Staff experiences of significant moments in systemic team formulation on adult inpatient mental health wards.

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Author Declaration

I, Claudia da Rocha Kustner, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that: This work was done wholly or mainly while in candidature for a research degree at this University;

Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

Where I have drawn on or cited the published work of others, this is always clearly attributed; Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work; I have acknowledged all main sources of help;

Where the thesis or any part of it is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

Either none of this work has been published before submission, or parts of this work have been published in the following publication of mine:

Kustner, C. (2017) Team formulation, post-incident debriefing and staff support in *Oxford Textbook of Inpatient Psychiatry* (Ed.) Oxford University Press.

Acknowledgements

“Poems are like flowers

They draw your eye to something beautiful

But they remain creatures of rain and soil.

The work to lift a violet into the light happens down in the dark.

Each bright petal marks the passing of a hundred earthworms. -Anderson, 2022, p57

To the rich soil, the fertile seeds, and hundreds of loving earthworms that laid the foundation for this research to blossom -

Thank you to my past and current research supervisors and mentors at the Tavistock, for all your thoughtful feedback and support - Sarah, Stephen, Britt, Rabia, and to my supportive and encouraging M10 colleagues – Vanja and Andre.

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Abstract

Although studies have found potentially positive benefits and challenges of team formulation practice, what the research field is currently lacking is context around why team formulations are seemingly having this impact. In this practice-based research, I aimed to examine my practice of systemic team formulation, and to explore what moments team members experienced as being transformative and/or significant in the process of systemic team formulation. I conducted focus group interviews with staff at an acute inpatient mental health service, where I work, to explore this topic. I analysed the data using an interpretive phenomenological analysis framework for focus groups (Palmer et al., 2010) with some systemic adaptations of my own. There was some overlap of findings with regards to the benefits and challenges of team formulation cited in other studies, but there were also some novel findings about what staff members found to be significant in the process of systemic team formulation, such as giving team members permission to think systemically and relationally about client systems and themselves. There were also themes around some of the dominant discourses in acute inpatient mental health wards which systemic team formulation, perhaps inadvertently, challenges. These findings may give insight into the key change moments for teams in the process of systemic team formulation, and may have tentative implications for the practice of team formulation more broadly, and for the practice, training, and supervision of systemically influenced team formulation practitioners.

Key words:

Systemic team formulation, team formulation, acute inpatient mental health, change process research, systemic therapy, interpretive systemic phenomenological analysis

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Chapter 1: Introduction and Overview

"Step inside my cabin and hang your coat by the door…

It's no trouble that our meeting place is imaginary. Many worthwhile things are."

Jarod K. Anderson. 2022, p1[1]

1.1. Overview – What I am doing here and why?

Psychological formulation can be described as an outline of a client's difficulties, based on psychological theory, and informing the intervention (Johnstone and Dallos, 2014). Team formulation is the use of formulation in health and social care teams to develop a shared understanding of the client's difficulties. It is also a psychotherapeutic intervention for staff members who work with client systems[2] in health and social care. The objective of team formulation meetings is to facilitate a process of formulating a shared team understanding of a client system which can then be used in interventions and collaborative care plans with the client system and their wider support teams. Johnstone (2013) has even argued that team formulation also provides a radical alternative to psychiatric diagnoses; can be used as a powerful instrument for culture change in organisations; and provides a much-needed space for busy teams to think, process and understand intrapersonal and interpersonal feelings and behaviours.

[1] Reading poetry helps me with my systemic thinking and reflection. My research analysis and writing process was interspersed with restful breaks of poetry reading. Thus, I have interspersed quotes from my favourite poets and systemic thinkers in this thesis too, to share my creative inspirations.

[2] The term 'client system' refers to a group of people that a professional is responsible for helping. This can include the client and the members of the client's support network or can also refer to teams within an organisation. From a systemic psychology perspective, even when a therapist is only working with an individual, they are still considering and indirectly working with the client's system too.

Team formulation has been shown in research studies to have numerous intra- and interpersonal benefits for teams that engage in the process of shared formulations. When conditions for effective teamwork are prioritised, there is evidence that service delivery improves, and health care organisations operate more effectively (Onyett, 2007). Despite recent guidelines by the British Psychological Society (Onyett, 2007, p22) and other researchers (Johnstone and Dallos, 2014) recommending the applied psychology intervention of team formulation as "an effective use of a psychological practitioner's limited time" and a "powerful way of shifting cultures towards more psychosocial perspectives" (DCP, 2011, p9), very little has been written about the actual psychological and social processes which happen in team formulation (Corrie and Lane, 2010; Kuyken, et al 2011), particularly in adult acute inpatient mental health contexts. There is still limited although growing evidence to support it as a specific intervention for staff, in its own right (DCP, 2011). To date, there have also been no studies evaluating the impact of the team on the formulation (Short et al., 2019) i.e., how do the beliefs, thoughts, and feelings of the individual team members, as well as of the team as a whole, impact on the formulation that is put together.

While there have been numerous studies in recent years about the benefits and challenges of team formulation (as discussed and referenced in the next chapter), there is not yet clarity about what specific processes and moments of team formulation elicit change in teams and/or are experienced as being transformative or significant by team members. There is a gap in the research about what are the key *differences that make a difference* in team formulation, and why. As team formulation is a key area of my clinical practice, I also wondered what these possible significant moments in team formulation might reveal about me; the teams I work with; and the acute adult inpatient

mental health context where I regularly practice as a systemically trained clinical psychologist. These were some of the initial musings that prompted me to explore this topic and to conduct the research from a practitioner-based, insider research position.

There are innovative approaches to supporting staff in acute settings (Bullock et al., 2021), but there is limited research investigating the use of team formulation as a staff-focused intervention on acute psychiatric wards. A very recent study by Kramarz et al., (2022) had similar aims to my study and was conducted in a similar setting. It aimed to explore staff experiences of team case formulation with a particular focus on challenging behaviour on acute psychiatric wards. It differed from my study though, in that it was not specifically focused on exploring significant or transformative process moments of team formulation for staff, and it also focused particularly on team formulations to address challenging behaviour. As such the psychological models of formulation used in that study aimed particularly to increase understanding of challenging behaviour, such as the Newcastle model (James, 2017). Various models of team formulation based on psychological theories have been proposed in studies over the years, often CBT (such as Kennedy et al., 2003; Berry et al., 2009), 5 Ps (as in Roycroft et al., 2015), psychodynamic model (such as Davenport, 2002) and integrative approaches (such as Lake, 2008). In this study I will be exploring my practice using my own systemic adaptation of an integrative model of team formulation proposed by Lake (2008).

Systemic team formulation is an area that is yet to be researched, and one that I was interested in exploring, as it is a key area of practice in my work at an acute inpatient adult mental health care hospital. Another integral aspect of my clinical practice is

supervision of psychology staff, drawing on systemic approaches to make theory-practice links. Studies note that, for various reasons, nursing staff in acute mental health hospitals struggle with the implementation and facilitation of regular and reflective clinical supervision (Cleary et al., 2010). As such, the staff support groups I was facilitating including team formulation sessions, evolved into a form of team-centred supervision discussions, where staff used the space to reflect on their practice, on themselves, and on clinical cases. Systemic team formulation sessions thus offered a blend of supervision and clinical formulation using systemic principles to link theory to practice, both of which can be seen as transformative, applied psychological interventions (see figure 2.4 on pg. 55). I am particularly drawn to team-based therapeutic interventions and group supervision in my clinical practice, because those processes allow me to draw on my systemic therapy skills of facilitating multiple voices in the room.

Systemic theory provides a unique lens to make hypotheses about the reasons for people's difficulties, as it particularly considers relationships and interactional patterns, not only within the client system but also between healthcare professionals and clients. Systemic team formulation incorporates elements of the various approaches in systemic family therapy, including solution focused, strategic and structural approaches and, as seen in the results of this study, embodied aspects too. It also draws from attachment perspectives in that it endeavours to offer a secure base for staff members. This will be discussed further in Chapter 2, section 2.4.

In this study I wanted to better understand the process of systemic team formulation by exploring the moments of team formulation which team members working on an

acute, adult inpatient ward experienced as transformative and/or significant. Significant moments research is a specific approach to 'studying client-identified important moments in the therapy process' (Timulak, 2010, p421). Thus, when I refer to 'significant events or moments' in this study, I am curious about exploring what events or moments (cognitive, emotional, social, and/or physical) team members specifically remembered and experienced as being transformative and/or significant in the process of systemic team formulation for them. The rationale for this type of change process research is based on the premise that moments which clients perceive and identify as being significant, often point to the 'most fruitful therapeutic work,' with regards to helpful or hindering events in the process (Timulak, 2010, p422).

Change process research (Elliott, 2011) aims to understand the nuanced and complex processes of therapy from a constructivist paradigm by means of hermeneutical methods. These change processes are often understated in some evidence-based psychotherapy research studies, which are based on a positivist paradigm. Research focused on client-reported descriptions of aspects of therapy which they found significant, known as significant moments research (Elliott, 2010; Timulak, 2010) is a strategy in qualitative, discovery-orientated methods to better understand therapeutic processes from the position of client and therapist. Whilst the literature on change mechanisms for team formulation is limited, there have been recommendations for future research that focus on specific changes that occur because of team formulation (Ingham et al., 2011).

1.2. Research questions, aims, and processes

The central research questions of my study were:

1. What types of events or moments in the process of systemic team formulation do team members describe as being transformative and/or significant for them?
2. Why do they experience those events as being transformative and/or significant?
3. What are the emergent individual, relational and /or organisational experiential themes and patterns mentioned?

