnel succeed in uniting Open Dialogue and a medical world view, and that the capacity to do so is a prerequisite for Open Dialogue and a necessity for the team personnel’s own survival in the psychiatric system.

**Conclusion – Collectivity and hierarchical trails united without tension**

It has been described in this analysis that renegotiation of practices can be an inclusive process where both purified elements of Open Dialogue and challenging elements can be connected. This time it seems that the purified ideal of Open Dialogue and stereotypical hierarchical trails are connected in a non-conflicted way. It shows that innovating an alternative treatment approach is not only a matter of establishing an idealized version of care that is excluded from the existing practices. Rather, in this analysis, performing an alternative is a non-conflicted mixture that succeeds in challenging the powerful centre of the execution of care.

The analysis indicates that introducing the Open Dialogue approach may be a reinforcing motivational factor and that it allows the possibility of renegotiating professional identities for the personnel. On the one hand, we have seen before that particular spatial and temporal configurations perform a possibility of collective participation. This means that professionals are involving each other in exploring treatment solutions in ways they would ideally do in the network meetings where patients and their relatives are also participating. A central argument is that the individual ethical project of the introduction of a new treatment approach is connected to the psychiatric teachings and doctrine in a non-conflicted manner. As with the analysis on multiple presences, to become a psychiatric professional, therefore, means to have the ability to navigate between principles of cure (expert positions, diagnostic principles, a medical world view etc) and the principle of care (working in the present instant, subjectifying the patient) where individual existential ethical considerations are necessary to encounter. However, the difference here is that the meeting between innovative efforts of the team are not performed in a conflicted way. Rather, they are performed as being necessary to each other.
The next analysis is describing another situation of how existing practices are performed in relation to the innovative efforts of the team. But here it is not Open Dialogue that is fragmented but the existing practices.
13. **Fragmenting diagnostic recruitment procedures**

**Introduction**

The previous analysis presented a description of how innovative efforts are not always about tensions that clash between existing and new practices, but they can also be about how things are added together by the members of staff. In this chapter how a tension is handled through *fragmentation* will be explored. The empirical data drawn upon here is an interview with the leader of the team. The theme of the conversation is the standardized recruitment procedures that affiliate patients to the team and whether or not these recruitment procedures align with the team’s efforts to innovate their working practices. The analysis is about how the recruitment procedure is an obligatory point of passage to get patients affiliated to the team and how this, from the researcher’s perspective, initially posed a problem to organise network meetings in an Open Dialogue way. The researcher’s surprise at the reaction to a question that she construed as a potential tension is taken as a point of departure for the analysis.

**The researcher is connecting continuity and continuity**

In this paragraph I describe my motivation and argument about why I have formulated a question in the interviews with the members of staff in the team about recruitment procedures and its link to establishing Open Dialogue network meetings. I saw this as a potential contradiction.

As has been discussed when introducing the case study in chapter 4, the case manager function established in the psychiatric organisation in 2000, on the one hand, and the constitution of the professional team holding the network meetings in the Open Dialogue approach on the other, have in both cases *continuity* as an important value. When doing Open Dialogue, network meetings are held by the same team of staff and, in principle, this is the primary contact with the patient (Seikkula, 2002/2000; Seikkula & al., 1995; Seikkula, et al., 2000). The principle basis for conducting the network meetings is also, but not only, continuity. In spite the fact that both the case manager function and the principle of continuity that is established through having the same staff responsible for conducting the network meetings in Open Dialogue treatment, continuity is not performed in the same way in the two approaches. The similarities between the case manager and the network meetings in Open Dialogue are to do with the establishment of trust and confidence.
Looking at the difference in the two ways of organising psychiatric healthcare on a theoretical level, the existing psychiatric organisation can be said to be primarily *logistical* with the aim of providing continuity and trust, while for the network meetings in the Open Dialogue treatment approach *security and trust* are at its very foundation. In spite of similar ambitions in providing trust and confidence to the patients, practices around network meetings are potentially controversial because the means to acquire trust and confidence has different points of departure. The case manager function still aligns with, and refers to, the expert position, the diagnostic system and the psychiatric organisation’s governmental technologies, while the network meetings fundamentally link the creation of trust and confidence to human equality whilst backgrounds the diagnostic system and the expert position. My initial curiosity was triggered by this potential conflict inherent in the different performances of the principle of continuity. This is what is explored in the first extract of the interview with the team manager below.

**The researcher asks an odd question**

As network meetings are a central way to perform the continuity described above and are central to the systemic inspired elements of the Open Dialogue approach, I was curious to understand how these meetings proceed and asked the team personnel on different occasions how they organize them. The dialogue below is from an interview with the team leader where she tries to answer the question. I start by asking how the concrete practice around inviting relatives to network meetings is done, assuming that the team has some kind of procedure.

The team leader laughs and answers: “But that is just straightforward, as one just does.” (Interview with team leader 30.Aug. 06)

On the one hand, the first reaction where the team leader laughs was surprising. Is that a funny question? In fact I found the question rather logistically and practically oriented. This surprise suggested some kind of non-alignment between what I asked about and what the team leader could come up with as a response. It is carrying a meeting point between something that seems to be very straightforward (how do you organise a network meeting). And something that helps perform the laughter.

The performance of laughter has been described elsewhere (Mik-Meyer, 2004; Ås, 1987) as a demonstration of power and hierarchy. But another study made by Verran (1999) suggests laughter may be understood as a way to connect different knowledges.
Verran (1999) gives an account of her teaching in Nigeria in the early 1980s where certain incidents, especially in classes of science and mathematics, made her laugh. She describes that she experienced “puzzling, small moments” in the contemporary life in the Nigerian classrooms. Initially she would ridicule these moments with knowledge that she already had acquired (in the West):

“Conventional wisdom would pass these [puzzling, small moments] by as irrational glitches, yet because they challenged my assumptions about numbers, they shook me. [...] These moments of disconcertment sometimes spontaneously expressed themselves in an up-welling laughter. In responding to the stories I argue that keeping the disconcertment is important, it alerts us that here is an occasion for telling stories which might generate new possibilities for answering moral questions of how to live.” (Verran, 1999)

I would like to elaborate a little on the situation in which Verran had these experiences. In the classrooms she witnesses a local Yoruba teacher teaching about length. The local teacher lets the children measure an object with a string. When they have measured the object in order for them to find out its length, they are to wind the string around a 10 cm card and count how many times the string is wound around it. The children are taught that by multiplying the number of winds by ten, they would get the length of the object in centimetres. Verran (1999) found this way of teaching length was one of these puzzling, small moments that made her laugh, because it does not resemble how the teaching of length is taught in the West. Teaching length in the West includes extension and this cannot be left out of the English concept of length. When winding a string around an object to measure length, extension is rendered incidental (p.139). Now the story does not end here. Verran’s task is to show both how this could be a story of not having taught Nigerians the ‘proper’ way of quantifying. Or it could be another story about how the Nigerian teachers resisted Western multiplication knowledge and taught their own version to their students. But both stories, Verran notes, imply a singular order: either the order of one proper knowledge or the order of one supreme power. These two stories explain away Verran’s laughter and, thereby, why she felt disconcerted by the confrontation of the English and the Yoruba ways of multiplying (Sørensen, 2005, p. 181).

However, this insight makes her want to include knowledge about such experiences from elsewhere as she does not find that singular orders provide her with an understanding of what took place in the Nigerian classrooms. In line with another example from the performance of the cervical programme among medical practitioners in the UK (Singleton & Michael, 1993) that I presented in the introduction of the thesis, Verran also wishes to reject “deleting and hiding the messiness and lack of smooth fit between the ‘ideal’ and the actual [way of] of quantifying” (p.149). She wants to allow incoherence and multiplicity in the practice that she observes. The point about staying true to laughter is, thus, about keeping open and sensitive towards how actors are
telling us that there things that one, as a researcher, has not accounted for (in Verran’s case multiple ways of quantifying). My aspiration, taken from Verran, is about remaining sensitive to laughter to let myself get surprised by the field. It makes explicit that things are not to be taken for granted, and that it is not possible to predict local performances of the researcher’s initial assumptions.

In the situation above where the team leader laughs and says that organising network meetings is “just straight forward”, she is the one who is surprised by the way I, as a researcher, have connected assumptions of how practices connect in relation to the team’s efforts to innovate their daily practices. The fact that it is the team leader who laughs at my question is not what is important. The point of importance is that laughter occurs, and draws my attention to the clash between my assumptions and the team’s efforts to innovate their working practices. This is what the laughter is an expression of.

What, then, is the clash of knowledges between my assumptions on patient recruitment procedures and the efforts of the team about? There is an extension of my description of what made the team leader laugh that I would like to develop further. The laughter is not only a clash between knowledges as I suggested above, but it is also a lack of knowledge that is funny because it is evident that I should already know about how the network meetings are set up. Recruitment procedures for making network meetings should be evident, it is “just straight forward”. The response from the team leader to my question is, thus, also about performing the organisation of network meetings as common knowledge. If this is a correct observation then the procedure of organising network meetings has become a taken-for-granted practice. The content of the response could then be explained by the fact that I question this commonality, in other words in the interview I attempted to open a black-box.

If the organisation of network meetings has become a black box, the team personnel no longer reflect upon how to invite relatives to a network meeting. They just do it. But in fact that is not the case. It is not as straight forward as initially suggested; the organisation of network meetings is not taken for granted by the team. It happens to be the case that neither standardization nor internalization of the organisation of network meetings is established. This is known because several members of personnel mention, in different settings, that they are nervous at network meetings because it feels new to them, or they are nervous because they have not become accustomed to the role of a professional not being an expert88. So here are important factors in performing the

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88 These concerns are especially expressed by the social and health care worker and the psychiatric worker about
efforts of the team: nervousness and the aspiration to dissolve expert roles. The nervousness and the aspiration to dissolve expert roles make network meetings a new innovative practice when compared to existing practices. They also say that they do not organize network meetings around all patients. So there is other information apparently absent from the above excerpt which implies that network meetings are not yet established as a routine in the daily practice of the team (neither in a concrete manner nor emotionally to the team personnel). But if it is not the apparent obvious everyday practice of the network meeting procedures (the initially thought black box) that triggers the laughter to my question, what is it then?

As the following interview extract will show, the ‘straight forwardness’ of the way to conduct network meetings is not connected to Open Dialogue network meeting principles but to the existing procedures of patient recruitment of the psychiatric organisation in general. When the team leader answers that it is just straight forward (to my answer on how they organise network meetings) I subsequently find out that she is referring to existing patient recruitment procedures of the organisation, and not to the particular network meetings ways of organising. As will be elaborated below, the existing procedures are enrolled to make network meetings possible. The answer to the odd question of the researcher continues:

The team leader continues: “Right, the patients get referred to us either by their medical practitioner or in relation to a hospitalization and then a referral\(^{89}\) is made, and then they come for a pre-examination\(^{90}\) […]”

Interviewer: “Hm. You have a referral letter [from the medical practitioner or from the psychiatrist from the previous hospitalization]…what do you then do?”

Team leader: “I would say that in the referral letter it is always written some kind of…at least a formulation of some kind of problem. Then one can find out from that description what the patient is part of socially (whether there is a social network ed.). And in the establishment [of the initial contact with the patient] we have arranged the pre-conversation or the conversation taking place at the pre-examination meeting at a moment when the relatives had a possibility of participating. So already then it would have been natural…”

89 A referral recommending psychiatric treatment is made solely by a doctor or a psychiatrist.

90 The “pre-examination” is the meeting held to investigate whether the patient is suited for the treatment the team can offer. Usually two members of personnel meet with the patient. Most often the team leader or a psychiatrist and one of their colleagues visit the patient at those meetings. The meeting is then taken up for debate at a following morning conference and here it is decided whether the patient is to be affiliated to the team or whether the patient should be offered an alternative.
Interviewer: “Let’s try turning back time: There may be relatives, maybe not...how do you find out?”

Team leader (short pause to think): “Right, sometimes you have been able to see it. It has been written [in the referral letter or in the electronic patient record], that there have been relatives. And then this has given the opportunity to... I have suggested a conversation in the afternoon and asked the patient to consider whether the relative should participate [...]”

Interviewer: “Do you call the patient and say: “Do you want to invite your sisters and brothers?” Or what do you do?”

Team leader thinking for a while: “Yes but...if the problem is of a kind where this (the fact of including the relatives ed.) was important...even if there were no relatives [mentioned in the patient record], if one could not see it right away, but it has turned out to be that there were relatives, and the relatives have been part of the problem, where we have invited for the possibility of the relatives participating. Yes right, most times of course we have sent out a letter, but I have also taken part in telephone contact -after having received a referral letter - to ask whether a pre-examination meeting could take place at a time that suited the citizen (the patient ed.). So we have done both (sending letters and calling the patient to ask for the possibility of inviting relatives)...”

(Interview with team leader 30.Aug06)

The team leader enrols referral letter, pre-examinations, hospitalization, and the medical practitioner in her response about how relatives are included in the treatment. These entities are important obligatory passage points\(^1\),\(^2\) to receive psychiatric treatment and to be included in the psychiatric organisational setup. For example a referral letter is a central key to being admitted to public psychiatric treatment. A pre-examination is necessary for the psychiatric organisation to place and allocate the patient in the right treatment with the right group of personnel within the system (whether the patient, for example, is hospitalized in a closed or open ward or with the community psychiatric team according to the severity of the illness and diagnosis). This part of sorting out and distributing patients takes place outside the team at the time of the interview and, therefore, in theory it is difficult to adapt to the Open Dialogue approach since it was out of the hands of the team.

The point of the above interview excerpt is that the possible way for the team to conceptualize procedures around recruitment of relatives for Open Dialogue network meetings is done through the psychiatric standardized recruitment procedures. This means that patients appointed to the team carry a patient record with the indication of

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1 See definition of Obligatory passage point note 48.
whether there are relatives to be contacted or not. The patient record also indicates whether the patient has a problem where inclusion of relatives may be relevant. The patient record and the referral and examination procedure connect the psychiatric system and the team through a diagnostic number indicating the diagnosis of the patient. These are manifest absent\(^2\) actors of central importance in this example, because the diagnostic system is necessary for the present situation to unfold. However, the paradox is that in other contexts team members distance themselves from the diagnostic system because it is objectifying and only relating to “symptoms of the ill patient rather than on the person” (interview with psychologist Sept.06, for more of this argument I refer to the analysis of the “alternative dialogue” in chapter 7).