I will attempt to answers these questions in Chapter 4 and 5, where I describe and discuss the findings of focus group interviews which I conducted with team members, where I explored these questions with them. I also include my reflections in the discussion, as a practitioner-researcher too. While this study has been immensely valuable to learn about my own team formulation practice, I also hope to add to the growing literature base of systemic therapy interventions and research methodologies, and hope that the process and findings of my study can be applied within an acute inpatient psychiatric setting, and in today's dynamic NHS mental health system - characterised by high levels of work demands and rapidly changing structures and culture (Onyett, 2007). As opposed to the once popular, scientific research model, recent studies show that advances in research are more likely to come out of clinical practice than out of research labs (Russell and Kelly, 2002). Researchers are thus more likely to be practitioners themselves, with a need to evaluate their own clinical hypotheses (Pistrang and Barker, 2010; Barker, Pistrang and Elliott, 2015).

A team of multi-disciplinary staff, including nurses; psychiatrists; support workers and therapists; working on an acute inpatient psychiatric ward where I currently practice, were invited to participate in focus groups where I asked them to discuss their perceptions and experiences of what events or processes were transformative and/or significant for them during a number of systemic team formulation sessions done across various wards, and what made these events significant. I analysed the data with an interpretive phenomenological approach outlined for use with focus groups (Palmer et al., 2010), with some systemic adaptations of my own, discussed in detail in Chapter 3. Systemic clinicians are trained and skilled at observing relational processes and attempting to understand complex interactions, and as such can offer creative ideas to the field of qualitative research methods with regards to interactional methodologies (Burck, 2005). I endeavoured to identify systemic themes and patterns discussed within my practice of team formulation sessions, with the aim of exploring what processes team members experienced as being significant in these sessions.

In response to a general call for a closer link between clinical practice and research (Pinshof and Wynne, 2000; Barker et al., 2015), my study attempts to bridge systemic therapy theory, qualitative research inquiry, and systemic therapy practice. I also considered and explored the ways in which systemic ideas could be integrated into team formulation as a therapeutic practice. Heatherington et al., (2015) argue that there is an increasing need (practically and theoretically) for systemic thinking and therapies, which involves attention to interpersonal and contextual variables, to move beyond family and couple therapy. They state:

> “The fields of systemic psychotherapy and clinical psychology need to transcend the arbitrary family, couple and individual therapy distinctions and

> move toward a more inclusive, applied, and integrative perspective that links the systemic, organisational, and individual into an optimally successful psychotherapy" (p.359).

I believe that team formulation practice is a useful and essential tool to add to a psychological practitioner's therapeutic toolbox. It can enhance and improve family, couple, and individual therapy work, as it provides an opportunity to work in a more inclusive, applied, and integrative way with teams caring for client systems, and is a therapeutic avenue for supporting teams working with client systems too.

1.3. My professional and personal context, influences, and journeys

"I have slow, apricot memories.

> *I think I seek them in a grandmother and a kitchen heavy with years.*
>
> *Gabeba Baderoon, 2006.*

When I started thinking about pursuing a Doctorate/PhD study at the end of 2015, my initial intention was to pursue a career in academia. I had immigrated to the United Kingdom from South Africa over a year and a half ago and had just about learnt how to 'speak NHS.' I was working as a clinical psychologist at my then (and still current) work context – an acute adult inpatient mental health hospital in Berkshire and was adjusting to working in a context defined by chaos, containment, control, and crisis (Kustner, 2019).

I was getting monthly systemic supervision from Dr Arlene Vetere, which was helping me ground and affirm my systemic skills in a new country. She encouraged me to consider a professional doctorate in systemic psychotherapy at the Tavistock, and she

continues to provide a safe base for my personal and professional systemic practice. It was then that my journey into exploring my own systemic practice in the UK began, and my learning about what holding a both/and position really entails started. In considering an ocean of research topics, I remember pondering in my research diary and with my M10 Doctorate colleagues and mentors:

What aspects of my practice am I interested in exploring? What am I proud of? What do I have to offer to the field of clinical psychology and systemic therapy in this new country I find myself in? What do I bring with me from my professional fields in South Africa? What do I have to learn? What challenges and dilemmas have I faced working as a systemically trained clinical psychologist in the UK, and in a work context which privileges psychiatry, objectivity, and neutrality?

In South Africa I had worked for over seven years as an 'applied clinical psychologist.' My 'therapy rooms' were often universities, community centres, charities, schools, board rooms, and training centres where I worked as a health psychologist in the field of HIV/AIDS counselling, and behaviour change work. My practice was heavily influenced by my systemic training and mentors at the time (Vorster, 2003; Mtimkulu, 2002; Marchetti-Mercer et al., 1999; Brouard, 2009), all of whom had a strong background and passion for general systems theory, structural and strategic systemic therapy approaches, community work, and multicultural practice. Alongside my systemic mentors and role-models here in the UK (Vetere, 2007; Krause, 2010; Malik, 2003; Helps, 2017) their voices and perspectives echo in this thesis and in the systemic language and perspectives I use throughout.

Both personally and professionally, I especially value the skill and art of observation, taking a meta-perspective on life, viewing things from above, taking a bird's eye view, and widening perspectives. All of which team formulation encourages. I enjoy partaking in aerial silks, which I think metaphorically embodies this position. I acknowledge however, that what I am 'viewing from above,' is very much from my lens and coloured by my beliefs, experiences, and feelings.

My professional identity cannot be separated from my personal identity (Krause, 2010). I am a white, cisgendered, childless, able-bodied woman, working in a position of high banding in the NHS. I am an immigrant from a working-class background, but with access to a myriad of financial, educational, and occupational privileges, which affect how and what I observe. I am thus limited by what I choose to observe and attend to; and I am mindful of always trying to hold my hypotheses lightly (Cecchin, 1987). From a second-order cybernetic perspective, I am not separate from this meta-perspective, I create it, and I am influenced by it, from my frame of reference and position. I try and hold this perspective and epistemology throughout this research study.

Systemic ideas about taking a self-reflexive meta-perspective, looking for patterns, interactional dances, and feedback loops in organisational cultures and structures, is at the heart of how my practice of systemic team formulation evolved. When I started working at the acute inpatient hospital in this study in 2014, there was already some advocacy for the provision of team formulation on the wards by psychologists who had some, but limited, input on a few of the wards. I was the first psychologist employed

to work full-time across two of the five adult mental health wards. The model of team formulation that was being used was the integrative model by Lake (2008). Over the years I have adopted this model in my practice and slowly shaped it, aligning with aspects of it that resonated with my systemic background – I did this by choosing to centre the team in the formulation, and focusing particularly on the relational and circular dynamics between staff and patients, as well as including discussion on issues of power and difference. I will discuss this further in the next chapter in the section on systemic team formulation.

The hospital leadership team at the time of the study supported the provision of team formulation on the wards, as they saw it as a useful space for staff supervision, debriefing, and support. They continue to do so currently. Over the last 6 years, with my perseverance to preserve team formulation as an essential practice of inpatient psychology practice, the ward teams have also started to view team formulation as an integral space to discuss complex client systems, to reflect on ward-based care plans, and to explore alternative ways of engaging with client systems, which highlights the progress in it being used as a relational and systemic intervention. Due to continued support and advocacy from the consultant psychologist (and my line manager) at the hospital, team formulation is now seen as a vital element of psychology provision on all the wards, but there is still some work to do to embed it as an essential practice on the wards, given the continuing and dominant biomedical discourses of treatment and care.

1.4. Insider practice-based research

'I' is a verb masquerading as a noun.

Julian Baggini, quoted by Grayson Perry, The Guardian, 4 October 2014

In this research study I was researching my own practice, as such I was an insider researcher. I was also in the position of being both a participant-observer and facilitator of the team formulation sessions I conducted for this study.

Current qualitative research models advocate for a reflexive evaluation of the research process and promote an explicit deconstruction of discourses to ensure research is more transparent and accountable. The professional Doctorate at the Tavistock encourages practice-based research, as it is helpful for systemic practitioners to understand, build upon, and disseminate research about their everyday practice (Helps, 2017). It does not, however, come without ethical dilemmas and complexities, particularly around roles, position, and power. It was thus important for me to examine how my role as the researcher, and intra-subjective factors affected the research methodology, results, and discussion (Finlay, 2002).

Helps (2017) argues that it is important that insider researchers consider reflexivity throughout the *whole* research process, and not just as an add-on reflection section when discussing data analysis. In this research study, I endeavoured to adopt a 'withness' position rather than an 'aboutness' position in relation to all elements of my research process (Shotter, 2004). I attempted to do this by transferring my regular clinical, relational, therapeutic, and ethically guided skills from my practice work into

my research work. Helps (2017, 361) refers to this as a ‘dynamic relational ethics of care’ (see figure 1:1 for a visual diagram of the two key elements I held in mind).

In my research journey, this meant:

- Managing the tension of moving between the role of clinician and researcher (Stensland, 2003) by creating a distinction between my clinical practice (the team formulation sessions, which I facilitated as part of my usual practice with teams), and my practice-based research (the focus group interviews, which I facilitated as part of the research practice, with team members who volunteered to participate in the research). This distinction was made clear to team members in the team formulation sessions prior to the focus group interviews and was also clearly stated and discussed with research participants in the information sheet and in the informed consent forms and discussion.
- Using my therapeutic alliance with participant team members and my clinical skills to create and maintain a safe, dialogical space in the focus group interviews.
- Anonymising my material to protect the identity of participant team members, while also attempting to present the findings authentically to contextualise their roles and positions (Helps, 2017).
- Explicitly incorporating the use of self in my data analysis process and in my write up of the findings.
- Being mindful of the words and language in my research write-up, as I attempted to compassionately reflect on the words of participant team members (Helps, 2017).

- Conducting team formulation sessions and focus groups on a range of wards (some where I knew and worked with the staff, and others where I did not) also allowed for me to experience different positions as a researcher and allowed for a varied and richer set of data to be collected.
- Considering how the research process and findings have affected my practice.

Figure 1.1: Figure illustrating the key elements of the 'dynamic relational ethics of care' which I held in mind as a practitioner-researcher (Helps, 2017)

I was aware that asking fellow team members to reflect on an aspect of my practice would possibly affect their openness and feedback to me. However, I also think that my therapeutic relationship to them may have served as an important starting point for a successful therapeutic process and as a medium for change, both in my position as facilitator of team formulations and as a practitioner-researcher. Clearly et al (2012) have suggested that much like the creation of a safe, therapeutic space built on 'contextual rapport' and shared experiences, the relationship between the facilitator of a team session and the team is key. The same could be said of the relationship

between researcher and participants in qualitative research. The facilitator and researcher cannot come into the space as a neutral, unbiased visitor (Simon, 2014). While this may, from a positivist view, create possible ethical dilemmas, it is also an opportunity for me as a facilitator/researcher to be more easily able to immerse myself in the narrative identities that are developed in conversation with others. The skill of the therapist thus, is the expertise to participate in this process and to observe it, which is key in psychotherapy process research (Jensen in Vetere and Stratton, 2016).

It was important for me to acknowledge the possible power imbalances between myself and participants (Finlay, 2002). Threaded throughout my research study, I have tried to explicitly examine my own roles and values (Burck et al., 2013) as well as acknowledging my subjectivity in the research processes (Finlay, 2002). Foucault reflected that power is relational and that power builds as more people come to accept the specific views associated with a belief system (Jensen, in Vetere and Stratton, 2016). I unavoidably share my belief system and worldviews when discussing systemic ideas and relational hypotheses with teams in team formulation sessions, and these beliefs and views are also inevitably infused in my data analysis and findings too. I kept a research diary to make process notes and self-reflexivity notes throughout the research process, and I have attempted to incorporate these self-reflexive aspects of my own practice in the research findings and discussion.

Campbell (in Barrett et al., 2018) notes that team members in organisations often hold beliefs and perspectives not about themselves, but about how they position themselves, and are in turn positioned in their relationships. This systemic understanding is made explicit in the systemic team formulation sessions I facilitate,

and I also considered it in the data collection and analysis of this study. To gain perspective on these possible positions, I asked another therapist to interview each me after the focus group interviews. I shared these reflections in my data analyses and findings too.

1.5. Organisation of thesis

This thesis has five chapters.

Chapter 1 - In this chapter, which you have just read, I provide some contextual information about the overall aims, rationale, and process of the study and state my research questions. I offer some personal and professional reflections to introduce myself and explain how the model of systemic team formulation emerged and evolved in my practice on the wards. I also explore my position as an insider researcher-practitioner.

Chapter 2 – In the literature review I critically present a broad range of research studies and literature in relation to the key factors of my research questions and aims. I discuss my practice-based perspectives on systemic team formulation.

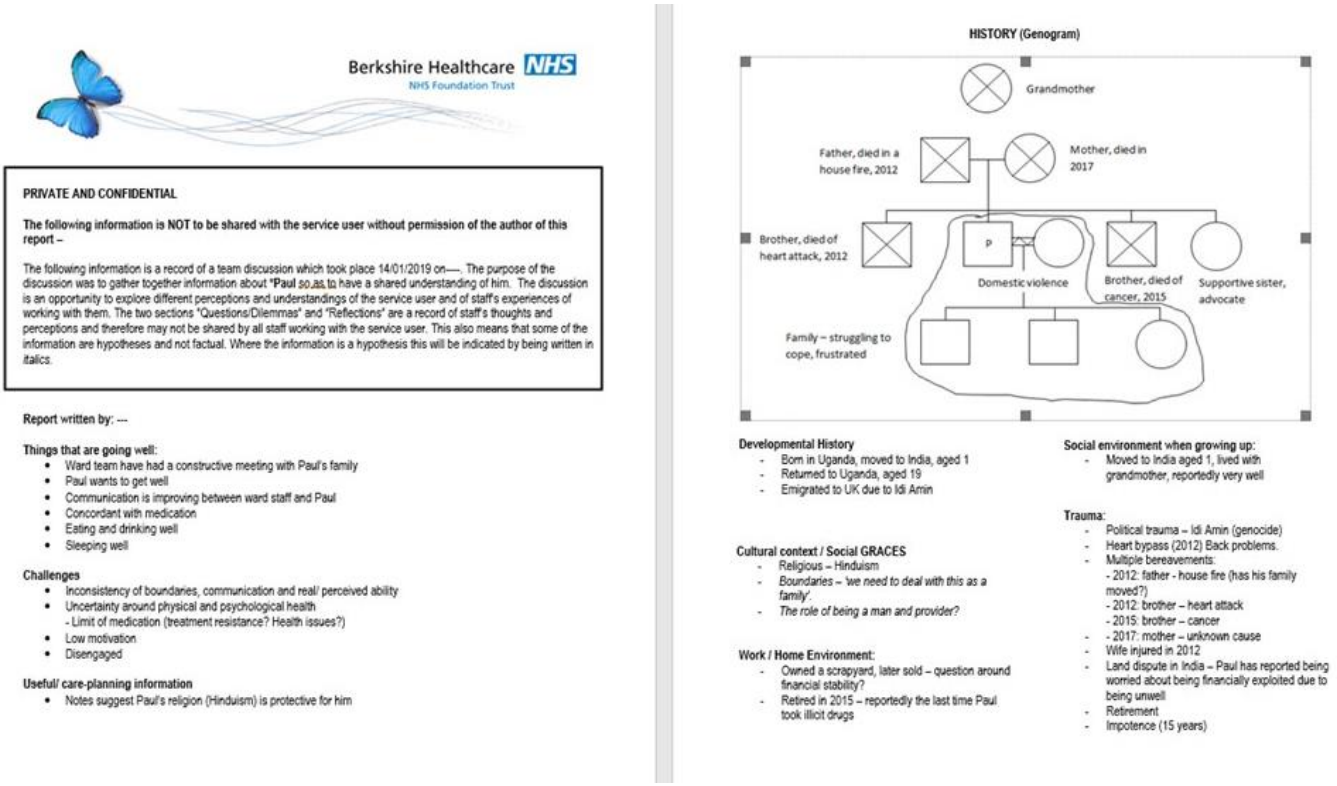
Chapter 3 – In this chapter I describe the methodology and methods, research design and ethical issues. I clearly outline my epistemological position which was a guiding framework for my research, and I describe the adapted IPA data analysis methods I developed and used.

Chapter 4 – In the findings and discussion chapter, I describe the various layers of analysis and present the findings and themes in relation to existing literature.

Chapter 5 – In the conclusion, I draw out limitations of the study, and present concluding remarks in relation to implications for training and practice and ideas for further research.

Chapter 2: Literature Review –Systemic Team Formulation

"What is the pattern that connects the crab to the lobster, and the orchid to the primrose, and all four of them to me? And me to you?" - Gregory Bateson, 1979



Berkshire Healthcare NHS
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL

The following information is NOT to be shared with the service user without permission of the author of this report –

The following information is a record of a team discussion which took place 14/01/2019 on—. The purpose of the discussion was to gather together information about *Paul so as to have a shared understanding of him. The discussion is an opportunity to explore different perceptions and understandings of the service user and of staff's experiences of working with them. The two sections "Questions/Dilemmas" and "Reflections" are a record of staff's thoughts and perceptions and therefore may not be shared by all staff working with the service user. This also means that some of the information are hypotheses and not factual. Where the information is a hypothesis this will be indicated by being written in italics.

Report written by: ---

Things that are going well:
- Ward team have had a constructive meeting with Paul's family
- Paul wants to get well
- Communication is improving between ward staff and Paul
- Concordant with medication
- Eating and drinking well
- Sleeping well

Challenges
- Inconsistency of boundaries, communication and real/ perceived ability
- Uncertainty around physical and psychological health
  - Limit of medication (treatment resistance? Health issues?)
- Low motivation
- Disengaged

Useful/ care-planning information
- Notes suggest Paul's religion (Hinduism) is protective for him

HISTORY (Genogram)

Grandmother
Father, died in a house fire, 2012
Mother, died in 2017
Brother, died of heart attack, 2012
P
Domestic violence
Brother, died of cancer, 2015
Supportive sister, advocate
Family – struggling to cope, frustrated

Developmental History
- Born in Uganda, moved to India, aged 1
- Returned to Uganda, aged 19
- Emigrated to UK due to Idi Amin

Social environment when growing up:
- Moved to India aged 1, lived with grandmother, reportedly very well

Trauma:
- Political trauma – Idi Amin (genocide)
- Heart bypass (2012) Back problems.
- Multiple bereavements:
  - 2012: father - house fire (has his family moved?)
  - 2012: brother – heart attack
  - 2015: brother – cancer
  - 2017: mother – unknown cause
- Wife injured in 2012
- Land dispute in India – Paul has reported being worried about being financially exploited due to being unwell
- Retirement
- Impotence (15 years)

Cultural context / Social GRACES
- Religious – Hinduism
- *Boundaries – 'we need to deal with this as a family'.*
- *The role of being a man and provider?*

Work / Home Environment:
- Owned a scrapyard, later sold – question around financial stability?
- Retired in 2015 – reportedly the last time Paul took illicit drugs

Coping Strategies / Strengths:
- Concordant with medication
- Physical assistance form staff
- YouTube – listening to prayer music
- Historically, illicit drugs

Social Support:
- Family, though they're frustrated and unsure of what to do next

ONGOING CYCLE

Hypotheses – Client beliefs:
- "I'm a failure."
- "I'm useless/ worthless."
- "I'm doomed."
- "I need care."