When the team leader is asked about the organisation of network meetings, her answer connects to standardized procedures of the psychiatric organisation where the reception of patients happens through diagnostics. It is a standardized procedure that is performed through the logic of cure, as Mol (2008) puts it, that resonates with the possibility of healing and is applied to interventions in the course of the disease (p.1) and what I elsewhere have termed the performance of singular knowledge claims (p.86 and 129ff). Doing network meetings are not primarily aligning with neither cure in that sense of the term nor the production of singularity in the meetings. Network meetings connect to continuity and the establishment of trust as its prerequisite, and is not standardized. The network meetings have the aspiration to conduct collectivity and not to fix what knowledge is to be produced in those meetings.

The team leader refers to information about the patient gathered through knowledge accessible to her gained through, for example, patient records. These are the existing and functioning procedures. Open Dialogue network meetings are organised around existing procedures. How does the team deal with that?

Something is going on in the relation that the researcher created between the psychiatric recruitment procedures and the recruitment procedures of the network meetings. But apparently not what I presumed. The team leader’s surprising reaction to what I thought might pose a tensional problem makes me search for reasons for this ‘something’. Even though network meetings are still not a routine in the practices of the team, it might not be that which is the problem. And it might not be a clash or tension, as in the Nigerian class room either. But there is something going on, it is something that makes the team able to deal with both the patient recruitment procedure of the

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\(^2\) Manifest absent actors (Law, 2004) are actors that are absent but are necessary references for what is present. (See also the elaboration of this concept footnote 64, and p.135 ff)
daily practices and the ambition of holding network meetings. The “just straight forwardness” in the team leader’s answer illustrates how distant connections, such as the diagnostic and referral procedures, link up with the local efforts of the team. What was described previously as the performance of a ‘closed configuration’ in chapter 9 is here leaking. ‘Leaking’ is Callon and Latour’s (1981) description of how practices can collapse the distinction between micro-macro. It is the term that signifies the fact that configurations can never remain totally closed and autopoietic but will always have connections outside their network. Their contribution tries to move beyond the micro-macro distinction in social theory by viewing the presumed macro-actors as micro-actors situated “on top of many (leaky) black-boxes” (Callon & Latour, 1981, p. 286), containing more or less stabilised associations between human and non-human actors. Surprisingly, it is not the innovative efforts that are leaking here, but the diagnostic system that is not entirely closed in on itself.

Organizing network meetings are dependent upon the diagnostic system that can connect to other places in the organisation and travel in and out of the team. At the same time the diagnostic recruitment procedure is made trivial and seems to be detached from the organisation of network meetings. No tension is created between the patient recruitment procedures and the team’s aspiration of making network meetings that are not based on diagnostic measures. Rather, the team seems to be able to deal with that presumed tension by translating the referral system to being trivial and “just straight forward”, so that it does not pose any substantial problem to the ideal integrity of the network meetings.

To summarize this section, the laughter and the initial response of the team leader put me on the track of four things: Firstly, the clash between the assumptions of the researcher about how the organisation procedures work in the team, secondly, as I initially suggested, the occurrence of the initial response was an expression of a black box, a taken-for-granted organised routine. Thirdly, I had to disregard that suggestion, knowing that network meetings provide nervousness and are not well-established, fourthly, it made me aware of how not only innovative practices but also existing practices are fragmented in the daily work of the team. The place given to the innovative efforts the team, on the other hand, also needs to align with actors that perform singular knowledge claims such as diagnostics and patient recruitment systems. When organising network meetings this is, at the same time, a performance that enrolls objectifying configurations that are fundamentally against the Open

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93 The definition of Luhmann’s autopoietic (self-referring) system is defined on p.151ff.
Dialogue ideals but when keeping the recruitment system as merely logistical, it does not offer any therapeutic value and does not, therefore, conflict with the ideals of the network meetings either.

**Conclusion on fragmenting existing practices**

What has been described here about innovating efforts in the team?

First, the team leader was asked to refer to some kind of standardization, as the questioner asks for it, but, in principle, the Open Dialogue approach does not have this. Though the Open Dialogue approach, ideally, does not refer to standardizations, is it possible to talk about the recruitment of relatives and friends without standardizations? In this case, it is only possible to draw on standardizations as they are made available in the existing patient recruitment procedures. These organisational procedures are made trivial and, as such, fragmented into only serving a logistical purpose in order to be able to connect with the ideal of the Open Dialogue. One could say that the standardization practices established through the letter of referral from the medical practitioner, from the examination meeting, or the information about relatives written in the electronic patient record, are examples of a fragmentation similar to the one described in the analysis of the head manager (chp. 8). Here the Open Dialogue was fragmented into adaptable and non-adaptable elements to the psychiatric organisation. However, I will argue that it is, in fact, not the Open Dialogue approach that is fragmented, but the diagnostic system as a therapeutic tool. When recruiting patients the diagnostic system is not used as a therapeutic tool, which is similar to a point raised by Dodier (1998) on the use of diagnostics among medical practitioners. Using the diagnostic system as a therapeutic tool would be contradictory to the purpose of the network meetings. Rather, the recruitment procedures are reduced to being trivial in their way of being “just straight forward”: An organising or logistic tool and does as such, contrary to my expectation, not pose a problem to the execution of the Open Dialogue network meetings in practice - though only in principle. The recruitment procedures cannot be disregarded. At least on an administrative level, at present, diagnosis cannot be disregarded as it constitutes the key to having contact with patients and, therefore, comprises a core function in the psychiatric system. Since the recruitment procedures cannot be disregarded, the survival of the Open Dialogue requires that it mobilizes actors that make available a possibility of connecting the patient recruitment procedures and the ideals of Open Dialogue. This adds to the previous analysis of how innovating mental health care is a balance between making compromises to existing practices and translating existing practices into something that fits the innovative initiative better. In this context, fragmenting the existing practices to be about logistics only (and not a therapeutic tool) may help the organisation of network meetings in the team.
14. Silent work

Introduction

The importance of silences in innovation processes in mental health care has not been investigated previously. But during my shadowing of the team I identified silences as something that are specific to what the team is trying to change in their current practices. As such silences do a lot of invisible work which is important to how we can understand innovation processes. This chapter will explore how that is done.

This analysis attempts to show how silence becomes a central actor in how to perform a specific configuration that produces human collectivity – in similar ways as the circle of chairs has been shown to do. In order to demonstrate this, a specific analytic approach to study the performance of silence is suggested.

The argument in this chapter is that silence distributes authority, responsibility and decision making. The chapter raises questions about how knowledge claims in the realm of silence are produced as something that is not singular and not fixed. Silences make available a fluid decision making process.

Silence in the performances presented here is partly conveyed by sound and partly by absence of sound. However, that does not entirely capture its particularity. The aim is to show that silence is not only a matter of sound and absence of sound in a linear matter, but involves, like the other configurations, connections to other entities that give it life. Further, silences make a difference as to how we understand the team’s efforts as innovative.

This final analytical chapter has a different weight than the other analytical chapters. The reason for this is exactly due to its subject of investigation; the silences. Silences are not words, and in order to explain and describe a silence it is, ironically, much lengthier to describe it. Consider olfactory senses; it is impossible to describe the nuances of smell without referring to other categories. How does the sea smell? It smells like the sea, yes, but what does that smell of the sea consist of? We have specialists that can fragment this smell into components. The sea smells of a bit of salt, a bit of wind, a bit of dawn, and a bit of moisture and a bit of seaweed. To say then what the sea smells of has just added five more words. And these words are again referring to other categories that will never pinpoint exactly what the smell of the sea smells like. Silences and its characteristics, therefore, necessitate a great deal of words to be described. Furthermore, as mentioned earlier, silences have not been described in research on innovations in mental health, and it is, as such, invisible to the research
community within this field. I have, therefore, drawn upon related fields to support my argument in the chapter.

**The how of silences**

Silences are extensively performed as part of the innovative efforts of the team. During my observations in the field, at first I took notice of instances where the staff would initiate a discussion of a definition or an idea connected to the Open Dialogue approach in both formalized settings (e.g. study group, supervision sessions and interviews with me) and in informal settings (e.g. amongst themselves over lunch, in the car to visit a patient, or in the corridor). In these situations the rhythm of the talk was encompassed by long silences. Silences were frequent and long when the staff members discussed amongst themselves the implications of a specific notion or principle of what they wanted to change in their working practices. Also, in the interviews silences were frequently coupled with circling around the answers to why Open Dialogue is important to mental health care. Thus, I noticed that conversations that concerned Open Dialogue and decision making processes around Open Dialogue treatment took a specific shape. These conversations took shape through the silences.

Therefore the quality of the silences is seen to be important to explore in order to understand the performances of the team, not only the silence itself as an isolated thing, but as a part of a particular configuration. Is silence important merely because there are so many instances of it? The quantity of silences is, indeed, interesting and is also the reason my initial attention was caught by them, but this is not the entire answer.

**What kind of silence?**

Many different silences have been identified in different fields. We might ask if the silences we encounter in relation to the efforts of the outreach team is like the silences of the individual psychotherapeutic silence, where the silence poses a challenge to the individual to search back in her inner thoughts and feelings in order to unravel the faraway hidden sources of traumas (Koester & Frandsen, 1997)? Or is it a silence that resembles the psychotherapeutic silence in groups (Heinskou, 1995; Heinskou & Visholm, 2004), where the silences of the group are a type of self-governing technology that directs the behaviour and participation of the individual in the group? Or is it what could be recognized as a musical silence (Hennion, 1993; Hudkinsons, 2007), where the human-non-human collective makes something collective to occur? Where the focus of the individual is detached in favour of the collective? Or is it more a form of linguistic synchronization (Auer, Couper-Kuhlen, & Müller, 1999)? Lastly, we could ask
if this is more of a spiritual silence (Law, 2004) with metaphysical references, where the collective is not configured between human and non-human only but also with reference to metaphysics, where the abandonment of self is an abandonment to the divine, that in Protestant versions feed back to the individual and a connectedness to God? I think that it would be possible to show that the silences in the outreach team do, in fact, contain elements of all these. Silences indeed perform a wide range of effects. Silences perform uneasiness and silences produce power (Mazzei, 2007). Silences perform taboos (Zerubavel, 2006) and silences perform the nearness to God (Law, 2004). These silences are, of course, not irrelevant. However, what I lack in their approaches is the “how” of the silence. The performative abilities of the silences. The how of silence is what I would like to contribute with in this chapter. Of course the material from the outreach team that I have at hand also includes silences that perform the elements suggested above. However, here the scope of the thesis leads me to ask how the efforts of the team are configured. I have found that the efforts of the team do not encompass uneasiness, power, and nearness to God or taboos, but something rather different. 94 Silences produce intriguing things, therefore, they are qualitatively important. They connect ways of being present with the normativity and politics of knowledge production in this particular health care setting. This qualitative importance will be described through a rather detailed analysis of a sequence in a supervision session. But before I examine this I will present some of the theoretical background to this topic.

**Silences as a configurating actor**

Silences are not extra-ordinary but rather they are very mundane. In ANT mundane things that are made invisible in their ‘taken-for-grantedness’ are crucial to understanding the development of the world (Pols, 2006; Shove et al., 2007). The fact that I have chosen to foreground silences as a particular central actor in the configurations of the innovative efforts of the team is also in line with this.

The analysis of rhythm in general, and silences as a configurating actor in particular, is a fairly unexplored field of research within the analysis of practices in health care. As mentioned I have found no studies on the organising role of silences in innovating processes in health care or mental health care. However, I have found one study on a

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94 Further, when silences were not directly linked to the configuration of Open dialogue, or when the possibilities of explaining the silences were too vague (meaning along a different theoretical line than a symmetrical ANT approach applied here), it was omitted. An example of this kind of silence is the one where it produces tension as two staff members are asked to make a team reflection in a study group session.
related topic, namely time, in health care (Zerubavel, 1979). Within the field of ANT and STS Law and Mol have written about the divinity of silence in a Quaker community (Law & Mol, 1998). Another related topic of which silences are a part is rhythm. Sonic rhythms95 have been researched extensively in linguistics (see Auer et al. 1999 for an overview of rhythm in linguistics), and in music, naturally, (for an overview on particular the importance of silence in musical rhythms see Hudkinsons (2007). Within the field of linguistics conversational analysis focuses on human language and defines rhythm in a broad sense as verbal interaction (Auer et al., 1999). Sonic rhythms within conversational analysis are not necessarily stable: they may emerge or disintegrate. But as Auer et al. (1999, p.13) argue, rhythm and tempo are not only in the linguistic features of syntax and phonology, but include aspects within the broader field of psycholinguistics, discourse analysis and micro-ethnography as well. However rhythm seems, to a large extent, to be a linear and/or language related matter, even in those fields outside linguistic features of the language. As a consequence, when analysing silences from a linguistic point of view the actual socio-material configuration of silence becomes less important than the humans performing the silence. Auer et al (1999, p.14) describe that different things can influence the perception of a rhythm. For example, different cultural backgrounds and different language and text structures all affect the perception of a rhythm.

Overall, it seems that rhythm analysis within linguistics offers the possibility of investigating verbal exchange as either ‘on the beat’ or ‘off the beat’ which determines interactions between people. It builds on a perception of time that is linear, and the participants in the rhythm are predetermined (human) senders and receivers (Auer, et al., 1999, pp. 18-19). Therefore rhythm is a constituent of social meaning and, therefore, of a “normal condition” of interaction (Auer, et al., 1999, p. 21). But even if some approaches in conversational analysis argue that there is something more than what they call the “physical signals” that compose the interpretation of a rhythm, this something more is the interpretation of the “human receptor”. I would like to expand on the scope of the rhythmic perceptual potential. I will propose the lessons learned from linguistic rhythm analysis could be taken to a different field and to different entities. I suggest that we stress that:

The very configuration of rhythm is already socio-material. It is not only a matter of physical signals or solely the human perception of the physical signals, but it is also about the space and material surroundings of these physical signals that make the

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95 The rhythms that are related to silences are the ones that deal with the absence and presence of sound.
rhythm possible. In this sense it is understood as a way of ordering practices (and not only what constitutes human interaction).

When analysing the material of the study group meetings, and interviews and supervisions it appears that long silences are suitable for a linguistic analysis. Silences are difficult to visualize in written texts as they are only visible when mapped as ‘in betweens’ sounds. And this is what a linguistic analysis does: To map out talk and silence in a linear manner. The focus in a linguistic rhythm analysis is to understand the basis of human interaction (Auer, et al., 1999, p. 13). So from the perspective of linguistic rhythm analysis I understand rhythm as a way to coordinate verbal interaction between humans, where the dynamics and interchangeability in the group is explored through a linear timing of sender and receiver. Auer et al. (1999) suggest the need to investigate "actually performed rhythms" (p.13) and not abstract or virtual rhythms (which is formulated as a rather imprecise criticism forwarded by Auer et al. 1999, p.13 to social scientists, especially in the field of anthropology, and researchers who are inspired by post-structuralist readings, because of their lack of concrete applicability). But does performance of silent rhythms only lie in the verbal interaction between humans? Performance of rhythm happens in the verbal interaction, but silent rhythm is configured in a heterogenic manner, through and because of space, time outside the verbal interaction, hierarchical positions, expectations, invitations of rounds, tapping of fingers, pauses taken behind a coffee cup etc. This is not an abstract approach to silent rhythm, in fact on the contrary, it is very concrete, and it does expand its scope to include other things besides the actual verbal interaction as we will see in the following.