(Family beliefs)
- "Our family is doomed"
- "We can't trust healthcare"
- "We feel trapped/hopeless"

Symptoms / emotions:
- Low confidence
- Rumination
- Depression
- Anxiety

Behavioural patterns:
- Calls family often (anxiety)
- Complains
- Mumbles
- Needs reassurance when staff are visible, but is observed to be independent when staff aren't visible

Our Feelings / Our beliefs
- Fed up
- Worried about physical causes
- Frustrated – inconsistency
- Stuck – complexity
- Sympathetic – difficult to understand
- Begrudging

"He's just attention seeking"
"He's high risk / complicated"
"Medically unexplained"

Responses/ repeated relationship responses:
- Irritable with him and family
- Assertive (sometimes stern) encouragement
- Silenced (due to continued frustration)
- Over help to pacify
- Avoid him
- Refer him to specialists? ECT?

REFLECTIONS/ ACTIONS
- Remind Paul of his strengths, discuss strengths and positive achievements with family
- Try to balance caring and encouraging independence; patiently wait during assistance
- Approach Paul with curiosity – what are his interests?
  - gaming

Figure 2.1:

Team formulation template example

(See appendix A)

The aim of this literature review is to critically present a broad range of research studies and literature in relation to the key factors of my research questions and aims. I used a range of databases, including Google Scholar, PsychSource, PsycInfo, and the Family Therapy and Systemic Research Centre, to search for literature on formulation and team formulation, staff experiences of team formulation, systemic formulation, and research on team formulation, in various contexts particularly in inpatient wards. I also requested an evidence search from the library services with those key terms too.

As team formulation is a form of psychological formulation done with groups, I have also looked at, and included in this literature review: some relevant and current literature on psychological formulation; reflective practice in groups; systemic theory and formulation; and relational reflexivity, as they encompass key factors in my research too.

In addition, in the Methodology (Chapter 3), I have done a literature review on the change process research framework and have explored some literature on my epistemology in relation to this method too.

When I started my research study in 2016, there were not many studies on the topic of team formulation, but since then, there has been a growing evidence-base on the topic, from various psychological modalities and in a range of clinical contexts. To date and to my knowledge, there have been no studies specifically looking at staff experiences of *significant or transformative moments* in team formulation using change process research as a framework and IPA for focus groups as the analysis

method, but there have been numerous studies on staff experiences of team formulation, and a few studies of staff experiences of team formulation done in inpatient settings, which I discuss in this chapter. There is also not much literature on team formulation using systemic theory and principles, however I have included literature on systemic formulation in general (Johnstone and Dallos, 2014; Vetere and Dallos, 2019).I will be structuring this chapter in a similar format to how I would usually structure a team formulation session in my practice (see figure 2.1), as a way of demonstrating the iterative and unfolding nature of formulation sessions in my presentation of the literature.

Much like team formulation sessions start with a brief explanation of what team formulation is, I will start by exploring the definitions of formulation and team formulation in section 2.1.1. Team formulation session reflections usually begin by exploring with team members what is going well for the client system and what the challenges are, so in section 2.2. I will describe the researched benefits, opportunities, barriers, and challenges of team formulation. A discussion on historical background factors, including a genogram, usually follows in team formulation sessions, similarly I will elaborate on the development and growing evidence base on team formulation in section 2.3.

As the team formulation sessions which I facilitate are based on a systemic therapy model, an essential element of the sessions includes reflecting on wider systems, possible interactional feedback loops, and ongoing circular cycles and relational patterns between staff and patients. In section 2.4. I will elaborate on what I consider are key elements of *systemic* team formulation sessions, which are based on systemic

therapy principles and theories. Team formulation sessions usually end with a summary and reflection points; thus, I will end the chapter with closing reflections on reflective practice in teams.

In this chapter I consider the following questions in relation to relevant literature:

- *What is team formulation?*
- *Why is it done, where is it done, how is it done, by whom, and to/with whom?*
- *What do we know about the benefits and opportunities of doing team formulation in clinical practice?*
- *What are the possible ethical dilemmas and challenges of doing team formulation?*
- *What are the key concepts in systemic team formulation?*
- *How does it differ to other models of team formulation?*
- *What does it offer for clinical practice? What are its limitations?*

2.1. Formulation and Team Formulation: definitions and aims

"If you've ever grabbed a stick from the ground and thought

'Oh, this is a good stick' then we are family. – Anderson, 2022, p16

One could argue that formulation is a key characteristic of being human, and that sense-making and story-construction is embedded in our everyday lives and relationships. It is also an essential aspect of therapy practice, as people often seek help to better understand their experiences and manage distress. Formulation represents a key link between theory, practice, and intervention (Vetere and Dallos, 2019). A formulation can thus be defined as a tentative, provisional, and revisable explanation or summary about how come an individual and/or system (such as a family, team, or organisation), experiences the problems they do (Johnstone and

Dallos, 2014). Based on the latter explanations, a formulation can also include an exploration of what might be helpful for the client system[3], in relation to any problems, circumstances, or concerns they are having.

Constructing meaning out of mental distress is a central thread in psychotherapy practice that has a long history that can be traced back to the 1950s. Formulation is, arguably, an integral aspect of all psychotherapy traditions, which involves: integrating all the knowledge acquired by assessments; it involves developing and/or co-developing an ongoing summary of a client system's core problems; constructing meaning and making sense about these problems *in relation to* psychological theory; which then informs a tentative and open-ended plan of intervention (Butler, 1998; Harper and Moss, 2003; Johnstone and Dallos, 2014; DCP, 2011).

The Division of Clinical Psychology (2011) have developed best practice guidelines which state that formulations should be based on client assessments, and should consider a range of developmental, interpersonal, social, biological, and systemic factors such as: trauma, context, relationship to help, societal factors, and the role of services in relation to current difficulties. The DCP (2011) advocate that formulation is a core competency for clinical psychologists[4] at all levels, and should be used within multidisciplinary teams and organisations, as well as with client systems. Team

[3] The term 'client system' refers to a group of people that a professional is responsible for helping. This can include the client and the members of the client's support network or can also refer to teams within an organisation. From a systemic psychology perspective, even when a therapist is only working with an individual, they are still considering and indirectly working with the client's system too.

[4] I will be discussing formulation and team formulation from my position as a clinical psychologist, and will thus, at times, refer to literature on clinical psychology. I also advocate that formulation and team formulation are useful skills for any psychological therapist, and hope that the information discussed is applicable to and transferrable across psychological professions. Hence, I will use the term 'therapist' throughout.

formulation is also a key technique which can be used by other psychological practitioners, and especially by systemic therapists, as it provides a useful format to help health care teams 'widen their lenses' when observing, assessing, and intervening with client systems. A more detailed exploration of the benefits and challenges of team formulation will be explored further in this chapter.

Across psychotherapeutic modalities, formulation can be understood as both an event and a process (Johnstone and Dallos, 2014). As an *event*, formulation can be seen as a therapeutic technique used at a specific moment in therapy, such as sharing a formulation diagram with a client, or a formulation summary written in a referral letter. These formulations are usually devised by psychological therapists who summarise the client's difficulties and hypothesise why they may be occurring, based on psychological (and other) theories and research. Teams then use these hypotheses to inform a more tailored psychosocial intervention (Johnstone and Dallos, 2014, Christofides et al., 2012). Formulation can thus be seen as "the lynchpin that holds psychological theory and practice together," in the form of hypotheses to be tested and explored further (Butler, 1998, p.2).

These theory-practice inferences are often an important aspect of the therapeutic process too, and as such, formulation can also be seen as a dialogical and recursive *process* of suggestions; discussions; reflections; giving and receiving feedback; and revising hypotheses between therapists and client systems and/or teams (Johnstone and Dallos, 2014). Approaching formulation as a process, acknowledges that hypotheses formed are social constructions, developed relationally between therapists and client systems, and are informed by and embedded in the whole process of the

therapeutic relationship (Johnstone and Dallos, 2014). These hypotheses are often about the background history, probable causes, and maintaining factors of a client system's presenting problems (Pain et al., 2008). Thus, when formulation is described as a process, there is an acknowledgment that it is a shared narrative or plausible story that is constructed between people, as opposed to discovered by an expert (DCP, 2011), and as such, when formulation is understood as a process, it is more likely to be implemented in a relational, dialogical, and collaborative way.

While formulation is a definite key skill area for psychologists (Division of Clinical Psychology, 2011), team formulation is a more recent and specialised development in the field, with a growing literature-base focused on the implementation of team formulation in varied services and facilitated by varied professions (Kennedy et al., 2003; Davenport, 2002; Johnstone and Dallos, 2014; Lake 2008; Summers, 2006; Division of Clinical Psychology, 2011). Some studies have focused on the actual practice and experience of team formulation (Christofides et al., 2011; Kramarz et al., 2022; Wainwright and Bergin, 2010; Whitton et al., 2016). These studies will be discussed in more detail further on in this chapter.

Systemic team formulation is an area that is yet to be researched in depth. Formulation, however, has a strong history in systemic family therapy. Early and later schools of systemic family therapy have all highlighted key aspects of formulation in their principles and theories of change, such as focusing on the important process of asking interventive questions, reflecting on feedback, and eliciting new information to hypothesise ideas, meanings, and narratives, to create change within systems (Dallos and Stedmon, in Johnstone and Dallos, 2014). Systemic theory provides a unique lens

to make hypotheses about the reasons for people's difficulties which specifically considers their relationships and interactional patterns with others, including health care professionals and wider systems. The value of hypothesising in systemic team formulation facilitates understanding and communication in the team and helps teams to manage the complexity of clinical practice in acute inpatient mental health settings. A description of the benefits, challenges, and processes of systemic team formulation will be elaborated on towards the end of this chapter.

2.1.1. Defining Team Formulation

Team formulation can be defined as the use of formulation in teams to provide a thinking space for staff where they can develop a shared, biopsychosocial understanding of the client system's difficulties, drawing on the range of knowledge, experiences, and skills of the team (Hollingworth and Johnstone, 2014; ACP-UK, 2022). Team formulation has been described as a necessary alternative to psychiatric diagnosis; a powerful tool to shift organisational culture; and a useful space for busy teams to think, process and understand intrapersonal and interpersonal feelings and behaviours in a non-judgemental way (Johnstone and Dallos, 2014; ACP-UK, 2022). A study which explored psychiatrist's views of team formulation showed that formulation was seen as a helpful *addition* to diagnosis, brought about due to a need for a more in-depth understanding of complexity and risk (Mohtoshemi et al., 2016).

Team formulation includes the use of psychological formulation (based on specific or integrative therapeutic models) within a team of professionals, whereby the facilitator and team collaboratively develop a shared understanding of a client system's

difficulties. It is thus, a socially constructed process within the team, where the team jointly develop an awareness of a client system's past and present concerns and behaviour, including reflecting on possible behavioural feedback loops between team members and the client system. This process of collective and relational curiosity can challenge the team to reflect on themselves and on interactional patterns between themselves and client systems (Johnstone and Dallos, 2014).

Thus, team formulation can be seen, in and of itself, as a psychotherapeutic intervention and supervision space for staff members working with client systems. It helps facilitate a space to think and plan and challenges the dominant discourse of the biological model of mental illness in mental health services (Kennedy et al., 2003; Johnstone and Dallos, 2014). The Department of Health National (1999) service framework for mental health standards also advises that teams which create shared formulations with regards to client care are also more likely to work successfully as a multidisciplinary team, with good communication and clear objectives across services.

One of the key aims of team formulation, which aligns with the main aim of the systemic team formulation process explored in this research study and in my clinical practice, is to provide a space for team members to *relationally* reflect on and be curious about a client system's current problems, and to develop a holistic and systemic understanding of what interventions, strategies, and responses might create or inhibit change in that system (Kustner, 2019). It should thus be noted that in this study's proposed version of team formulation practice, the main client system is the staff team, whose relational feelings of being curious, stuck, hopeless, angry, worried, or despairing are likely to have prompted the request for a team formulation

discussion. Client systems are thus, often not directly involved in a team formulation. Due to team formulation meetings often being a type of peer supervision activity for staff teams, it may not always be appropriate or helpful to include client systems in the sessions, as team formulation discussions often deal with strong staff reactions directly with the client system (Johnstone, 2018).

The DCP (2011) recognise four elements that are central to the process of team formulation across modalities: 1) Defining, exploring, and understanding the client system's presenting problems; 2) reviewing the client system's life events and history as a way of hypothesising possible predisposing factors; 3) exploring psychological theories in relation to the information discussed in team formulation; and 4) highlight possible interventions and strategies by means of care planning decisions, different ways of engaging with client systems, and/or changes to risk management. These key elements of the team formulation process are echoed in other studies, which highlight the importance of reviewing the client's history to generate ideas in a collaborative, integrative, and tentative formulation meeting with team members, which includes exploring psychological theory-practice links often from cognitive behavioural, psychodynamic, systemic, and cognitive analytical frameworks. (Berry et al., 2016; Geach et al., 2019; Hollingworth and Johnstone, 2014). When appropriate, adapted versions of the formulations are sometimes shared and developed with client systems either verbally or in writing, and then discussed again with the team.

While some studies have suggested that therapists also sometimes use formulation skills informally in teams, such as chipping in psychological formulations in team meetings (Christofides et al., 2012), formal team formulation meetings within a

healthcare setting can also be seen as a form of clinical supervision, consultation, or group therapy (Johnstone, 2013), whereby team members, who are in effect, the client system, approach the facilitator of team formulation, usually a psychologist within the team, with a presenting complaint of feeling confused, stuck and angry in their interactions with certain service users in their care. The team formulation meetings, much like group therapy sessions, often need to be facilitated with psychotherapeutic and systemic skills such as: containing, reflecting, reframing, and allowing multiple voices to be heard; as feelings of anger, frustration, stuckness, or sadness are often expressed. Disagreements, splits, and conflict within the team are also often discussed. These moments in team formulation may often mirror significant issues in the client system's own conflicts, dilemmas, and relational narratives (Johnstone, 2018; Davenport, 2002), indicating the benefit of facilitating team formulation with a systemic perspective in mind.

Team formulation has also been recommended in studies as being particularly useful for teams to better understand and care for client systems with complex histories and traumas, who have long histories with mental health services, where 'transference and countertransference issues are likely played out in relation to the whole team' (Onyett, 2007, p22). These are the type of clients that are often admitted into acute, adult inpatient mental health wards. Systemic team formulation, which is the model I am proposing in this study, can be helpful in this regard as it allows for 'symptoms' and 'challenging behaviours' to be seen as problems in interactions and communication *between* people and within larger systems, rather than residing *within* individuals. (Dallos and Stedmon in Johnstone and Dallos, 2014; Kustner, 2019).

2.2. Benefits and challenges of team formulation – Research Review

2.2.1 Benefits and opportunities

Research on team formulation has shown that it has numerous intra- and interpersonal benefits as well as wider systemic benefits, for teams that engage in the process of shared formulations. When conditions for effective team working are instilled and team-focused interventions are regularly implemented, there is evidence that there is an improvement in service delivery and health care organisations operate more effectively (Onyett, 2007). Despite recent guidelines by the British Psychological Society (DCP, 2011, p9) recommending the applied psychology intervention of team formulation as 'an effective use of a psychologist's limited time', little has been written specifically about significant change events experienced by team members within this process (Christofides, 2012; Johnstone and Dallos, 2014).

It has been argued by researchers that team formulation is best assessed for its usefulness (Butler, 1998), and as such, there have been some studies which have explored the benefits that team formulation can have on team members; on the team as a whole; on client systems; and on wider systems (see figure 2.2 below of how I structured the discussion on these studies). These studies will be described below (Christofides et al., 2011; Berry et al., 2009; Kennedy, 2009; Summers, 2006; Wainwright and Bergin, 2010; Craven-Staines et al., 2010; Hollingworth and Johnstone, 2014; Butler, 1998, Kuyken et al., 2011; Corrie and Lane, 2010)

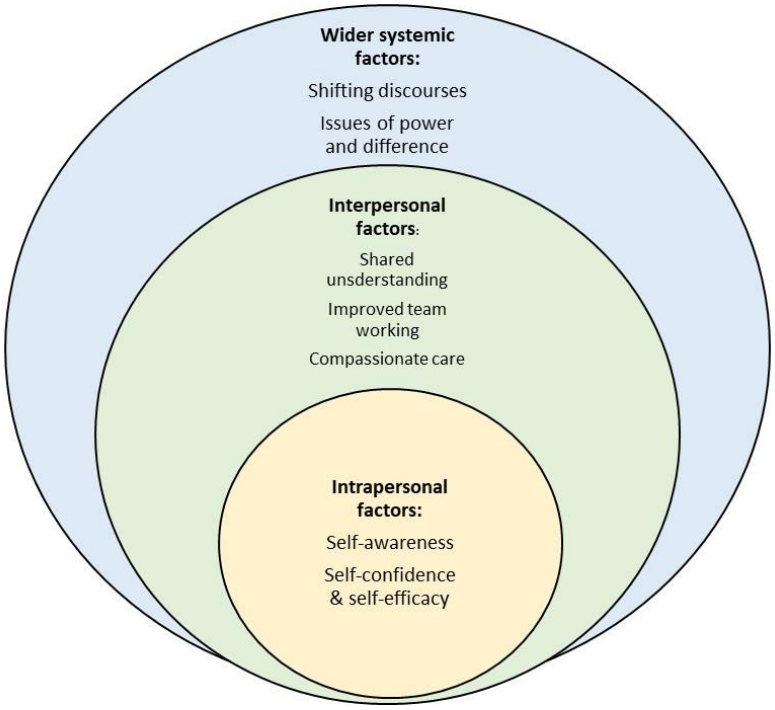


Figure 2:2: Nested model of factors and benefits elicited in team formulation studies

The ***intrapersonal* benefits** of team formulation (for individual team members) include providing a necessary space for team members to:

1. **Become more self-aware**

It can provide a space for team members to become aware of, share, and normalise their own thoughts, feelings, and reactions towards client systems; and towards each other in the team. It has been noted in research that these sessions can be a helpful space to self-reflect and can help address team dynamics (Russell et al., 2022). One study (Berry et al., 2016) found that team members felt less emotionally distanced from client systems after attending team formulation sessions. It can also encourage staff to reflect on positioning and their Social Graces (Burnham, 2018) such as professional status, gender, class, ethnicity, age and how these may impact in the care delivered, especially as the work context is often highly emotive. Increased self-awareness amongst healthcare professionals can minimise decision-making biases

and increase transparency amongst staff and between staff and patients. (DCP, 2011; Priddy et al., 2021; Beardmore and Elford, 2016; Cole et al., 2015).