Now I return to my argument about why silences are important in the composition of configurations in the outreach team. They simply have qualitative, performative effects. The aim is to describe silence as something that goes beyond the structure of the conversation, something that goes beyond its temporal linearity. This analysis draws on empirical material gathered through a supervision session with an external psychologist. What will be highlighted are the silences that appear to be of great importance in being able to define Open Dialogue as a collective.

The analysis will show how silences compose a human collectivity where knowledge claims are not singular and are not fixed.

Through a description of the first eight minutes of the supervision session of 24 October 2005 I will extract two examples of silences in which I will analyse the following aspects: Firstly, I show that what is happening in these eight minutes is that the silences are creating space for not taking decisions immediately. Secondly, I would like
to show how that is performing human collectivity. Thirdly, I discuss how performing innovative work is not an easy, straightforward process but is detailed and subtle work and fourthly, connected to this, I would like to show how this description forwards examples of what is going against these efforts.

The silence of the passive collectivity

The first extract of the video is taken from the beginning of the supervision session (24th of Oct. 05) that was held in the lunch and conference room of the psychiatric team. The participants are only members of staff from the team and an external supervisor, a psychologist by training, who facilitates the session. The staff members have been presented on page 55ff. The spatial setup is different from that in study group sessions. Here there is a table, calendars, post-it notes etc.

The opening of the session is different from the study group sessions as well:

A clearly marked formal role of expertise is given to the external psychologist who is supervising the session. As usual in these sessions the supervisor opens up the session by asking if there is anything that has to be followed up from last time they had a session (24 Oct. 05). The team’s psychologist starts reporting on a patient whom they spoke about at the last supervision. The rest of the team listens quietly. The mobile phone of the consultant psychiatrist rings. He attends to it; he presses a button to make it stop and does not answer the call. The noise of the phone does not interrupt the speaking of the psychologist. He does not pause and he does not turn his head towards the sound. When the psychologist ends his explanation, the social and health care worker continues and reports on another patient whom they spoke about at the last session. The rest of the team still listens quietly. The supervisor asks a couple of questions to get the social and health care worker to elaborate a little on how the development in that particular relation feels to her. When the social and health care worker finishes talking about the patient who was discussed at the previous session, there is a long silence (9 sec), and the supervisor then asks the group to decide what to talk about in today’s session. (This description is compiled from observation notes from supervision videos).

What happens in this first part of the supervision session is a focus on reporting back to the supervisor on what has happened since the last session. There is a no salient distribution of talk or input among the group of personnel. And when the reporting back is potentially disturbed (by the phone), the mode of conversation continues unchallenged. The flow of talk between, first the psychologist and the supervisor, and then secondly, between the social and health care worker and the supervisor is different to a previous analysis on configuring a practice of closed dialogue through the present (see chapter 9). During these two dialogues in the beginning of the supervision session there are connections made to the temporal past. The supervisor would like to know
how things have been and sets the agenda of the beginning of the session. There is a commonly agreed understanding and acceptance of how the session should be run, both in form and content. This is not discussed, and the purpose of the presence of the supervisor is clear. She is helping the team to discuss their relations with patients along lines that are formulated in the principles of the Open Dialogue approach. However, the supervision, unlike the study group sessions, starts off with a reporting back to the supervisor. Counter to the other configurations presented, expertise is performed in these first minutes of supervision. The supervisor is provided with information, but, surprisingly, not to make a judgement or to take a decision. When this first information is given, neither decisions are made, nor conclusions drawn about what has been reported back. During the reporting back, both reporting staff members have been encouraged to tell more and the supervisor has asked the two staff members to elaborate, especially on their relations to the patient in question.

In this reporting back part of the beginning of the supervision session, there is first a particularly salient and interesting silent effect to bring forward: The silence of the remaining witnessing group whilst the two staff members are speaking. I will call this first silence witnessing silence, that is a silence of making a specific kind of knowledge and participation available.

**The witnessing silence**

The witnessing silence is a silence witnessing a stream of information transferred from team staff to the supervisor. The reporting back happens by directly speaking to one person (the supervisor), the pitch is slightly higher than in the remaining of the supervision sessions, the speed of talking likewise, and there is no hesitation between the words and there is no repetition of words, recurrence or circular argumentation in what is said. This information remains singular, as the information is not transformed or challenged and it is contained and remains with the supervisor. The silent witnessing of this reporting back makes that transference of information possible. It makes the transferring of the information undisturbed, unchallenged. However, this knowledge is indeed shared with the rest of the group. But even if it is shared in the rest of the group, the group is passive and only witnesses this transfer: The silent witnessing of the reporting back is, thus, a silence that supports not a collective but neither a singular type of knowledge. It is not a collective because the information transferred is not challenged or disturbed. It is not singular because no decision or judgment is taken upon the information transferred. The witnessing silence makes available something in between, a sharing without participation. It is a passive collectivity.
The silence of the ontological shift

The next particularly clear and interesting silent effect in the reporting back part of the supervision session is the silence between the reporting back part and when the supervisor asks the group to decide together what to talk about today. This second silence is a silence of an ontological shift.

When the reporting to the supervisor finishes, a silence appears that facilitates this shift. The supervisor breathes in, adjusts her body to a slightly more lolling body position by pushing her back a bit down on the back rest of the chair and sits nearer the edge of the chair and says slowly:

“good, interesting...yes...should we continue...and see if anybody would feel like raising somebody [a patient red.) today?”

The supervisor says this softly but with a clear voice, slowly, with pauses between nearly every word, raising her two hands holding her tea cup while she twists it slightly between her hands transferring the weight from one hand to the other. She looks around the group and waits. There is no awkward tension in the room, or sense of nervousness. This is how I read the body language. Eye contacts are calm and do not shift around. The participants do not move around on their chairs. There is no frequent turning of heads in different directions or eye contact seeking to connect with the supervisor.

The shift that is made available through this silence is from the opening reporting back part to the discussion about what should be the content of today’s session. The opening reporting back part consisted of two staff members talking directly to the supervisor about their experiences and developments in relations with the patients whom they have been speaking about in the previous supervision session. However, the shift is not only a shift in topic. It is also an ontological shift in practice configuration. It is a shift from a creation of knowledge that is formulated in singular terms, to a configuration where active collectivity is made available. I will elaborate on that in the following: The 9 seconds of silence occurring before the supervisor suggests that the group finds out what to discuss in today’s session is what is making available to the supervisor the opportunity to ask this question. I argue that the possibility to make

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96 In spite of the fact that this more or less one way communication characterizing the reporting back in the beginning of the supervision sessions, this kind of ordering the communication also happens in study group settings. For example, when the team leader is giving information to the group (12. Dec. 05) or the psychiatrist and the psychologist are reporting back to the group about their trip to Network therapeutic training in Norway. This is happening when the content of the conversation is not performed as a subject of discussion and when information is performed as if it is not connected to personal reflection or thought but has its connection to external factors.
things (including practice configurations) different is created by this silence. When the reporting back part is exhausted the silence is what makes something new available to happen. The silence makes the difference, not the talk of the supervisor.

Silences as shifts are prevalent in other types of situations in the practices of the outreach team as well. For example, in the study group sessions when the group commonly has to decide what to talk about at the start of the session. (See chapter 9 for an elaboration of this argument). In comparison, in the beginning of the study group sessions the staff members become present before starting to discuss something together. The shift in the study group is from a temporal collectivity of becoming present to a content oriented collectivity. However, the shift in the study groups is not an ontological shift. There the temporal composition is aligning with the content composition of the configuration. In the study group sessions the fact of being present in the ‘now’ blends well with being collective97. In the supervision session, the argument about what type of knowledge is produced in the reporting back part at the beginning of the session is contrasting with the collectivity. This is why I argue for the silence as an ontological shift in this example.

**Collective silence**

The two previous analyses on witnessing silence and silence of the shift raise the question of how decisions are made or how the progress of the supervision session actually happens through these silences.

In speech one could argue that the performance of talking is limiting how to participate and what knowledge is produced to the person that is talking or the person who is addressed. For example with the first reporting back part of the supervision session, in principle the external psychologist is given the authority to take decisions and to make judgements on the basis of the information given to her by the two staff members who talk to her. The two staff members, of course, decide on what to say, however in this situation we see that the external psychologist is the receiver of information and is performed as the expert. The speaker can also be the person directing the way the decision is taken and what knowledge is produced as the possibilities of decisions are explicitly mapped out. For example, if the supervisor suggested a specific topic to discuss in the session, rather than asking the group to decide among themselves. The

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97 Being present in the ‘now’ as aligning with collectivity is a rather simplified statement that can be challenged as well. However, for the purpose of mere illustration I will not analyse this further.
speaker or the supervisor, in that sense, would be directing the way of participation and also what knowledge would be produced. However the silences in the group are different. They are making talk absent. When there is just silence there is, at first sight, nothing or nobody directing what should be decided. The silence does direct how to participate. But this decision cannot be said to belong to somebody or something. This silence does not belong to anybody or anything. It is a platform of potentiality. Silences contain the possibility to turn in all possible directions and, thus, also to delay the possibility of not taking decisions. Silences are from their outset creative in terms of what their effects can be, and they seem to have the ability to transgress the ordering of existing ontological knowledge claims in a similar way to music (Deleuze & Guattari, 2004/1980).

The collectivity that the silence is creating, I suggest, is, thus, to do with its potentiality in multiplying the possible knowledge claims. Such configurations of silence are not aligning standardized measures (diagnostics, patient lists, expert roles etc.), because standardized measures put closure around the definitions of meaning and minimize collectivity. Silence, however, is not per definition the creation of collectivity. And it is not per definition stable. It is a matter of heterogenic configurations through voices, timing of that particular silence in the session, what the topic of conversation was before and so forth. Thus, the efforts of the team that are performed through silences make a configuration where definitions, and answers, solutions and agendas are vague and not attached to any particular thing (diagnostic system) or person (expert). Silences are the quintessence of Openness in ‘Open’ Dialogue. The silence contains the Other, it makes the Other able to listen, while speech, in principle, excludes the Other and puts the individual back in focus. The Openness in the Open Dialogue approach is, thus, placed in the gap of the silences. In the exchange of arguments (the dialogue) it is only made open when the dialogue is making available the silences. The silences are the collectivity, what is not yet decided and what has not yet any owner. Benjamin’s term ‘now-time’ (1994), referred to in the chapter 9 on ‘closed dialogue’, is connected to creating an ‘authentic’ presence, a ‘now’ that is conditioned by the release and loss of individuality. In spite of the fact that this thesis does not have phenomenological resources, there are still elements in this connection to the loss of individuality through the construction not only of the presence but also of the silences that could be added to this configuration. Benjamin (1994) argues that the loss of individuality through ‘now time’ contains a unique form of tolerance. This tolerance is a tolerance towards the

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98 Of course this is relative. One could argue that, for example, the clock hanging on the wall in the room is directing the silences to end, because of the limited linear time that is put aside for these sessions.

99 I owe the development of these analytical ideas to very inspiring conversations with Marie Bruvik Heinskou.
Other. The Other is your colleague sitting next to you. It is a tolerance that links to the equality between humans that was explored in the chapter 7 on ‘alternative dialogue’. Thus, several efforts of the team (temporal presence, circle of chairs and now silence) seem to produce what I will call specifically performed collectives. Collectives are configurations where the production of knowledge claims is not reduced to one or few answers. They are configurations that do not predict what kind of knowledge is produced, and it is configurations that makes available that everybody can have a say.

Silences here are in opposition to having a written agenda (which is absent in both study group and supervision sessions) where the content and the rhythm of the meeting would be determined by the paper and its contents. Silences in such an agenda led setting would not be about how to decide the content of the meeting or how to be present, because the paper would order and direct that. In this instance that is not the case. There is no paper. Making a decision about what to talk about has to happen in a different way. It happens through the silence (together with the absence of the paper). Silence is therefore producing collectivity

**Configuring silence and expectations**

If we continue watching the video of the supervision session we will experience further silence. After the witnessing and shifting silence and when the supervisor has asked the group to raise a patient for discussion, the members of personnel sit calmly and look ahead, but not at any specific person. The social and health care worker is the only person looking at the supervisor. The video recording transmits a calm atmosphere.

In this calm atmosphere nobody says anything for 12 seconds.

However small ripples in the quality of the silence appear. The social worker glances briefly at the video that is recording the session and then shifts her eyes to the psychologist of the team. The consultant psychiatrist, who is sitting diagonally across from the psychologist, takes a sip from his tea cup and also directs his look towards the psychologist. The team leader, who sits next to the consultant psychiatrist, also glances at the psychologist.

The different staff members attending to the psychologist do not at first impel him to speak. He has registered their ‘call’ as he has fleeting eye contact with them but he waits.
The psychologist, sitting on the right hand side of the supervisor, places his left clenched fist calmly at the table. He lifts up his fingers while keeping the palm on the table, waves them a bit and then clenches his fist again. While doing this he turns his head inward towards the group, apparently not looking at anybody in particular, and then turns his head back again looking past the person in front of him, directing his gaze out of the group. He draws his hands together and places them on his lap, breathes in and says:

“I don’t really have anything... obvious... to bring into the group today...I think.”

He then turns his head and looks back towards the person on his right side, the social worker. He was ‘called’ by the glances of his colleagues. He was ‘called’ by expectations to come with an input.

The silence as collective and commonly owned is challenged here. The expectations from several of the staff members, facilitated by the timing, the questions of the supervisor and the silence to get the psychologist to provide an answer are what challenge the collectivity. Due to the glances of the colleagues, the facilitation of the round allowing everybody the opportunity to speak and the fact that this happens right at the beginning of the session, when the group has to decide the topic of the day, is challenging the collectivity of making common knowledge claims. Collective knowledge claims have shown to be an ideal that is described in the Open Dialogue principles, but is also a product of several of the configurations in the team (circle of chairs, present temporality for example). Here this ideal is challenged and the situation opts for the reinsertion of making the psychologist speak. It is thus also a challenge that opts for the reinsertion of singularity and clear answers.