2. Build self-confidence and self-efficacy

Team members have reported that team formulation sessions help team members increase confidence, reduce anxiety, reduce frustration, and increase empathy in understanding challenging behaviour and difficulties of client systems (Hollingworth and Johnstone, 2014; Summers, 2006; Bealey et al., 2021; Short et al., 2019). It can also provide a space to improve team member's perceived self-efficacy and hopefulness when working with client systems (Cole et al., 2015; Short et al., 2019). Team members reflected that when working with complex client systems, team formulation gave a feeling that staff were 'doing something'

Kramerz et al (2021) explored the concept of 'team holding' that can occur in team formulation sessions. This holding space can provide team members with a crucially supportive supervision context, where they can reflect on their attitudes and interactions with client systems. This potentially has the benefit of reducing staff burnout too.

Lake (2008) proposed an integrative team formulation approach in their study, which was experienced positively by all staff, in terms of confidence building and feeling valued. Berry et al. (2009), Whitton et al (2016), Beardmore and Elford, 2016, and Waugh et al (2010) also found that formulation meetings increased team members' confidence in their work and shifted team members' perspectives about clients more positively and optimistically. Increased empathy is crucial in clinical care as it can lead

to good patient outcomes, work satisfaction and compliance to best practice, as well as lower rates of complaints, cost of care, and errors (Whitton et al., 2016). Increased empathy is also related to staff wellbeing and may reduce burnout, as well as punitive and restrictive practices. Therapeutic alliance is crucial for service user satisfaction and recovery (Sweeney et al., 2014)

The ***interpersonal* benefits** of team formulation (for the *team* as a whole) may include providing a space for team members to:

3. **Develop a shared understanding of others**

Most studies on the topic indicate that creating a shared formulation space can be helpful, in that team members can increase their knowledge about client systems, shift negative attitudes, discuss different perspectives, and build a shared understanding on the relationships and dynamics between them and client systems, between staff members within the team, and with the wider hospital and mental health system (Berry et al., 2015; Ramsden et al., 2014; Whitton et al., 2016; Priddy et al., 2021; Turner et al., 2018; Gregson and Delaney, 2021; Short et al., 2019).

A very recent research study in an acute inpatient hospital in London (Kramarz et al., 2021) aimed to explore staff experiences of team formulation in addressing challenging behaviours on acute inpatient mental health wards. The results indicated that team formulation sessions can serve as a useful learning space, where teams can explore and understand the client system's history more holistically, as well as maintaining and perpetuating factors with regards to their presenting problems.

Davenport (2002) reported on the use of team formulation in a low-secure rehabilitation setting with the aim of developing the team's psychological understanding of patients within the first few weeks of admission. They were particularly interested in using a team formulation approach which particularly highlighted the restrictive and punitive dynamics that can often occur in inpatient environments. Staff who were interviewed about the team formulation sessions, felt that developing formulations helped guide patient care plans and interventions, improve relationships between staff and patients, increased staff work satisfaction and team cohesion. Some participants reflected, however, that team formulation could sometimes limit the care that was provided, and that ideas shared were too speculative. Despite these challenges, when used curiously and tentatively, team formulation sessions can provide a useful space for staff to develop psychosocial formulation-based plans of intervention, which can improve care and risk management, and increase staff confidence (Hollingworth and Johnstone, 2014). It also crucially, challenges the dominance of a biomedical diagnostic perspective.

Butler (1998) describes the multiple interpersonal roles of formulation in individual therapy which may also apply to team formulation too, including: collaboratively prioritising tasks to work on; planning care and treatment strategies; predicting responses and obstacles to intervention plans; deciding on therapeutic goals; and exploring and evaluating lack of progress. It is worth noting that team formulation does not always lead to the development of an intervention, but a shared formulation can still enable change through the process of formulating together (DCP, 2011). The team formulation thus becomes a systemic intervention, in and of itself, as it can provide team members with a space to share feelings and views about a client system, with

reference to psychological theory, and with a view to develop new insight, compassion and hope (Johnstone, 2018). It can also thus, improve understanding and respect for psychological input too.

4. Improve team working

Team formulation as an intervention has also been shown in studies to encourage teams to work more consistently and collaboratively with client systems and with each other (Hollingworth and Johnstone, 2014; Murphy et al., 2013; Short et al., 2019; ACP-UK, 2022). It can lead to improvements in ward atmosphere (Berry et al., 2016) and more consistent MDT working, as agreements and objectives amongst various stakeholders can be clarified (Department of Health, 1999) and complex processes of care can be negotiated (Summers, 2006; Davenport, 2002). It can also improve team working and cohesion, in that it provides a space to acknowledge the expertise across a range of professional groups (Hollingworth and Johnstone, 2014; Summers, 2006). Team formulation sessions can help team members bond and bounce off each other, and create a supportive team ethos (Cole et al., 2015). It is worth noting that staff in some studies felt that when they were unable to attend team formulation sessions, they felt unsupported by colleagues and like they had missed out (Murphy et al., 2013).

The recent study on team formulation in an acute inpatient hospital in London (Kramarz et al., 2021) indicated that team formulations provided a safe space for staff to discuss the impact of working with complex and challenging behaviour presentations and concluded that it improved communication and teamwork. Participants shared that team formulation insights increased their ability to identify and support the needs of client systems and enhanced therapeutic relationships. It also

provided a space for staff to reflect on challenges of caring for client systems, with the biggest theme being struggles around establishing continuity of care.

In a similar study by Christofides et al (2011) participants felt that there is an important need for a space and framework to help teams understand and discuss clients' difficulties together. Interestingly, team members in this study noted how these formulation discussions often occurred between the team in an informal 'chipping in' way, for example sharing thoughts and hypotheses during routine team meetings, handovers. They felt these ad hoc formulation discussions were more common and as fruitful as planned formulation or case presentation sessions. The term 'formulation' was seldomly used to describe these informal discussions; however, the team had been introduced to the idea of using formulations to discuss psychological understandings.

5. Engage and interact more compassionately with client systems

Studies of staff experiences of team formulation sessions show that staff feel that their relationships with client systems improved after the sessions, there was increased empathy, compassion, and collaboration increased too (Geach et al. 2019; Priddy et al., 2021; Short et al., 2019; ACP-UK, 2022). Staff felt they were less blaming towards clients and felt more optimistic about treatment (Berry et al., 2009, 2015; Ramsden et al., 2014). This was felt to have occurred because of problems and behaviours being understood and normalised in team formulation discussions, which reduced linear thinking and blame, and changed attitudes (DCP, 2011). Team formulation sessions can encourage a more holistic and trauma-informed understanding of a client system's background and developmental history; it can provide a space where hypotheses and

questions about clients and their families can be clarified and explored; it can help staff prioritise current issues and problems (Cole et al., 2015); and plan and predict responses to a range of possible interventions and behavioural strategies that can help create meaningful change for clients and the team (Johnstone and Dallos, 2014).

Team formulation thus can provide a space to change the lens on the 'problematic patient' to the problems being seen as a possible product of the interactional dynamics between staff, client systems, and the wider mental health system. Incorporating a greater emphasis on psychosocial elements in team formulation sessions may help to empower staff to explore interventions beyond the use of medication alone. It also provides a space to emphasise the client system's strengths and needs, which can increase a sense of agency and hope (DCP, 2011).

Team formulation is also often recommended for the management of challenging behaviour amongst complex client systems, as the behaviour is often the manifestation of unmet needs and distress. Having a space to understand these needs and collaborate with client systems to address them is essential in developing effective interventions and care plans. (NHS Protect, 2013).

6. A ***wider systemic*** **benefit** for client systems that team formulation has been seen to encourage is that it can **shift discourses and approaches to care**

Team formulations can shift staff attributions about presenting problems (Ingham, 2011). Research studies have shown that team formulation can also provide a crucial space for trauma-informed care (Cole et al., 2015). Trauma informed care recognises

the impact of trauma on a client system's response to others, and the importance of mental health services providing compassionate care that avoids re-traumatisation (Sweeney et al., 2018.; Bloomfield et al., 2020). Acute inpatient mental health can trigger trauma responses due to the restrictive and potentially acutely distressful nature of the environment. Patients can often feel trapped, disempowered, coerced, and unsafe (Wampole and Bressi, 2019). When team formulation uses a trauma-informed approach to care, care-planning can be positively impacted, and includes more psychological thinking (Hollingworth and Johnstone, 2014; Cole et al., 2015). This process is possibly facilitated by team members reflecting on the developmental history and attachment styles of client systems, and being given a space to reflect on their feelings and to identify possible interactional patterns that may perpetuate trauma responses in client systems (Kramarz et al., 2021). Team members may unknowingly re-enact early patterns of abuse and perpetuate unhealthy and ineffective interactions with client systems (Davenport, 2006; Johnstone and Dallos, 2014).

Using team formulation as a trauma-informed process could also have potentially far-reaching impact on services and the NHS, as client systems who receive appropriate and supportive care in the community are less likely to become dissatisfied, 'revolving door' clients in acute inpatient services. In some services, team formulation sessions have been a useful tool to triage referrals too (Dexter-Smith, 2015).

Team formulations can be useful to improve service effectiveness in the following ways (Onyett, 2007): to notice gaps in information; encourage culture-sensitive perspectives about client systems; help the team feel understood and contained; strengthen the team alliance, encourage collaborative work; emphasise strengths and

needs; normalise problems, reduce blame; and ultimately increase sense of agency, hope and meaning for all. (DCP, 2011)

It can also be an effective way of shifting cultures towards thinking more psychosocially, and a strategic way of developing psychological leadership within teams (Geach et al., 2017). It has been suggested that team formulation can help reduce restrictive practice, such as the use of restraints and seclusion (Whitton et al., 2016). As such, the Division of Clinical Psychology (DCP, 2011) recommends that multidisciplinary use a formulation-based approach in their work. They also advocate that psychological practitioners should be present at team decision-making forums where sharing a psychological formulation would be helpful in understanding mental distress, such as during care planning meetings.