Now why the psychologist? Here a bit of background information from the chapter introducing Open Dialogue is reinstated. The psychologist is recruited to the team (and by the team) exactly because of his experience and training in systemic therapy, which is a treatment approach that aligns with some of the principles in Open Dialogue in terms of including patients and relatives in the decisions around the treatment. He is employed here because of his ‘expert knowledge’. However, the staff members explain both during study group sessions and in interviews that the dilution of expert positions is important in Open Dialogue. They say that experts usually provide answers and solutions to problems but here, on the contrary, they explain that answers and solutions are supposed to be developed in the social network group and not provided in advance. However, what seems to happen during the silences in the extract above is the
attempt to challenge the purity of this flat hierarchical ambition by the reinsertion of hierarchical expert positions.

The psychologist does not provide an expert answer. He does not tell the group what should be the topic of the day. Instead he waits and thinks and waits again to see what happens and then by his body movement he invites the social worker to speak. Inviting his colleague to speak is simultaneously an invitation to start a ‘round’ of conversation, because the invitation is directed to the person right next to him and not somebody elsewhere in the room.100

Here, it is what one could call an ‘opening round’ because it is placed at the beginning of the session. In these cases people do not reflect on what has been said in the session, but bring in things from outside (in this example the supervisor has asked about what they would like to talk about today which usually, but not necessarily, implies discussing a relation with a patient). Another reason for reading this move as an invitation to make a ‘round’ is due to the linear timing in the session.101

Thus, in symmetrical terms the dissolution of the psychologist’s expert position is configured by the silence, the ‘non-answer’ of the psychologist and the round that make it possible to dis locate the expectations of providing answers directed/assigned to the him. As the analysis shows, the effects of silences are not to be taken for granted. In spite of its facilitation, a multiplicity of factors is performing its effects.

When time is not carved into the body we forget it, because it leaves no traces (Latour, 1997, p. 173). But how does one trace the scent of time? The traces are intense when negotiations are taking place with other actors that are not aligned. This argument is in line with the analysis of the circle of chairs (chapter 10) that seem to foreground intensity through the displacement of agency to human bodies. When something attempts to destabilise what occurs, in this case the collective silence, there is an instance of uncertainty about how the configuration of what occurs is going to shape the configuration that might emerge. This is seen above when the glances of the colleagues worked against the collective silence, as they tried to direct agency to a specific expert. It was a move from how silence proposed a multiplicity of possibilities,

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100 As mentioned in the description of the study group a round’ is a circle of talk that is taken up in turn by the members of personnel, where each person expresses her state of mind, her wish for the content of conversation or makes associations to what has been said previously in the session.

101 As described; after the reporting back to the supervisor, there is a silence that, as argued, is making an ontological shift available from a knowledge produced along singular lines to knowledge produced along lines of multiplicity. After this shift the silence performs collectivity as for the group to decide what to talk about in today’s session.
towards directing the cause of events to have an owner (the psychologist). But alignments of actors are re-established in the next course of events. As we will see, the psychologist does not take up the expected expert role, but, with an implicit reference to one of the principles in the Open Dialogue approach that is about letting all voices be heard, he allows uncertainty to endure in the communication.

So what can be said on a meta-level about the configuration in this example? The configuration of glances, expectations of expert roles, silence etc. composes a configuration where a negotiation against collectivity is taking place. However the collective silence seems to help making a platform of how to produce knowledge claims and participation.

**Configuring silence and emotions**

But as I have argued, configurations are hard and subtle works. This is why they cannot be taken for granted. Collectivity (or collectivities for that matter) is not easy to maintain, especially not in a health care system that, in many respects, produces singular knowledge claims that are not based on collectivity. The following analysis explores one way of how the collectivity is challenged, namely through the reference to personal emotions. Expressions of personal emotions that are detached from the working relations seem to create a different kind of silence than the one analysed above. In the following analysis the silence is interpreted as frictional.

All types of conversational rounds in the supervision session and in the study group sessions can be mixed with expressions of how one feels personally. However, references to personal emotions have different effects. In this example I will argue that these emotional references can be disrupting of the collectivity that is made available by silence. The social worker takes up the invitation. Her body is slightly twisted towards the psychologist (implying that she is not totally facing the table and the other team members). She has her hands folded in front of her.

> Smiling the social worker says softly: “I have just come back from holiday. I feel I just need to settle (before saying anything ed.)”

> The supervisor laughs in a recognizing way and says: “yes”

This is the first emotional claim that will be discussed below in this analysis: “I feel I just need to settle.”

The consultant psychiatrist leans over the table and sips his hot drink. Apart from him everybody else has now folded hands and one person has crossed arms. The psychiatrist at the opposite end of the table silently flicks through the pages of her
calendar.

There is silence for 9 seconds.

The social and health care worker looks from the consultant psychiatrist to the supervisor, she then smiles and look down at the table:

“I have somebody that I sometimes find it difficult talking with.”

She mentions the patient’s name directing her speech towards the consultant psychiatrist that now also has clasped his hands and he nods and says “ahh jah” (recognizing the name of the patient). The team leader sitting next to the consultant psychiatrist also nods. And the social and health care worker continues, still directed towards the consultant psychiatrist:

“The one that repeats and repeats and start over again...It is very difficult for me once in a while not to appear arrogant when I question her.”

This is the second emotional claim that will be taken up in this analysis below: the feeling of arrogance.

While the social and health care worker says this, the consultant psychiatrist keeps nodding but does not keep eye contact with her. He crosses his legs, looks down and up again, directing his gaze to the table and then to somewhere else in the group. He again sips from his cup. The social and health care worker shifts from looking at him to looking at the supervisor who also nods and expresses sounds of appreciation and encouragement like “aha” and “yes”.

There is a slight silence

The supervisor then says: “So that was at least one thing we could bring in today” (min6:30)

She pauses her talk, rearranges her back to the left side of the back of her chair facing more directly the social and health care worker, shifting her cup from one hand to the

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102 Apart from the fact that the supervisor engages with the input from each staff member (which is different in the study group where there is no single person acknowledging or engaging with each member’s input into the group) another reason for the ‘round’ to get disrupted by a slight silence here could be connected to the fact that the next person in the round is the Polish psychiatrist. She has difficulties speaking in Danish. It might, therefore, be difficult for her to contribute to the supervision session and her abstention from adding input is, in that sense, blocking the flow of the round. Suggestively, this is both connected to the slight silence and to the fact that the supervisor is summing up before every member of personnel has had their say in the round, making the disruption of this chain of talk possible and legitimate by asking if anyone else has something to add.
other and looks to one side of the group where the psychiatric worker, the team leader and the consultant psychiatrist are sitting and adds:

“Are there any others with a burning issue (to bring in a patient relation or a topic for discussion ed.)?”

After a moment the psychologist takes up the conversation and identifies with what the social healthcare worker has just been saying about feeling arrogant. He says that it makes him think of a relation with a patient and that it would be possible to discuss that relation but as a “second priority”, which means that he does not want to put his case first. The supervisor makes sounds of approval like “ok” and “yes”.

The supervisor then again asks: “could there be others” (and then very quietly) “who would like to add something?”

A slight silence and then she says while pointing her cup at the psychologist and the social and health care worker interchangeably: “Now, it was also you two that ‘put forward’ last time (at the previous session ed.)...not that it should prevent you from ‘being on’ again, but...”

The social and health care worker laughs and smiles. The psychologist smiles. The consultant psychiatrist says that it is good to get the chance to discuss this patient who the social and health care worker is putting forward, and continues to say that he has his mind elsewhere on the piles of work on his desk in his office (as if to say that he has not been thinking of a case to bring into the group which would be any better than the one suggested by the social and health care worker).103

There is a silence again.

The social and health care worker looks at the consultant psychiatrist, sips her cup, nods and says “yes”. The supervisor directed towards the social and health care worker and says:

“Ok, would you like to hop on again?”

The social and health care worker agrees and the next couple of moments are used to

103 Reference to personal emotions are supporting attributes of professionality, for example when the consultant psychiatrist refers to the piles of books that he simply has not had the chance to look at due to what he feels is a great work load. This is a reference to emotions that at one and the same time refers to the inner state of himself as an individual and yet, simultaneously is performed collectively and is a positive attribute to him as a competent doctor, because he appears as busy in a relevant way.
discuss how they should place themselves in the room in order to be able to discuss that particular patient in front of the rest of the group.

So what is going on in this magnified part of the supervision session focusing on the connection between silences and emotional expressions? I will here briefly turn to classical social psychological research. In classical social psychological research “the mirroring effect” is about how we tend to copy each other’s behaviours when being in a group (e.g. Wetherell, 1996). I suggest that this process is not only determined by what other people do or say, but is also determined by the space in between what they do or say. In other words it is determined by the silences of the practices they are in. It means that what people do or say does not, in itself, determine the direction of our own behaviour or our emotional state, but the ways these things are put together does determine how it is possible to create presences. The argument is that ways of being present are not only defined by mirroring and observing other people, but that ways of determining presences is a matter of displacing or abandoning oneself (Gomart & Hennion, 1999) to the rhythm of the particular practice you are engaged in. Now when the staff members refer to their emotions, it does influence the way the group can be configured, because these statements are contributing to how it is possible to maintain or disrupt the collectivity of the group.

Especially in these last two analytical examples of the active collective silence and the silence and emotional expression, silence is challenged by subtle and detailed work against the silence as a collective performance. One could say that there is a chain of availabilities that supports the silences as collective decision making processes, and actors that work against that. The example shows two trajectories of resistance going against the collective configuration, namely:

1) Expectations directed towards one specific member of staff (the psychologist is silently expected to talk) is occurring during the 12 seconds of silence.
2) Emotional input that is not work related when the social worker is talking about settling in after having had a period of leave on holiday followed by 9 seconds of silence.

The first argument is connected to the fact that three members of staff start glancing at the psychologist during the long 12 seconds of silence that follows from the supervisor’s request for the group to decide what to talk about in this particular session. The psychologist refrains from taking up that call and says: “I don’t really have anything…obvious… to bring into the group today…I think”: When I use “refrain”, it is due to the expectations of him to say something that is expressed through the eye contacts and glances in the group prior to him talking.
When practice is not configured in a purified manner through, for example, silences, it is illustrating two things:

Configurations are not per definition purified versions of knowledge and thus it is not possible to argue for one reality of practice relying on one version of knowledge claim. Realities are performed and challenged: Here, where minute gestures suggest that silence as a collective practice is challenged. It is difficult to keep bodies still, glancing in the air, referring to oneself and the group at the same time without expecting the ‘expert’ to speak up.

The other point is that it illustrates a sophisticated learning process. The psychologist could just respond to the call of the staff members by suggesting a theme for discussion. The quality of the silence would have collapsed and the quality of what they aspire to in their work with Open Dialogue would also dissolve. The way the staff members speak about Open Dialogue in all kinds of different settings, not only in the supervision sessions but in the study groups and in conversations with me as well, supports their wish to do collectivity. However, this example also acknowledges that that is very hard work to perform. One could say that other staff members’ expectations or wishes for somebody to take the lead, in spite of the collectivity made available through the silence, is working against such an aspiration. The psychologist refrains from taking upon himself the call and he adds a different tool to maintain the struggle for the collective decision of the topic, namely the ‘round’ and invites the social worker sitting next to him to speak. This leads to my second argument about forces going against the silences as facilitators of collective decision making processes.

The second argument I draw from the social worker’s input into the group (where she has been invited by the psychologist to continue the ‘round’). It is part of the basis for being able to discuss collectively what the topic of discussion should be at this session. Interestingly, the psychologist calls for the round as an option when the silence does not seem to provide the collectivity. How does the social worker respond to that? She says that she has just come back from holiday and feels that she just has to settle in. What is happening? The social worker is not reprimanded as if it was wrong of her to say what she did, but the round is provisionally disrupted by a silence of 9 seconds. What is she saying? She does not talk about relations with patients; she does not talk about what other people have said. It seems difficult to carry on the round without any of those types of attachments to the group. She does say that she needs to settle in, but that is exactly a detachment from the group. It is as if she is saying: “I am here, but not here. I am here with my body, but cannot yet contribute to the collectivity of the group”. In that sense the silence as a collective decision making process is challenged, because she does not provide material for the group to think about or to take decisions about.
And the group has to use the silence to resettle or find ways to continue. The rest of the example is also illustrating this. The supervisor is helping along the group to find out what to talk about and keeps the possibility open for others to come with suggestions. One could say that, together with the silences and the ‘round’, she is trying to facilitate the learning process of becoming collective in the group. However, as the example shows, accentuating silences as collective performances are subtle and not everything is aligned in order for this to happen. It takes a lot of effort to make collectivity available, among other things silences.

**Conclusion:** *Silences are important to acknowledge innovative work*

In this last empirical analysis of silences we have seen that intangible and invisible work is important to state the efforts of the team as innovative. The analysis of the silences is the last of a range of different examples of micro–analyses that all show detailed and subtle efforts to make mental health care practices different. Each example has shown, in their way, how much work it takes to change practices and that this sometimes does not succeed. As such the examples of silences shown in this chapter are different ways of performing Open Dialogue, just as the circle of chairs, the rounds of conversation, the absence of diagnostics, the universal dialogues, the present temporality and the adding together of medical doctrine and Open Dialogue ideals. Silences have been particularly interesting because the way they are often performed in the material seem to be the quintessence of what the staff members wish that Open Dialogue to be about. Namely listening and collective decision making processes.

As such silences work in different ways:

In the chapter, I have pointed to four empirical examples; each exemplifying different ‘kinds’ of silence. I have shown how the witnessing of silence is composing a *passive collectivity* when two staff members reported back to the non-judgemental supervisor. The next analysis concerned the silence of the *ontological shift*. A shift that was defined from the reporting back type of knowledge construction to making available a collective knowledge construction. And finally the chapter gave two examples of how collective decision making is challenged through first, *expectations*, and secondly through *emotional expression*.

There are four points for theoretical discussion derived from the above analysis.

Firstly, the silences that perform the collective in turn produce: 1) A heterogenic decision making process where silence is an important actor in defining and deciding what occurs in the room, and 2) Extension of knowledge claims. The negotiation of knowledge is performed through silence. To establish a space where the negotiation of
meanings and definition can take place, in a figurative sense, a waiting room is established. All knowledge is put on hold for the moment of silence. It is never finally defined as to what a definition or a meaning is. And further, this ideally transforms disagreement to the creation of multiplicity of knowledge rather than composing a configuration that is tensional or has inherent power oppositions.

Secondly, silence creates a collective in the way meanings and definitions can be discussed. This collective is performed as an alternative to what seems to be the exclusions of standardized measures where definitions and agendas are predefined.

Thirdly, talking with the personnel in various settings one gets the impression that the prerequisite for change is constituted as an 'inner condition' within each member of personnel. In these examples, through the silences, each member is training herself how to listen to silences and to talk. They do that with their body language; glancing about in the air or at the floor. Collective silences necessitate attendance and presence no matter how well the rhythm flows (meaning no matter how repetitive these types of silences have become). As with the performance of the circle of chairs in the analytical chapter 10, the performance is accentuated on the bodies and the silences in the room. Everything they do is with attention to what is happening in the room and not outside of it. The collectivity of the silence makes each member of staff attendant upon the silence. The reason for this is because in the settings where the discussion and practice of Open Dialogue is put on the agenda, the important performing actors are the bodies and the silences (and the particularity of the spatial and temporal setup of these situations that has been shown previously). They are not the written agendas, the tables and the diagnoses.

Finally, the silences make available certain professional ways of becoming. Silences in these settings perform a platform where the multiplicity of knowledges can be negotiated. This is constructed as a relation to each member of personnel in the sense that the change towards multiplicity is coming from 'listening' and reflection which is a continuous oscillation between referring to oneself and participating in the collectivity of the group. Professionalism is, thus, not merely performed through acts of individuals acquiring standardised knowledge through for example the medical doctrine, but how to become professional – in the case of Open Dialogue – is a matter of being able to listen to other colleagues and patients in specific ways.

In terms of analysing what happens in the silences as innovative it is especially the struggles to keep out expectations and hierarchical positions that make clear how the subtle work with silences is important to change the existing practices. This means that the investigation of the silences actually makes visible what would before be invisible. So even if we recognize that innovation is non-linear and not only about technological
development in isolation from bodily interaction, this is not enough. Silence is productive. If we did not put our attention to this subtle work, we would not know how much effort it takes to make things different.
Conclusion: Intangibility in innovative mental health care practices

This is a thesis that has been concerned with innovating mental health care practices. It took its point of departure in the problem that psychiatric professionals have expressed frustration of the difficulty of finding meaning in their work. One group of staff in an outreach team in Southern Zealand in Denmark tried to deal with this frustration by introducing the treatment approach called Open Dialogue. However, as we have seen innovating mental health care is not an easy task at all. This thesis has shown that efforts to innovate are about defining one’s practices as unique, making them adaptable, giving them a protected platform of execution, unlearning to have expectations that go in certain directions, being present and silent, and about combining old and new forms of knowledge.

By analysing these efforts, I contribute with three elements to the field of innovation studies within the field of mental health. Firstly, I show how it is possible to grasp especially new innovation processes that are in the making. Secondly, I show how the field of mental health produces practices that are intangible and low-technological, and thirdly, I show that not only people’s sayings matter but also room setups, temporality, silences, absences of diagnostics etc. matter, when trying to innovate new practices. Thus, what became important was not the beginning of a new era in local mental health care practices, but subtle, laborious efforts that sometimes succeeded to be sustained and sometimes did not.

Through an ANT inspired approach to innovation processes, this thesis offers micro-sociological analyses that show how these efforts were performed in the daily practices of the team. The first part of the research question is thus:

“How is the newly introduced treatment approach called ‘Open Dialogue’ configured in the daily working practices of a psychiatric outreach team?”

The first section of the conclusion will take the reader through an overview of the seven analytical chapters dealing with how the intangible and fragile configurations were analysed, and what I found. On the basis of these analyses of the team’s innovative efforts, the second section will discuss and reflect upon what we have learned about innovation processes from an ANT perspective. This provides us with the answers to the second part of the research question:
"And how can the outreach team’s configurations teach us anything about innovation processes in mental health care?"

The third section of the conclusion will discuss what kind of political and ethical questions the thesis raises, while the fourth, and last, section of the conclusion presents a number of propositions as to how innovation processes can be addressed when wanting to take into account heterogeneity, intangibility and multiplicity.

**Configurations**

Firstly, the configuration of the *alternative dialogue* showed that innovating mental health care can be about establishing oneself as exclusive and very different from the existing practices. As illustrated in the first analytical chapter, the way the Open Dialogue became exclusive and unique was through contrasting itself to the medical world view. The analytical term used here was “*cutting connections*” drawing on Strathern. It is a term used to explain how borders between one configuration and what is outside of that configuration are established. For example, this was done by establishing Open Dialogue as an approach that performs humaneness and equality in contrast to the medical clinical practices in mental health care that are based on diagnostics, which produce differences between normal and abnormal.

Secondly, innovating care has proven to be about compromising and adjusting what it is to be innovative. The second analytical chapter has shown how this can be done. With respect to the Open Dialogue, the ideal and uniqueness approach was challenged and divided into universal values and non-applicable elements. This means that some elements of Open Dialogue, like respect and patient inclusion, were seen as transferable to governmental mental health care services whereas other elements, such as the ways it establishes itself as a therapeutic tool, were seen as not transferable. The chapter on universal dialogue shows how new practices in mental health are dependent on being acknowledged by existing ways of conducting practice in order to become visible.

Thirdly, innovation processes are also constituted through a specific temporality and in a specific spatiality. Thus, innovation processes are heterogeneous. The analyses on *closed dialogue* and *intensive dialogue* dealt with how the innovative efforts are heterogenically configured. Here, heterogeneity was introduced in the form of chairs and a specific temporality. These analyses took point of departure in the observation of the spatial and temporal setup of the study group sessions that the staff held to practice the new approach. The way the staff settles into the study group sessions performs a certain temporality without reference to past and future. I have called this a performed present temporality. I discussed how this type of configuration creates a type of
knowledge that seems mutable in the space in which it is created, because it is collectively created anew at every session. However, present temporality has difficulties travelling across practices; the knowledge that is created is created in the room and remains in the room as a shared experience. What becomes transportable is the form of the sessions (spatial setup, the way of settling in, rounds of conversations etc.), but not the knowledge that is performed in the sessions. Therefore, it is referred to as a mutable immobile and adds to the invisibility formerly described.

When analysing the spatial setup, I found that what happened in the room created intensity. I had three reasons for employing ‘intensity’ as an analytical term to describe the effects of the configuration. First, intensity was again a way of contrasting to the external “hard-technologies” like diagnostics, hierarchies, written agendas and decisions about future actions which are prevalent in other settings of the governmentally owned psychiatric services. Second, intensity related to specific alignments between the different actors in the room – the fact that the human bodies were interacting. Third, intensity was a sign of unbalancing certain types of actors. This means that the human bodies defined how the practices were performed rather than the agenda for instance. The analysis of the room where intensity is produced suggests that this intensity can be characteristic to the field of mental health, where the use of low-technology is prevalent. It questions how psychiatric work can be organised when the intensity puts clear (singular) answers, control and predictability on stand-by, in order for human interaction to reign instead.

Preserving purified (exclusive and closed) configurations is hard work, not only because of competing technologies but also because things always leak and seek to connect and negotiate with the surroundings. This is also one of the elements that explain the intensity.

Fourthly, the chapter on multiple presences showed that innovation processes cannot be controlled and fixed by, for example, solely changing the spatial setup. In the fourth analysis, the seemingly ideal spatial setup from the purified previous two analyses was challenged, which showed that spatial setups are not stable and static but open to variability in participation possibilities. This means that even though circles of chairs or other ways of setting up a room is meant to discipline the staff to participate in a certain way, the setup is not stable. The chapter described a process where ideals are mixed with hierarchical stereotypical traits and governmental technologies. It was argued that when the ideal of human collectivity and dissolution of hierarchy become blurred and disturbed, the spatial setup also makes available performances that do not correspond with that ideal. This analysis showed that for professionals, multiple performances also seem to sometimes enact sophisticated governmental technologies where, for example, it becomes ambiguous who has the right to define the agenda, who
has the right to participate as a manager, and who has the right to give advice to fellow colleagues. This analysis made it especially salient how hard and difficult it is for the team to innovate their working practices. Even changing the spatial setup and the way conversations are usually run is not enough to stabilise something as new. The seemingly purified setup (the circle of chairs) and the principle of equal opportunity to speak through rounds, which should make equality and non-hierarchy available, become disturbed by the enrolment of managerial responsibilities.

Fifthly, innovation processes are not always about conflicting programmes. The chapter on adding together singular and collective professionalism offered an analysis of a configuration that is not antagonistic and tensional. It was not about clashes or divisions between ideals. Rather, it was configured through positive relations where the mixture of humaneness and the psychiatric doctrine co-exist and are added together. A compromise has taken place between the professionalism of the existing psychiatric teachings and the efforts to change those things. The considerations of the staff members to innovate their practices concern, therefore, also renegotiating the ability to care (i.e. be present in the now and include patients and colleagues in the decisions) and at the same time rely on the psychiatric teachings of cure (i.e. diagnostics and making decisions on the foundation of expert knowledge).

Sixthly, innovating mental health is also about changing the existing practices, rather than only inserting new practices. The chapter discussed how some elements in the existing practices are unavoidable. They can simply not be disregarded. They are so-called obligatory passage points. Such a point is the patient recruitment procedures governed through diagnostics. The Open Dialogue approach is not based on diagnostics. The recruitment procedures were fragmented to a logistic tool that could be used for organising the Open Dialogue network meetings, whereas the therapeutic tool, which it also contained, was disregarded. The chapter showed that it is not only what is introduced as new that is subject to change. The adaptation of existing practices is also subject to compromise and change if innovation initiatives are to be sustainable.

Lastly, silences constitute a particular specificity in my case and add to the previous local analyses that have been absent in ANT and innovation studies within mental health. They have proven important to investigate in order to understand the exact efforts of innovation done in the case. The argument in the chapter on silence was that silence, as a central actor in this configuration, distributes authority, responsibility, and decisions. The chapter investigated how knowledge claims, in the realm of silence, are produced as something that is not singular and not fixed. Silences made available a fluid decision making process and produced yet again other types of collectivities. I have showed how different types of silences produced different types of collectivities. In terms of perceiving what happen in the silences as innovative, the struggles to keep
expectations and hierarchical positions out of the practice played a particularly salient role for the way in which the subtle work with silences is important when changing existing practices. This means that the investigation of the silences actually made visible what would before have been invisible. Had we not put our attention to this subtle work, we would not have known how much effort it takes to do things differently.

Bringing attention to the invisible work of innovation processes also connects my contribution to the field of post-ANT. The overarching analytical resources I draw upon, when looking for incoherency, invisibility and multiplicity through the tools of performance and symmetry, are central to the post-ANT research agenda. As mentioned in the introduction, post-ANT research investigates networks, not as patterns of relation that are coherent with only one obligatory point of passage and with a powerful centre of execution, but as configurations that do not necessarily link in coherent ways and that can have multiple power centres. Post-ANT also focuses on the silent and usually invisible work that make practices change over time. Where I have placed an emphasis on the importance of this intangible work, I do so acknowledging the effort it involves as part of creating new ways of doing things. I therefore conclude, that:

Innovations do not start with a decision and do not end with a result. They start with a dream and end with practical negotiations.

In addition, the thesis contributes directly to the advancement of the post-ANT research agenda through the analyses of the constitutional importance of silences in the heterogeneous configurations of Open Dialogue practice, as a case study of innovation in mental health. Addressing silences are not only a matter of acknowledging invisible work to make it visible; it is also about stressing that, following the ANT-research principles, when actors are invisible they also produce specific things worth while learning about. Low-technological mental health innovations produce specific things, very different from high-technological mental health practices. When applying post-ANT principles to these types of practices new forms of knowledge are constructed. In my case it was knowledge on the distribution of authority, responsibility and decisions.

So all in all what do we learn from all these configurations? The brief summary above of each of the analytical chapter have illustrated how the newly introduced approach was configured. Now what, then, can we learn about these negotiations?
To change or to disappear – Innovation processes are hard work

To elaborate on what the local efforts to introduce the Open Dialogue approach have taught us about innovation in mental health care, I will take the reader on a short generalizing detour to contextualize the following argument. There are two models for studying innovations (under which it is possible to group a wide range of other models):

“the linear model and the whirlwind model or if you prefer the diffusion model and the translation model” (Latour, 1996a, p. 118).

In the first case, one has an object that does not allow change. It lives by itself and is autonomous. It sets out to spread across the world. Usually people do not accept such a finished and fine idea, but sometimes the idea survives and continues to go its way. Such a narrative of a successful innovation captures the image of an object that does not transform itself or make any compromises. It is maintained intact, allowing only a few minor adjustments (Latour, 1996, p.119).

In the second model, the initial idea barely counts. It has no autonomous power, nor is it boosted by a brilliant inventor or manager. It has no inertia and it only moves if it interests one group or another (Latour, 1996a, p. 119). The project can only attract interest if it translates the interests of these groups. In this model the innovative object transforms itself, compromises, blends in, and does all sorts of negotiations in order to be able to travel (Latour, 1996a, p. 119).

Where do the efforts of the outreach team fit in these models? With Latour (1993/1991) we have learned that purity is constantly challenged by a vibrant messy world. Therefore, there is also something in the Open Dialogue approach that links to the diffusion model and there are elements that link to the translation model. The efforts to innovate in the team started with an idea of wanting to change the working practices and a wish to make mental health care better. This idea flourishes and develops in the informal talks of the team. The team decides to establish the study group sessions, but it gradually became clear that to embed the approach in the daily working routines of the team it would become more complex. How to be a professional in the circle of chairs and the round of conversation? How to recruit patients when trying to refrain from using the diagnostic system? These were questions that arose as an effect of the compromising efforts in the team. The negotiations were effects of the translation model of innovation. These negotiations were sought to compromise, stand strong against and mix with the existing practices, and thereby these negotiations were also the staff’s attempts to establish their innovative efforts as sustainable. Thus, as we have
seen, the people and the enrolled interested things transform the Open Dialogue approach. These are performances where the ideal of the Open Dialogue is disturbed and challenged. This is the model that is about negotiation and translation of the initial idea of the project.

However, there are also elements in the configurations that are not seeking to compromise the pre-conceptualized model of the Open Dialogue approach. Those elements are illustrating the first diffusion model of innovation. When the Open Dialogue is configured as a unique alternative that offers equality in the relation to patients, and when it establishes a temporality that does not connect to past or future but only to the present and thereby closes in on itself, and when it attempts to exclude practices, such as diagnostics, questionnaires and agendas, prevalent elsewhere in mental health care services, then the Open Dialogue is uncompromising and fits the diffusion model described above. When the Open Dialogue is uncompromising it refuses to contextualise itself to practices outside the team. That can be illustrated by the following quote:

“The only thing a technological project cannot do is implement itself without placing itself in a broader context. If it refuses to contextualize itself, it may remain technologically perfect, but unreal.” (Latour, 1996a, p. 127).