Formulations offer a key alternative perspective to the medical model (Onyett, 2007). Onyett also suggests that using formulation in teamwork provides a useful framework which can enable change in the team and the client system, thereby supporting recovery. Staff working in a dominant biomedical system may experience a culture where it can feel shameful to show vulnerability, thus providing a space for personal reflection is important. In addition, providing staff with a regular space for support is key in an acute inpatient mental health setting where staff are often exposed to intense emotional distress and challenging behaviour, and struggle with management of workload and continuity of care. Team formulation could help with retaining staff by providing support to them.

2.2.2. Challenges, barriers, dilemmas of team formulation: Research Review

Despite the numerous benefits which studies have shown in favour of team formulation, there are also challenges, barriers, and dilemmas with it according to recent research studies and literature. Questions that are often asked (DCP, 2011) when debating the use and ethics of team formulation as an intervention include:

- Who is the formulation for?
- Who has the problem?
- Who are the stakeholders and their interests?
- Whose voices are privileged and marginalised?
- How is diversity and inclusivity considered? How is it evaluated?

1. Client involvement?

One of the biggest challenges, and criticisms, of team formulation sessions is regarding the consent, involvement, and collaboration of the client and their families - when it is used as a staff-focused intervention and often excludes the voices of client systems who are being discussed (McCelland in Johnstone and Dallos, 2014; Wainwright and Bergin, 2010; Whomsely, 2009; ACP-UK, 2022). As the process involves teams of professionals discussing clients and their families, the dilemma revolves around how the process can be respectful of the client system's views about what is helpful or accurate.

There are some models of team formulations which seek out consent and/or the perspectives and feedback of client systems, particularly when there are difficulties in engaging client systems with the service (Geach et al., 2019; Milson and Phillips,

2015; Ingham, 2012; Lewis-Morton et al., 2015). In a study by Kramarz (2021) service users' perspectives, views, and wishes were incorporated throughout the team formulation discussion through information from healthcare records and staff observations. The Division of Clinical Psychology (2011) advocates for collaborative formulations in their best practice guidelines for team formulation, but some studies (Geach et al., 2019) have noted that there may be barriers and challenges when involving client systems in team formulation, including the practical difficulties of involvement, the need to formulate professional dynamics between team members and client systems, and the potential of that leading to increased distress. It is key that the purpose of team formulation is considered when think about the involvement of client systems.

Team formulation often involves acknowledging and understanding the team's feelings, so it is not always appropriate for client systems to attend these sessions. The same principles are upheld with regards to how much information is shared with client systems from a professionals' meeting or a clinical supervision session. It is, however, good practice for a parallel formulation or follow up care plan to be drawn up with the client system, if needed and appropriate. In these cases, staff feelings and reactions from the team formulation are not incorporated and are only added to the official records if appropriate, and if staff give consent for that information to be shared. (DCP, 2011)

Research studies which have however, explored the impact of directly sharing case formulations with clients, have found limited evidence of short-term benefits on perceived helpfulness of sessions, therapeutic alliance, or decrease of presenting

problems (Evans and Parry, 1996). Some process studies have highlighted that clients may have mixed responses to formulations being shared with them - some positive, such as perceived improvement of the therapeutic relationship, and some negative, such as eliciting feelings of hopelessness. These studies did however show that doing formulations was beneficial for clinicians, as it allowed for a better understanding of a client's problems; it enhanced the therapeutic alliance; it increased optimism about therapy; gave a clear sense of direction; and it enhanced theory-practice links. (Pain et al., 2008; Chadwick et al., 2003; Butler 1998; Cole et al., 2015; Roycroft et al., 2017).

Clients do not typically come to psychological therapists requesting a 'formulation' of their problems, so there may be a question about 'who's need is it' to do the formulation. It can however be argued that clients do seek explanations and help in constructing meaning and making sense of their distress (Johnstone and Dallos, 2014). All psychological therapy modalities can be seen to have an aim of summarising meanings and finding shared ways to understand and communicate these summaries with client systems (Butler, 1998) in a process of continuing, collaborative sense-making (Harper and Moss, 2003).

A reflective space for staff without the client system present is important in developing a shared understanding of information and coordinating treatment planning (Ingham, 2015). There have been no research studies to evaluate the outcome of team formulation sessions on client system's mental health and measuring this is likely to be challenging due to the indirect nature of the intervention (Christofides et al., 2011; Short et al., 2019)

2. Which model of formulation to use, and who facilitates it?

Team formulation is viewed as one of the key recommendations for best practice in acute inpatient settings and commonly implemented, however, approaches vary widely in terms of theoretical models used, frequency of meetings and their structure. This means that there is no clarity about how it is used consistently as a practice, and thus there is limited outcome-based research on it (Berry et al., 2016; Raphael et al., 2021, Geach et al., 2017, DCP, 2011; Bealey et al., 2021). Some researchers have advocated that there is a need for more standardised and specific models of team formulation practices to be developed, to measure outcomes and determine best-practice guidelines (Geach et al., 2017; Mann, 2022). This could prove to be challenging as there is no uniform definition of formulation, and its practice varies in relation to the practitioner's training, work context and theoretical leanings (Bealey et al., 2021).

There are a range of structured, semi-structured, and unstructured/informal approaches (Geach et al., 2017), as well as single-model and integrative team formulation models (DCP, 2011) which have been proposed, based on psychological theories, such as CBT (Kennedy, 2008; Berry et al., 2009), psychodynamic (Davenport, 2002), emotion focused (Clarke, 2015), and integrative approaches (Lake, 2008). Some models have been developed with specific client population groups in mind, such as the Newcastle Model (James and Jackman, 2017), which was developed in the context of caring for clients with dementia and focuses on reframing challenging behaviour as unmet needs, while considering wider psychosocial factors. Some team formulation models are structured more as psychological consultations aimed specifically at improving service delivery and effectiveness (Berry et al., 2009;

Ingham, 2011; Ramsden et al., 2014; Berry et al., 2015), while other models resemble semi-structured reflective practice meetings focused on the emotional impact of working with client systems (Davenport, 2002; Murphy et al., 2013; Wilcox, 2013). Some studies have considered how team formulation can often happen in 'corridor chats' between professionals where there is an informal sharing of ideas to encourage team members' understanding of client systems (Christofides et al., 2012).

Within the NHS, psychological therapists work in multidisciplinary teams not only as therapists, but also as leaders and consultants, and are often called upon to offer specialist knowledge and skills to help client systems as well as teams (Christofides et al., 2012). As such, the facilitators of team formulation sessions are often psychological therapy practitioners (psychologists and therapists). In this study, the facilitators of team formulation sessions are psychological therapy practitioners. However, it may be difficult for psychological practitioners to find time to facilitate team formulation sessions, given staff shortages and lack of time. Studies have also found that non-psychology staff often lacked the skills and confidence to facilitate team formulation sessions even after they had been trained, which highlights the need for ongoing mentoring and supervision (Craven-Staines et al., 2010).

3. What impact does team formulation have and is it sustainable?

One of the key, critical debates regarding team formulation is whether it is a 'valid' and evidence-based practice, indeed because as human beings, we are all constantly formulating and creating theories of the world and its people (Johnstone and Dallos, 2014; Cole et al., 2015; Short, 2019; ACP-UK, 2022). Given the collaborative and socially constructed nature of team formulation sessions, it is a challenging practice to

standardise and evaluate. Systematic reviews of team formulation have shown that most of the research is small scale, qualitative and variable in quality, which has implications for its evidence base in terms of outcomes for clients and impact on staff (ACP-UK, 2022). The facilitator/therapist must also be attentive to their own assumptions, meanings, and feelings while remaining respectful to of the team and client system's meanings and feelings. There have been some guidelines written to assess the quality of team formulation sessions (Butler, 1998; Kuyken, 2006; DCP, 2011) but since team formulations involve a process of sense-making, they should be understood more as thick and rich stories to somewhat orientate team members to the client system's story and to describe a relational process between staff and clients. Thus, it has been argued in studies that team formulation is better seen in terms of its usefulness, rather than its validity - as a map rather than the territory (Harper and Moss, 2003; Johnstone and Dallos, 2014). There are however some studies that have shown that the recommendations from team formulation meetings are sometimes difficult to implement in practice (Cole et al., 2015). One study which involved providing cognitive analytical therapy-based team formulation sessions to teams showed no differences in client outcomes compared to treatment as usual but did show positive changes in team practices (Kellet et al., 2014).

In a study by Summers (2006, p342), some team members seemed to view formulations as factual, certain, and leading to the 'correct' way of managing client systems, so it is crucial for therapists and team members to remain curious, and to acknowledge that the perspectives or hypotheses shared in team formulations are contextual, socially constructed, and derived from knowledge and experience (Harper and Moss, 2003; Summers, 2006).

Team formulations are also challenging to evaluate, partly because of their varied definitions and varied ways of implementing it, found in the literature (Short et al., 2019). This makes it difficult reach a consistent understanding of the key processes and to research the outcomes of team formulation and the use of formulations in practice (Geach et al., 2017; Chadwick et al., 2003). There have however been recent developments of tools to assess the quality of team formulation (Bucci et al., 2019; Ingham et al., 2020; Jackman et al., 2013; Roycroft et al, 2015) which opens possibilities for more outcome-based studies on team formulation.