In some ways, the performances of the Open Dialogue approach has remained technologically perfect when it has insisted on its incompatibility and exclusiveness and this is why, in some ways, it also has performed itself as unreal. Therefore, this diffusion of the Open Dialogue poses some dilemmas for its survivability and recognition. When the Open Dialogue is unique it is not compromising and in ANT terms this means it has difficulties connecting to other practices in the organisation. When this happens it cannot travel outside the space where it is performed and therefore it is rendered invisible to the outside organisation. Leaving traces is an important component of being remembered and recognized as valid knowledge (Latour, 1999a). If there are no traces it becomes invisible and not possible to be either recognized, acknowledged or practiced outside the team. Furthermore, this also raises the question about which practical implication these efforts inside the isolated space of, for example the study group sessions, have for the patients? If human collectivity and equality are only exercised and practiced in the group of staff how is the contact with the patients then changed? Therefore, despite the necessity to establish a room where the team could exercise and get experiences and be confident with the approach in tranquillity away from the daily practices, it may be exactly the mixtures with the daily practices that were necessary for it to be acknowledged outside the team. Yet, when compromising too much and when something becomes universal, as in the interview with the head manager, it poses the opposite dilemma; that the new approach cannot be recognized as new or unique. Innovating is, thus, about balancing between
compromises and standing strong on one’s unique contribution to the field.

In sum, the efforts of the team contain both of the innovation models. The efforts both contain the willingness to make compromises and they also contains the exclusiveness. Therefore, various performances made the innovating efforts possible to gain foothold while, at the same time, other performances closed down this possibility.

However, I do not dare to say that the ways the Open Dialogue initiative has been configured locally alone explain its disappearance. The scope of my study is too limited for that. The performances that I have suggested perform invisibility; however, they also raise normative questions about mental health care, which have wider implications than what happened locally in the team. The team’s efforts revolved around inserting equality and human collectivity. The reason by which these performances come to be invisible can also be explained through the fact that governmentally owned mental health care practices are not, at least not primarily, performed through equality and human collectivity, in the ways they have been performed in the studied outreach team. Therefore, the performances in the team also provide normative arguments about how mental health care services should be performed. This will lead to the next section which is about how to connect politics and mental health care.

(In)-visibility, politics and mental health care – Reforming mental health care

The question whether an innovation process has the chance of gaining foothold becomes political in two ways:

1. It is a matter of how a given project can attract allies and translate their interest to its own. To give an example, the innovative efforts have attracted allies of equality, universality, collectivity and multiplicity, but are these allies successful in travelling further? This leads to the second political issue:

2. How can the allies travel and get the public’s attention and enrol it in its cause. Equality, universality, collectivity, and multiplicity do travel. This is what initially made me aware of how mental health care could be thought of as different. These elements are important ways to configure mental health care and were present in the discussions in the anti-psychiatric movement of the 1970s in some organisations of patients and relatives, such as the Danish NGO SIND, as well as in some mental health care services in Denmark and beyond.

With my analyses, I have placed attention on the difficulties that are encountered when
trying to make alternative practices co-exist with traditional medically informed psychiatric practices. How do alternative practices gain foothold within traditional psychiatric practices?

When alternative practices are performed as intangible they have difficulties travelling, as discussed, and have difficulties being created as possible points of identification (i.e. meaning recognized beyond its instantaneous performance). This creates invisibility. However, it also creates a purified platform of performance that, at times, seems necessary to innovate. From that perspective, invisible work is not always something that should be made visible. Yet, invisibility is not only about performance. Invisibility is also political. It is not only about how things and people connect but also what can be seen and acknowledged as visible work. The consequences of the intangible strategies and invisibility of the innovative efforts of the team are, therefore, similar to the complexity forwarded by Star and Strauss (1999):

“On the one hand, visibility can mean legitimacy, rescue from obscurity or other aspects of exploitation. On the other, visibility can create reification of work, opportunities for surveillance, or come to increase group communication and process burdens.” (Star & Strauss, 1999, pp. 9-10).

Visibility is, thus, per definition neither necessarily good nor necessarily bad. The normativity that is constructed is something that is made locally. When making a performative analysis specific, objects and problems are performed and made to exist at the expense of others. This is what Mol calls ontological politics (2002). How, then, do we ensure the existence of intangibility in innovating efforts?

Could we imagine a health care where both collectivity and singular knowledge claims coexist? This becomes a matter of providing a health care service that is as multiple as the analyses in the thesis indicate it could be. The danger of that proposition resembles that of the critique of the prevalence of individualism and neo-liberal ideals in mental health care. Maybe what should be taken up for discussion is, thus, more fundamentally about how the mental health services are organised and for whose benefit? This thesis offers a contribution to this discussion in the sense that the local configurations in the team have shown how things can be different. I do not propose a strategically innovative approach but an approach which is sensitive towards heterogeneity; to processes that are intangible and unpredictable, and which is attentive to initiatives coming from people to whom these initiatives are of concern, in this case the personnel.

This study has, thus, been about raising interest by showing alternative solutions to transform our understandings of a problem. The problem here has been the staffs’ dissatisfaction with their current working practices. Thus, raising interest is about
transforming our understandings of that problem, and not about the success or failure of the innovative efforts in the team. The team wanted to add equality, soul, and human collectivity into its practices, and I have tried to investigate how it configured alternative ways of conducting mental health care services. My way of raising interest has, therefore, been through the contribution to the field of innovation studies within mental health. I have shown that invisible work is important to address especially when investigating innovation processes that have just taken off. At this point, they are particularly fragile and intangible because they have not yet found and stabilized their actors (if it is the translation model). Moreover, invisible work has proven important because of the specific low-technology that the psychiatric field is known for. Low-technology is harder to measure with tools, as we know from the research already conducted, unless we want to translate low-technological approaches to high-technological measurements in scales and indicators. Lastly, I aimed to raise interest by showing that innovating processes also involves much incoherence and non-linearity. Therefore, innovation processes can not necessarily be predicted through the determination of inputs and outcomes.

In an academic setting the investigation of the innovative efforts is a vehicle and means for understanding how practices might be different, rather than having, as an end result in itself, to find solutions to the formulated problem. It is problematic if one, as a researcher in academia, mistakes the interest in the understanding of an investigation with the interest in the success of a given project. So rather than suggesting solutions, I have done two things: I have investigated the innovation processes through an ANT informed perspective where the newness, the particularity of the mental health field, and the incoherence and multiplicity could come to its fore. Lastly, in respect of how things can be different, I will propose seven points of concern that innovators can take into consideration if they wish to start an innovation process that is sensitive to the same things that I have been sensitive to: Namely heterogeneity, intangibility and multiplicity.

**Propositions**

I have argued for the specificity of this case study, but I have also argued for its general interest. Its general interest can also be formulated as an interest in doing innovation projects that can draw upon the experiences from this case study, despite its specificity. Innovation projects are widely spread within the field of health, and mental health specifically. Thus, my recommendation here is not only deduced from the readings of STS and ANT research, but also from this case study. Bruun Jensen (2007) and Vikkelso (2007) have addressed the usefulness of STS analysis in health care research. They do that as part of a debate on how to make STS contributions action oriented. I
would like to take Vikkelsø’s (2007, p.208) recommendation of formulating symmetrical summaries further. A symmetrical summary is a way to generalise the analytical findings of a STS-case analysis that insists on addressing a heterogeneous and antagonistic collective. It is a way to list how the described performances connect their effects, their conflicts and dilemmas, and what they exclude. I find this somewhat similar to what I have provided the reader in the summary of the chapters. These symmetrical summaries do not necessarily please all the parties and stakeholders involved. In other words, the summaries need to irritate and interest all parties. Yet, they do raise a specificity that invites political discussions and democratic decision making.

I would like to take the formulation of symmetrical summaries one step backwards, towards the outset of an innovative idea. How to get started with the introduction of an innovative idea? How to get started in an ANT-sensitive way? My propositions are formulated in acknowledgement of the staff members, patients, and managers who wished to make mental health care better. Here better means along the lines of more sensitive, heterogenic, and multiple. Better does not necessarily mean without technology or without medical scientific criteria. However, following these kinds of propositions require discussions of the kind of mental health care one would like to innovate towards.

Therefore, the propositions are also formulated in order to be able to be reflexive about the consequences innovative efforts may have. It can have wide effects to make minute changes. Consequently, I would like to encourage not thoughtfulness, but thingfulness. A term invented for this occasion to encourage the awareness and sensitivity of things, including things that do not seem to have any purpose or influence but may, at a closer look, involve tremendous work and effort.

An ANT-tool kit is first of all not suitable for innovative projects that have a strategic or effective purpose (Vikkelsø, 2007). Rather, an ANT-tool kit is suitable for innovation processes that wish to introduce things which seem intangible and maybe vulnerable, but are things one would like to have as part of the working practices in an organisation, but for ethical or emotional reasons. As such, an ANT-tool kit is suitable for both innovation processes formulated on a managerial level (for example the implementation of a new set of values in an organisation), and, to a high degree, for innovation processes defined by the personnel, or even by patients, customers, and users that have a belief and wish to ameliorate their practices. An ANT-sensitive
innovative model is inclusive and does not necessitate coherence and agreement with all parties.

On the basis of this point of departure, I would like to present seven points\textsuperscript{104} of ANT-sensitive propositions for conducting innovative processes in organisations. They are propositions that I feel can be stated without contradicting the basic ANT and STS assumptions of taking into account symmetry, heterogeneity, incoherence, and the idea that nothing is ever stable.

1. Make an outline and a diagram of whom and what the innovative project involves. A symmetrical approach to innovation makes it possible to encounter the interest of both people and things in the project. If your project involves patients, the inclusion of patients may be considered. Likewise, the inclusion of computers may be considered if your project involves computers. Does your project involve transportation, maybe your project should include transportation and so forth.

2. Ask and try to answer the question: How are vulnerable and intangible processes received in the organisation? This question makes visible what work is visible and what is not. It also facilitates a discussion of whether some working practices should either remain invisible, or the opposite. For example, is it accepted to have independent and closed meetings that others are not informed about? Is it accepted that new things need time to develop on its own before other people in the organisation are involved?

3. On the basis of the answers to the above enquiry, ask yourself what must be compromised in order not to disappear and become visible. If you have found that invisibility and intangibility are worth maintaining in the organisation, ask how the innovation project might be secured a platform of execution that is not at risk of disappearing despite its invisibility.

4. Ask what it is necessary to be uncompromising about in order to resist the seduction and persuasion of other practices and, thus, avoid the risk of something disappearing. Sometimes compromises make something sustainable, other times it makes the new idea disappear into ordinary matters.

5. Consider and discuss how much the project is allowed to change when it meets the surrounding practices. There is a difference in the degree of

\textsuperscript{104} Seven is not an arbitrary number. Within cognitive research it has been found that we have the ability to memorize seven points at a time. In the hope that the interested reader will take these seven points and consider them for the formulation of innovative projects in the future, I hope that the number seven helps remembering the content of the propositions.
compromising. When wanting to innovate, one can begin by trying to introduce the ideal while the experiences in practice force us to amend and adjust our ideals. When knowing how much we will allow our ideal to change, it is possible to prevent the disappearance of unsatisfied staff or management closing down projects or taking away resources because the ideal and the organisation do not link up. The purpose of this proposition is also to suggest the innovators to be proactive on the requirements of compromise coming from outside. The innovators should agree together, not necessarily in the beginning of the project but along the way when discussing the experiences of the introduction of the innovation in the organisation, how much they are willing to yield from their ideal.

6. Consider where the project will meet resistance in the organisation and how this may be dealt with. This proposition is an attempt to predict necessary compromises and, therefore, to take a stand and develop ideas to ensure how the innovation process is to be run in practice.

7. Be prepared to not know what will happen. Accept that you will be surprised; that is part of the innovation process.
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Appendix: Ethical considerations

(project description 21. Dec. 2004) Methodological adjustments have been applied subsequently to the ethical considerations formulated below. For example I did not interview patients and participate in any network meetings. I refer to the chapter on methodology for an elaboration of these issues.

In relation to training of personnel and the field work concerning personnel

At the establishment of a study group session and a training session, and following network meetings and monthly supervision sessions, the personnel will be informed that the theoretical and professional discussions from these forums, in addition to having an educative purpose also have a research purpose. This means that the researcher will collect data in these settings through the group discussions, through observation and through videos.

All research related material will be made anonymous. Video recordings will only be shown internally for educative purposes and in supervision sessions. All the participants’ written consent is obtained, both for the recordings and for any subsequent use of the recordings.

Concerning the interviewing of patients and the collection of data material concerning patients

In consideration of any possible discomfort that may arise when participating in network meetings where several people are present, the responsible staff will seek to maintain the sense of confidence and security and be especially aware of the wish of the psychiatric user to participate or not to participate. They will also be aware if this person expresses any nonverbal unease.

In the meetings where the researcher is thought to participate in the network meetings, one will always seek the verbal consent of the psychiatric user and her or his relatives.

All psychiatric users will be informed about the purpose of the network meetings and that the participation in these meetings is voluntarily based. They will be asked who they would like from their environment to participate in the meetings. If the psychiatric user wishes to have her or his children present at the meetings, this possibility will be considered in each particular case. If children are to be present every effort will be made to have a children/youth psychologist present at those meetings, if necessary as support for the children.
The psychiatric user will be informed that the usual treatment and service will continue to be offered when they participate in the network meetings.

The psychiatric user and her or his relatives will, at each single network meeting, be asked for permission to record the session if a recording is being carried out. If the participants do not wish the recording to take place, the meeting can still be held. The participants will be informed that the purpose of the recording is to learn from the conversations and, subsequently, to be able to observe body language and nonverbal conversation in the participating group.

When a debriefing is held after the use of psychiatric restraint measures in the ward, the psychiatric user will be asked whether he or she wishes to participate in this debriefing meeting, and will have the option to be accompanied by a representative from her or his network.

Participating psychiatric users will be asked for permission to make individual interviews as a follow up to the network meetings. They will be informed that this is voluntary, and that the psychiatric user can at any time and without reason decline from the wish to participate. This will not influence her or his present treatment or future treatment.

The interviewed psychiatric users will be informed that the information that is collected at the interviews will be treated with absolute confidentiality. In later reports and further articles about the study, one will be unable to recognise the individuals in the study.
Appendix: Interview guide

How did you get the idea of wanting to introduce the Open Dialogue approach?

Who decided that you should start introducing it?

Have any patients expressed the wish for you to introduce the Open Dialogue approach?

Why did you wish to change your existing treatment practices?

What has prevented you or the team from conducting network meetings with all or most of the patients, as for example is done in Augustenborg (another place in Denmark where the approach has been introduced in a youth psychiatric service).

How are patients and relatives included in your interpretation of the Open Dialogue approach?

If you are invited to a network meeting, what do you then do?

What elements of the Open Dialogue approach do you think you have introduced or have started to introduce?

What elements have not yet been introduced, and why not?
**English abstract**

This thesis deals with innovation processes in adult psychiatry. More concretely, it is concerned with a local initiative to introduce a new treatment approach in an outreach team in Southern Zealand in Denmark. The thesis has taken its point of departure in the frustration of the difficulty of finding meaning in the work voiced by the members of staff in psychiatry. This problem has lead to a curiosity of how their frustration could be handled.

The literature within innovation studies and psychiatry is diverse in both form and method. It explores everything from different treatment technologies to computer programmes, training of personnel, handling of databases etc. In these studies the goals defining what innovation is and what measures whether innovation has taken place are often logical, linear and causal. This thesis contributes by adding three things to this field of study.

With inspiration from readings within Actor-Network theory, I add heterogeneity, multiplicity and sensitivity to the field of innovation studies and psychiatry.

In the analyses, sensitivity is developed through an acknowledgement of the hard work of innovation processes that at times cannot be seen as a linear process or an overall decision about changing something from one day to the next.

The analyses in this thesis show that innovation processes are often small hesitant efforts that meet resistance and are constantly negotiated to gain foothold. Thus, to see what the innovation processes are about, one needs to acknowledge these small and at times intangible initiatives to gain knowledge about what is on its way and what these things look like. The second argument applying to sensitivity concerns the specificity of the psychiatric field. Psychiatry is in many ways a low-technological (though not a non-technological) field in the sense that the psychiatric field is concerned with people's mind through therapeutic treatment or other treatment approaches that are often practiced solely among people. Usually in the psychiatric field (as in psychiatric research), these low-technological approaches are often rendered high-technological and hereby measurable/provable by, for example, the use of scales, patient records, and satisfactory schemes. However, if one applies sensitivity to the low-technological approaches other forms of knowledge are produced. This knowledge does not necessarily produce the type of answers that we know from the medical clinical practice, as I have shown in this dissertation.
The use of heterogeneity concerns the acknowledgement that much more than people’s talk and actions are important for whether something can be changed. In this connection, heterogeneity means that the non-human aspect plays a co-constituting role in how we understand innovation processes. Therefore, my analyses included spatiality, temporality, silence, and peoples’ talk as equal actors. These aspects all contribute to what creates innovation in practice.

Multiplicity relates to the notion that realities are local. Not only are they local they are also specific and situational. This means that my analyses also show that innovation efforts, even in a tiny place as in the outreach team that I have shadowed, are practices in multiple ways. It also means that one cannot reduce what innovation is to one singular thing. Moreover, one cannot control and causally determine what will be the result in the end. In this perspective, the ways innovation processes are performed involve their dependence on laborious negotiation processes; and the result of the negotiations is never known beforehand. This means that in the innovation efforts some things match the existing practices well while other things appear to be in conflict and others again will be subversive.

The analyses in this thesis are micro-analyses and several of the efforts analysed are attempts to negotiate a platform to establish something new. The following will present the key points of seven analyses.

Firstly, the first analysis shows that innovation processes can be practiced through exclusivity. This means that the newness is performed as something special and diametrically opposite to the existing. This can be done by dissociating the new from the existing. This is referred to as “cutting connections” in this thesis. Cutting connections is, for example, part of performing the Open Dialogue approach as an approach which creates equality, and which contrasts an approach with a point of departure in the medical scientific ideal, and which creates differences between the normal and the abnormal through diagnostics.

Secondly, innovation can be about compromising or adjusting the existing practices. The chapter universal dialogue shows how it is done; but, roughly speaking, the innovative aspect lies in the way the Open Dialogue approach makes up fragmented parts that can be adjusted to the patient, relatives, satisfactory surveys, and, in addition to this, to values in the psychiatric services that involve an increased wish for respect and inclusion of patients because the Open Dialogue approach is said to have universal values.

In this version, the Open Dialogue approach also comprises elements that are not possible to translate to the existing medical scientific ideal and are therefore not considered possible to introduce to the psychiatric practice. The analysis shows that to
gain foothold in the organisation, an approach like the Open Dialogue needs to be able to compromise.

However, the danger of compromising in innovation processes is that the ideal of the Open Dialogue may risk being translated so much that it can not be recognized as something new. Consequently, if Open Dialogue is translated to be just a question about universal values already existing in the psychiatric services, what purpose does the Open Dialogue approach serve?

Thirdly, innovation processes are created over time. In the analyses of this thesis, the members of staff become present in their study group sessions, where they practice the Open Dialogue approach in specific ways. It is a way where past and future become redundant and focus is on the present. This is what I call *present temporality*. The members of staff become present in the instant by taking decisions together about what is to happen, what is to be discussed, and how it is to be done. This way of being together produces a type of knowledge that is partly collective and partly has difficulties travelling out of the present temporality in which it is created. I discuss this as a form of knowledge that is mutable but not mobile and refer to it as *mutable immobile*. The chapter *closed dialogue* raises the question whether innovation processes are dependent on being able to move and connect to other practices in order to gain foothold and acknowledgement. If it does not leave traces outside the room its existence is not provable and its foothold and acknowledgement are therefore without foundation.

Fourthly, innovation processes are created spatially. In this connection, spatiality concerns how the practice, which the outreach team tries to introduce, is special in comparison to, for instance, the spatial setup in the morning conferences where the presence of the table together with expert hierarchy and solutions to problems and questions constitute practices. The spatial setup, which is created in the practice introduced by the outreach team, is without a table but with a circle of chairs in which the members of staff sit and talk about and practice the Open Dialogue approach. This spatial setup creates intensity in at least three ways. Intensity is performed because it is hard work to keep highly technological things outside the door. Ideally, there are no agendas, no diagnostics, no decisions, and no hierarchy inside the room. It is intense because these technologies are part of the team’s daily practice. To create something new, one must negotiate with these things. A negotiation is intensified by the amount of things as well as the relative strength of the things.

This means that when one creates something new and is in the initial phase of a project, one needs very good cases in point to argue for a compromise of something that appears to be well-established in order to give room for something new. Moreover, intensity is created in this room because specific actors get more space than others.
This, however, does not mean that other actors disappear or become less important; but, the heterogeneity in the room places primary importance on the bodily interaction. This is something that I call a purified collective intensity.

In this respect, the low-technological bodies become primary. Intensity is also produced because the ordering only refers to an internal ordering. It does not connect with what is outside the room. If you draw a parallel to a thunder cloud, the measurement of electricity is extremely high within the sky, and the discharges make it possible for this electricity to be spread. This metaphor can be transferred to the intensity, as I argue for in chapter ‘intensive dialogue’.

The analysis about the intensive dialogue which produces intensity suggests that intensity can be characterised as something special about the psychiatric field, where the use of low-technology is prevalent. The specific intensity can question the organisation of the psychiatric services when intensity may put clear answers, control, and predictability on hold in favour of what is called “to endure insecurity” in the Open Dialogue.

Fifthly, the chapter on multiple presences showed that innovation processes cannot be controlled and fixed by, for example, solely changing the spatial setup. This analysis describes how the setup of the room and how the communication is performed when the members of staff exercise the Open Dialogue approach and bring several ways of becoming professional in play. When spatial setup, ways of communication, presence, and managerial responsibilities are assembled they create a practice where both collective participation and managerial responsibility are present. With this analysis, I show that spatial setups also have variable and multiple effects from which one can understand the type of knowledge that is produced in the room. From the onset, the spatial setup in the room makes a more fluid decision making process and knowledge sharing available. Initially, the participants are equal but when connections to daily practices, such as management responsibilities, are included the fluidity also becomes something that makes everything possible. Therefore, the chapter raises the question as to what forms of governmental technologies are produced in the search to make new innovation with treatment approaches that question the existing ways of decision making processes.

Sixthly, to create a new practice that compromises with the existing practices is, however, not necessarily problematic. The sixth analysis illustrates that the psychiatric knowledge, which is learned on the basis of a specifically medical world view, is not necessarily in conflict with the practicing of the Open Dialogue approach. The introduction of the Open Dialogue may be a reinforcing motivation factor to the members of staff in relation to re-discovering the meaningfulness in their work and
thereby renegotiate the way they see themselves and each other as professionals. This is connected to the original problem formulated in the thesis, namely that to an increasing extent, staff members wish to be able to find meaning in their work. To introduce a new treatment approach, as an initiative taken from the group of personnel, is in itself something that puts things in perspective and creates room for renegotiating professional identities. In this sixth analysis, the considerations of the staff show that innovation processes are about connecting the ability to care (i.e. to be present in the instant and to include patients and colleagues in the decision making processes) and simultaneously be able to treat and cure (i.e. to diagnosticate and make decisions on the basis of expert judgements).

Seventhly, innovating mental health is also about changing the existing practices rather than only inserting new practices. The chapter on fragmenting diagnostic recruitment procedures discusses how some elements in the existing practices are unavoidable. They can simply not be disregarded. They are so-called obligatory passage points. Such a point is the patient recruitment procedures governed through diagnostics. The basis of the team’s existence is the patients. One is only a patient if one has been diagnosed and hereby received an entrance ticket to the psychiatric system. So how does the system handle the introduction of a treatment approach that is not based on diagnostics? The seventh analysis describes this. This analysis discusses how innovation processes are not only about negotiating the new that is introduced but also about negotiating the existing. The diagnostic system in the recruitment procedures was fragmented to a logistical tool that could be used for organising the Open Dialogue network meetings, whereas the therapeutic tool, which the system also contains, was disregarded. Consequently, it became unproblematic to run Open Dialogue network meetings that do not have diagnostics as a prerequisite.

The particular specificity of my case, which adds to the previous local analyses, has been the sensitivity not only to spatial setups and temporality but also to silences. Silences have been absent in ANT and innovation studies within mental health. They have proven important to investigate in order to understand exactly the efforts of innovation done in the case. Silence is not neutral, and the argument in the chapter on silent work is that authority, responsibility, and decisions are distributed in the group with and through silence. The chapter investigates how knowledge claims in the realm of silence are produced as something that is not singular and not fixed precisely because the silence in these situations is not owned by anyone. The talk can therefore be taken up by different people though different types of silence have generated different effects. The chapter shows how silence can produce a passive and active collectivity. It also shows that silence can produce shifts from one type of knowledge making to another. My contribution to innovation studies and post-ANT is particularly salient in this
chapter. The silent, and therefore normally invisible, work that is involved with changing practices would not be acknowledge if one did not investigate the silence. I stress the importance of this intangible work to obtain knowledge of the measure of the challenges connected with making things in new ways.

These analyses show that innovations do not start with a decision nor end with a result. They start with a dream and end with practical negotiations.

The ambition of the seven main analyses was to show how a local innovation initiative was performed in practice. They have shown that to understand what innovation processes are and contain, one needs to include small efforts and show how tables, rooms, and presences are important for these efforts. Further, it has been important to show that the knowledge which is produced about what Open Dialogue is and has become is multiple. Open Dialogue is an ideal image of an alternative to the medical scientific ideal. At the same time, the Open Dialogue also manifests itself as commonly owned values, and isolates itself as well as closes in on itself by not employing high-technologies nor the past and future in its practice. Moreover, the member of staff must fragment the diagnostic patient recruitment procedure to be able to run Open Dialogue network meetings. All these factors indicate that innovation processes cannot be a linear and causal process. They also suggest that innovation processes cannot be one singular thing.

In the following, I have formulated seven suggestions for how to get started or continue working with innovation processes that contain intangible and low-technological practices. All seven suggestions take their point of departure in the experiences and knowledge we have gained from the local analyses and are approached through an ANT perspective.

**Propositions**

1. Make an outline and a diagram of whom and what the innovative project involves. A symmetrical approach to innovation makes it possible to encounter the interest of both people and things in the project. If your project involves patients, the inclusion of patients may be considered. Likewise, the inclusion of computers may be considered if your project involves computers. Does your project involve transportation maybe your project should include transportation and so forth.

2. Ask and try to answer the question: How are vulnerable and intangible processes received in the organisation? This question makes visible what work is visible and what is not. It also facilitates a discussion of whether some working practices should either remain invisible, or the opposite. For example,
is it accepted to have independent and closed meetings that others are not informed about? Is it accepted that new things need time to develop on its own before other people in the organisation are involved?

3. On the basis of the answers to the above enquiry, ask yourself what must be compromised in order not to disappear and become visible. If you have found that invisibility and intangibility are worth maintaining in the organisation, ask how the innovation project might be secured a platform of execution that is not at risk of disappearing despite its invisibility.

4. Ask what it is necessary to be uncompromising about in order to resist the seduction and persuasion of other practices and thus avoid the risk of something disappearing. Sometimes compromises make something sustainable, other times it makes the new idea disappear into ordinary matters.

5. Consider and discuss how much the project is allowed to change when it meets the surrounding practices. There is a difference in the degree of compromising. When wanting to innovate, one can begin by trying to introduce the ideal while the experiences in practice force us to amend and adjust our ideals. When knowing how much we will allow our ideal to change, it is possible to prevent the disappearance of unsatisfied staff or management closing down projects or taking away resources because the ideal and the organisation do not link up. The purpose of this proposition is also to suggest the innovators to be proactive on the requirements of compromise coming from outside. The innovators should agree together, not necessarily in the beginning of the project but along the way when discussing the experiences of the introduction of the innovation in the organisation, how much they are willing to yield from their ideal.

6. Consider where the project will meet resistance in the organisation and how this may be dealt with. This proposition is an attempt to predict necessary compromises and therefore to take a stand and develop ideas to ensure how the innovation process is to be run in practice.

7. Be prepared to not know what will happen. Accept that you will be surprised; that is part of the innovation process.
Dansk sammendrag

Denne afhandling handler om innovationsprocesser i voksenpsykiatrien. Nærmere bestemt handler den om et lokalt initiativ til at indføre en ny behandlingstilgang i et udkørende team på Sydsjælland. Afhandlingen har taget udgangspunkt i, at personale i psykiatrien har givet udtryk for frustrationer over det svære i at finde mening i deres arbejde. Denne problematisering har ført til en nysgerrighed i forhold til, hvordan denne frustration kunne håndteres.

Litteraturen inden for innovation og psykiatri er mangeartet både i form og metode. Den udforsker alt fra forskellige behandlingsteknologier, computerprogrammer, træning af professionelle, håndtering af databaser og så videre. I disse studier er målene for, hvad det er, der er innovation, og hvad der måler om innovationen reelt har fundet sted stringente, lineære og kausale. Denne afhandling har som ambition at lægge tre ting til disse studier.

Med inspiration i læsninger af aktør-netværksteori tilføjer jeg til innovations- og psykiatrifeltet heterogenitet, multiplicitet og sensitivitet. Sensitivitet i analyserne er udviklet ud fra en anerkendelse af, at innovationsprocesser er hårdt arbejde, som til tider ikke kan ses som et lineært forløb, eller som en overordnet beslutning om at ændre noget fra den ene dag til den anden. Analyserne i afhandlingen viser, at innovationsprocesser ofte er små spæde forsøg, som møder modstand, og som hele tiden skal forhandles for at finde fodfæste. For at kunne se, hvad innovationsprocesserne handler om, må man således anerkende disse små og til tider uhåndgribelige tiltag for at få viden om, hvad der er på vej, og hvordan disse ting ser ud. Det andet argument for at anvende sensitivitet, handler om det særlige ved det psykiatriske felt. Det psykiatriske felt er på mange måder lavteknologisk (her skal ikke forstås "ikke-teknologisk"), i den forstand, at psykiatrien beskæftiger sig med menneskers ind i gennem terapeutiske forløb eller andre behandlingsformer, der ofte praktiseres udelukkende mellem mennesker. Almindeligvis ser man i psykiatrien (som i dens forskning) at disse lavteknologiske tilgange ofte søges at blive gjort "højteknologiske" og dermed bevisbare ved f.eks. at anvende skalærer, patientjournaler, tilfredshedsskemaer. Men hvis man derimod anlægger en sensitivitet overfor det lavteknologiske, produceres andre former for viden. Det er en viden, som ikke nødvendigvis producerer de svar, vi kender fra den medicinsk kliniske praksis. Jeg har vist hvordan i afhandlingen.

Brugen af heterogenitet handler om en anerkendelse af, at meget andet end folks talen og ageren har betydning for, om noget kan forandres. Heterogenitet betyder i denne
sammenhæng, at det non-humane får en medskabende betydning for, hvordan vi
forstår innovationsprocesser. Mine analyser inddrager således rum, tid, stilhed og folks
tale som ligeværdige aktører. De aspekter er alle med til at skabe det, som skaber
innovation i praksis.

Multiplicitet handler om, at virkeligheder er lokale. Ikke nok med, at de er lokale, de er
også specifikke og situationsbestemte. Det betyder, at mine analyser også viser, at
innovationsforsøgene selv på et så lille sted som i det udkørende team, jeg har fulgt,
bliver praktiseret på flere måder. Det betyder også, at man ikke kan reducere, hvad
innovation er, til én ting. Og det betyder også, at hvis man sætter noget i gang, kan man
ikke kontrollere og kausalt bestemme, hvad der kommer ud som resultat i den anden
ende. Det måde innovationsprocesser foregår på, handler i dette perspektiv om, at det
afhænger af morsomme forhandlingssådler. Og forhandlingens resultater,
kender man ikke på forhånd. Man ved heller ikke, hvad der forhandles om, på forhånd.
Det betyder, at nogle ting i innovationsforsøgene går fint i spænd med den eksisterende
praksis, andre ting viser sig som konfliktuelle, og endnu andre vil være undergravende.

Analyserne i afhandlingen er mikro-analyser af mange af disse forsøg på at forhandle
plads til noget nyt.

For det første viste disse analyser, at innovationsprocesser blev praktiseret gennem en
eksclusivitet, hvilket vil sige, at det nye bliver gjort til noget særligt og diametralt
anderledes end det eksisterende. Det kan gøres ved at tage afstand fra det eksisterende.
Ved at gøre sig selv forskellig fra noget andet. Det er det, der kaldes at "afskære
forbindelser" i afhandlingen. Det blev for eksempel gjort ved at skabe Åben Dialog som
en behandlingstilgang, der skaber menneskelig lighed, hvilket stod i modsætning til en
tilgang med afsæt i det medicinske videnskabsideal, som skaber forskelle mellem det
normale og det unormale gennem diagnostik.

For det andet handler det at skabe innovation om at gå på kompromis eller at tilpasse
sig de omkringliggende praksisser. Den anden analyse viser, hvordan det kan gøres.
Den handler om, hvordan Åben Dialog bliver fragmenteret i dele, der kan tilpasses
patienten, pårørendes tilfredshedsundersøgelser og i øvrigt værdier i psykiatrien, som
handler om et øget ønske om respekt og medinddragelse af patienterne, fordi Åben
Dialog her siges at have universelle værdier. På den anden side har Åben Dialog i denne
udgave også elementer, som det ikke er muligt at oversætte til det eksisterende
medicinske videnskabsideal, og som derfor vurderes ikke at kunne blive introduceret i
den psykiatriske praksis. Analysen viser, at en tilgang som Åben Dialog for at få en
chance for at vinde fodfæste i organisationen, må gå på kompromis.
Faren ved kompromisser i innovationsprocesser er dog, at idealet om, hvad helheden i
Åben Dialog er, oversættes så meget, at det til sidst ikke kan genkendes som noget nyt. Det vil sige, at hvis Åben Dialog oversættes til kun at være et spørgsmål om universelle værdier, der i forvejen eksisterer i psykiatrien, hvad skal vi så bruge Åben Dialog til?

For det tredje skabes innovationsprocesser også i tid. I afhandlingens analyser er personalet til stede i deres studiegruppe, hvor de øver sig i Åben Dialog-tilgangen på en helt særlig måde. Det er en måde, hvorpå fortid og nutid bliver uvæsentlig, og fokus holdes på det, der skabes i nuet. Det er det, jeg har kaldt, at der skabes en "nutidstemporalitet". Personalet er til stede i nuet ved ikke at trække dagsordener med ind i mødet og ved ikke at tage beslutninger om fremtiden. De er til stede i nuet ved sammen at tage beslutninger om, hvad der skal ske. Hvad der skal diskuteres, og hvordan det skal gøres. Den måde, at være sammen på, producerer en type af viden, som dels er kollektiv, men dels også har svært ved at bevæge sig ud over den nutid, den skabes i. Det diskuterer jeg som en form for viden, der er foranderlig men ikke mobil, det som bliver kaldt "mutable immobile". Dette kapitel rejser spørgsmålet om, hvorvidt innovationsprocesser for at finde fodfæste og anerkendelse således også er afhængige af at kunne bevæge og knytte sig til andre praksisser. For hvis det ikke efterlader sig spor udenfor rummet, er dets eksistens ikke påviselig og dets fodfæste og anerkendelse dermed uden grundlag.

For det fjerde skabes innovationspraksisser også i rum. Rum handler i denne sammenhæng om hvordan, den praksis, det udkørende team i af handlingen søger at introducere, er særlig i sammenligning med for eksempel teamets morgenkonferencer, hvor tilstedeværelsen af bordet sammen med eksperthierarki og løsninger til problemer og spørgsmål bliver praktiseret. Rummet, der skabes, er uden et bord, med en cirkel af stole, hvorpå personalet sætter sig, når de snakker om og øver sig i Åben Dialog. Rummet skaber en intensitet på tre måder: Det er en intensitet, som kommer til udtryk, fordi det er hårdt arbejde at holde de højteknologiske ting for døren. Der er ideelt set ingen agendaer, ingen diagnostik, ingen beslutninger, intet hierarki inde i rummet. Det er intenst, fordi det er teknologier, som er en del af teamets daglige praksis. For at skabe noget nyt, må man derfor forhandle med alle disse ting. En forhandling intensiveres af antallet af ting, men også af tingenes relative styrke. Det betyder, at når man skaber noget nyt og er i opstartsfasen, skal man have virkelig gode argumenter for at overbevise noget, som tilsyneladende er veletableret, til at gå på kompromis eller så at sige give plads til det nye. For det andet skabes der intensivitet i dette rum, fordi særlige aktører får mere plads end andre. Her er dog ikke tale om, at andre aktører forsvinder eller får mindre betydning, men at den heterogenitet, der er i rummet, gør kroppenes interaktion primært. Det er det, jeg kalder en purificeret kollektiv intensitet. I dette tilfælde de lavteknologiske kroppe. For det tredje produceres der intensivitet, fordi den orden, der skabes, udelukkende refererer til en intern orden. Den har ikke

Analysen om det ’nøgne rum’, der producerer intensitet, foreslår, at det kan karakteriseres som værende noget særligt for det psykiatriske felt, hvor brugen af lavteknologi er fremherskende. Det særlige intense kan rejse spørgsmål om, hvordan psykiatrien kan organiseres, når intensiteten måske sætter klare svar, kontrol og forudsigelighed på stand-by til fordel for det, som man i Åben Dialog kalder at ”udholde usikkerheden”.


Det at skabe en ny praksis, som går på kompromis med noget eksisterende, er dog ikke nødvendigvis problematisk. Det viser den sjette analyse. Her er der tale om, at den psykiatriske viden, som den læres med udgangspunkt i et primært medicinsk verdenssyn, ikke nødvendigvis er i konflikt med det at praktisere Åben Dialog. Introduktionen af Åben Dialog har muligvis været en forstærkende motivationsfaktor for personalet i forhold til at genfinde både det meningsfulde i deres arbejde og dermed genforhandle den måde de ser sig selv og hinanden som professionelle. Dette forbinder sig til det oprindelige formulerede problem i afhandlingen, nemlig at personale efterlyser i højere grad at kunne se mening i deres arbejde. At introducere en ny behandlingstilgang på initiativ fra personalegruppen er i sig selv noget, der sætter tingene i perspektiv og skaber rum for genforhandling af professionelle identiteter. I denne analyse viser personalets overvejelser, at innovationsprocesser også handler om at forbinde en evne til både at pleje (være tilstede i nuet, inddrage patienterne og kolleger i beslutningsprocesser) men samtidig også behandle og helbrede
(diagnosticere, tage beslutninger på grundlag af ekspertvurderinger).

Der er dog praksisser i psykiatrien, der er svære at komme uden om, og som er svære at forhandle eller ekskludere fra en ny praksis. En sådan praksis er måden, hvorpå man rekrutterer patienter til et team. Grundlaget for teamets eksistens er patienter. Man er kun patient, hvis man har fået stillet en diagnose og dermed fået en adgangsbillet til det psykiatriske system. Så hvordan håndteres det, hvis man introducerer en behandlingstilgang, som ikke er baseret på diagnostik? Det beskriver den syvende analyse. Denne analyse handler om, at innovationsprocesser ikke kun drejer sig om at forhandle det nye, der introduceres, men også om at forhandle det eksisterende. Diagnosesystemet i rekrutteringsproceduren bliver således fragmenteret til kun at have en logistisk anvendelse frem for også at have en terapeutisk anvendelse. Det gør det derved uproblematisk at holde Åben Dialog-netværksmøder, som ikke har diagnostik som udgangspunkt.

Det særligt specifikke ved min case har udover alle de foregående lokale analyser været noget, som i aktør-netværkslitteraturen og i innovationsstudier har været fraværende, nemlig stilhed. Stilheder har vist sig at være vigtige at gøre synlige for at forstå lige præcist de innovationsforsøg, der er blevet foretaget i det udkørende team i casen. Den måde, der er stille på, er ikke neutral, og argumentet i kapitlet er, at der igennem og med stilhed distribueres/spredes autoritet, ansvar og beslutninger til gruppen. Det sidste analysekapitel om stilhed diskuterer, hvordan den viden, der produceres i stilhed, er viden, som ikke kan være entydig og fikseret, netop fordi stilheden i disse situationer ikke ejes af nogen og talen dermed kan tages op af forskellige. Forskellige stilheder har dog forskellige effekter. Kapitlet viser, hvordan den kan producere passiv kollektivitet og aktiv kollektivitet. Det viser også, at stilhed kan producere skift fra en type af videnskabelse til en anden.

Det er særligt i dette kapitel, at bidraget til innovationsstudier inden for det psykiatriske felt bliver tydeligt. Det stille og derfor almindeligvis usynlige arbejde, der ligger i at forandre praksis, vil ikke blive anerkendt, hvis man ikke undersøgte stilhed. Når jeg understreger vigtigheden af at rette opmærksomhed på dette subtile arbejde, er det for også at få en viden om, hvor store anstrengelser der ligger i at gøre ting på nye måder.

Innovation starter ikke med en beslutning og slutter ikke med et resultat. Det starter med en drøm og slutter med praktiske forhandlinger.

Analyserne har haft som ambition at vise, hvordan et lokalt innovationsinitiativ blev til i praksis. De har vist at for at forstå, hvad innovationsprocesser er og indeholder, må man inddrage små forsøg, og vise hvordan både borde, rum og tilstedeværelsesformer

Såfremt man ønsker at arbejde videre med innovationsprocesser, der rummer det uhåndgribelige, det flygtige og det lavteknologiske, har jeg formuleret syv forslag til, hvordan man kan gå i gang. Alle syv forslag tager afsæt i de erfaringer og den lærdom, vi har fået fra de lokale analyser, og er set med udgangspunkt i en aktør-netværksteoretisk optik.

**Forslag**

1. Lav et overrids og et diagram over hvem og hvad innovationsprojektet involverer. En symmetrisk tilgang til innovation gør det muligt at tage højde for både mennesker og tings interesser i projektet. Involverer dit projekt patienter, så skal det måske overvejes, at inddrage patienterne i innovationsprocessen. Involverer dit projekt computere, så skal computere måske inkluderes. Involverer projektet transport, så overvej om transport skal involveres, osv.


3. På baggrund af svarene af ovenstående undersøgelse kan man spørge ind til, hvad der er nødvendigt at gå på kompromis med for at undgå at projektet vil forsvinde og etablere sit initiativ som synligt. Hvis du har fundet, at usynlighed og uhåndgribelighed er værd at opretholde i organisationen, spørger du hvordan innovationsprojektet kan sikres en platform for udførelse, som ikke risikerer forsvinden uagtet dets usynlighed.

4. Spørg hvad det er nødvendigt at være kompromisløs omkring for at undgå overtalelse og forførelsen fra andre praksisser og dermed undgå forsvinden i compromisser, der risikerer at udvande innovationsprojektets unikhed.

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5. Overvej og diskuter, hvor meget innovationsprojektet kan tillades at forandres, når det møder omkringliggende praksis. Der er forskel på graden og omfanget af kompromisser. Når man vil innoverer, kan man starte med at prøve at introducere idealet om innovationsprojektet. Men ens erfaringer fra praksis tvinger én til at ændre og tilpasse idealerne. Når man ved, hvor meget man vil tillade idealet at ændre sig, er det muligt at forebygge forsvinden af utilfreds eller udbredt personale, af ledere som lukker projekter eller fratager det ressourcer, fordi idealet ikke forbinder til organisationen, projektet er introduceret i. Dette forslag er også formuleret med henblik på, at igangsætttere kan være proaktive omkring de krav om kompromisser, der eventuelt skulle komme udefra. Igangsættelerne skal sammen blive enige om dette, om end ikke nødvendigvis i begyndelsen af projektet, hvor man ingen praktiske erfaringer har med det, eller er klar over hvor meget man er villig til at bortvige fra ideaflet.

6. Overvej hvor projektet vil møde modstand i organisationen og hvordan dette kan håndteres. Dette forslag fremføres for at forsøge at forudse de behov for kompromisser, der måtte opstå. Det gør det muligt at tage stilling og udvikle ideer til, hvordan innovationsprocessen skal forløbe i praksis.