On a practical and interactional level, team formulations can sometimes have a negative impact on client care and staff-client interactions. Some studies (Summers, 2006) have found that too much information about a new client system might lead the team to inaccurate perspectives at the start of care and getting to know a client system. Overemphasising information about the client system's past can also sometime be used to excuse challenging behaviour

In the NHS, healthcare workers often have stretched caseloads and an ever-increasing struggle to prioritise workload based on client need and risk. Another big challenge with regards to the impact of team formulation is to sustain it as a regular, staff support space and intervention. Attendance numbers can fluctuate depending on shift work patterns and staff shortages, which may make it difficult to have a meaningful and representative team discussion (Johnstone and Dallos, 2014).

Given the constant pressures in healthcare, the high turnover of staff in a permeable work context, as well increasing complexity of client presentations, any suggestions or

reflections on client care made in team formulation sessions may be difficult to follow through and sustain (Wainwright and Bergin, 2010). Staff often have to hold more urgent client demands and crises in mind, which may mean that team formulation reflections may be forgotten (Johnstone and Dallos, 2014).

4. Issues of power and difference

In terms of considering how team formulation could be used as an inclusive and culturally sensitive intervention, it is worth noting that most team formulation research has been conducted in the UK (Geach et al., 2017), with limited research on it on a wider, global level (ACP-UK, 2022). There is still much work and critical research to be done on culturally appropriate forms of formulation and intervention, which acknowledges how cultural and spiritual needs are understood, as well as the role of social inequalities in shaping people's life experiences and problems (McCelland, in Johnstone and Dallos, 2014; Fernando, 2010; ACP-UK, 2022). The very concept of formulation, which usually prioritises formulating an individual's problems based on internal causes, is in itself a specific cultural construct (Fernando, 2010).

It is worth noting that formulation as a socially constructed discussion between team members of various backgrounds, is not an impartial, decontextualised, and objective summary of evidence, and may not always lead to the best intervention for the client system. Formulations, and interventions thereof, can often be influenced by decision making biases, such as the anchoring and availability heuristic (Kuyken et al., 2009; Corrie and Lane, 2018). It is also important to take into account that there may be expectations that the psychologist facilitator is an 'expert' at formulation and assessment. Psychologists are often in a position to block feedback and/or lead the

discussion in a certain way (Vetere and Dallos, 2019). This might discourage or silence voices of healthcare professionals who do not feel like they have psychological expertise. The importance of remaining reflective, curious, critical, and psychologically informed when formulating hypotheses and care plans is key (DCP, 2011). Some literature has noted that team formulations are rather, stories shared and told to meet specific needs – an explanation agreed between stakeholders to explore and understand key issues and processes at a particular point in time. (Corrie and Lane, 2018). Thus, a key challenge in team formulation sessions is maintain the perspective that it is a dynamic and subjective process (Milson and Philips, 2015).

It is also crucial that team formulations acknowledge the presence of dominant ideologies and discourses, which may according to McCelland (in Johnstone and Dallos, 2014) serve to reinforce established power balances by masking and delegitimising inequalities. This is especially important in the inpatient psychiatric setting where I conducted my research, where the dominant discourses of diagnosis and pathology hold a lot of power with regards to patient care. Team formulation sessions could be used as a platform for social justice, where sense-making about a client system's problems expands further, in attempting to understand the role of local inter-personal and cultural contexts on the 'diagnosis' being considered. Reflexivity can only truly happen by using a social inequalities approach, which encourages personal and collective reflection on power, privilege, wider systems, contexts, and processes (McCelland, in Johnstone and Dallos, 2014; DCP 2011). Taking on a critical position and creating a discursive team formulation space that is inevitably, counter-cultural, can however be difficult to create, maintain, and sustain, as it often contrasts starkly to the dominant, linear discourses within a medical system.

2.3. Background research on Team Formulation – contexts, processes, and general finding

A substantial proportion of the research on team formulation has so far been limited to relatively small scale, practice-based studies in inpatient settings with varied population groups. Some of the results echo the benefits and challenges discussed in the sections above. Kennedy et al. (2003), conducted a study where the key intervention on a new inpatient service was the collaborative development of team formulation. They established that it was a useful systemic intervention which was valued by both service users and staff. Summers (2006) did a study exploring staff views of the impact of team formulation in a high dependency rehabilitation service. Staff shared that formulation had a positive impact on care planning; improved staff-patient relationships due to a broader understanding of patients' problems; and enhanced team-working as it encouraged creative thinking and brought together staff with multiple views. Wainwright and Bergin (2010) provided similar findings of staff views on the effectiveness of formulation meetings on an acute inpatient ward for older adults. There have also been numerous evidence-base studies on the use of team formulation as an important clinical process in services for people with learning disabilities (Ingham, 2011; Hymers et al., 2021; Wilcox, 2013; Beardmore and Elford, 2016; Turner et al., 2018).

Some studies have illustrated how formulation, in a broader sense, has been integrated, embedded, and evaluated across services within NHS Trusts (Chiffey et al., 2015; Dexter-Smith, 2015). These studies have highlighted the opportunities and challenges when attempting systemic and service-wide developments.

Whitton et al (2016) sought to investigate the impact of team formulation sessions for staff in a secure forensic learning disability and autism service. Findings indicated staff experienced the sessions as a positive experience which helped facilitate the following aspects: insight in psychologically understanding the patient's background, history and problems; a useful space for staff teams to work together and more consistently by sharing experiences and problem-solving ideas; and a useful space for self-reflexivity. Consistency amongst staff reduced the likelihood of challenging patient/staff dynamics and conflicting views on care and treatment plans.

The study by Kramarz et al., (2022) had similar aims to my study and was conducted in a similar adult acute inpatient mental health setting to the setting of my study. It aimed to explore staff experiences of team case formulation to address challenging behaviour on acute adult inpatient mental health wards. It differed from my study though, that it was not specifically focused on exploring the significant events and process of team formulation, and it also focused particularly on team case formulations to address challenging behaviour. As such the psychological models of formulation used aimed to increase understanding of challenging behaviour, such as the Newcastle model (James and Jackman, 2017). Participants in the study reported that team formulation sessions provided them with a safe space to explore and understand their emotional responses to challenging behaviour, and to identify ways in which staff could inadvertently be perpetuating the challenging behaviour. Staff reported feeling heard and reported the sessions had a positive impact on their wellbeing. Team members also felt the formulation sessions improved their clinical confidence, supported them in their work and improved their levels of job satisfaction. In having

the space to understand service users better, staff felt their therapeutic alliance with patients improved and they were able to implement more informed care plans.

A randomised-controlled trial of a cognitive-behavioural team case formulation intervention on mental health rehabilitation wards indicated that, post-intervention, service users reported better relationships with staff, who also reported increased optimism and lower depersonalisation - a known component of burnout (Berry et al., 2016).

A cross-service study by Geach et al., (2019) aimed to identify and distinguish the apparent forms, functions, and outcomes of team formulation, and to explore factors that promote and inhibit team formulation sessions from being implemented successfully. Participants of the study were clinical psychologists from a broad range of service populations, including community and inpatient settings. The study identified several types of team formulation formats which focused on the following areas – team formulation as a case discussion, team formulation to discuss behaviour perceived as challenging, team formulation to discuss the staff-client relationship, and team formulation using the client's views. There was also overlap of team formulation-type discussions being conducted in other team forums, such as MDT meetings. The study identified that team formulation as a stand-alone intervention was uniquely characterised by using psychological theory in sense-making, and that the sessions thus required facilitators who had specialist psychological knowledge and competencies.

The study (Geach et al., 2019) also found commonly perceived factors which were seen to support or obstruct successful team formulation practice. An integral factor of team formulation success involved the management of distress amongst attendees, which implies the importance of a good working alliance between attendees and facilitators. This distress was not limited to understanding a client system's distress, but also containing the emotional distress (and occasional conflict) amongst teams. This finding is consistent with research on reflective practice groups which highlights the importance of understanding and working with distress as a way of encouraging learning in teams (Binks et al., 2013). It is worth noting that the results from this study were self-reported accounts from clinical psychologists only, and could thus be limited in scope, however the results may have transferrable implications for other psychological professionals.

An interesting study by Short (2019) looked particularly at team processes and factors that may influence team formulation, such as team communication and knowledge sharing, team identification, and professional identification – all of which impact the transactive memory system, which ensures efficient sharing of knowledge in teams. Short (2019) suggests it is important that organisations and teams focus on these team processes and conditions to optimise team formulation practice.

2.4. Systemic team formulation

“Now.

Here.

Your skull is the garden where fact flowers into meaning.”

Anderson, 2022, p3

Systemic team formulation is an area that is yet to be researched extensively. There was a very recent study about the use of systemic principles in team formulation in supporting trauma-informed care of a client system in the learning disability context (Gregson and Delaney, 2021) which illustrated the benefit of systemic thinking and general systemic principles and theory in team formulation practice. This section sets out to summarise the important theoretical principles I believe are important to consider in systemic team formulation. It draws from literature on systemic formulation in general (Vetere and Dallos, 2019; Dallos and Draper, 2010; Johnstone and Dallos, 2014).

Systemic theory provides a unique lens to make hypotheses about the reasons for people’s difficulties as it considers relationships and interactional patterns. It can be applied invaluably within an acute inpatient mental health setting and in today’s dynamic NHS mental health system, characterised by high levels of work demands and rapidly changing structures and culture (Onyett, 2007). An acute inpatient mental health ward offers a unique opportunity to ‘map the family dance’ between inpatients and ward staff, whereby problems that patients face in their respective family systems can often be mirrored and maintained through circular processes, in their daily interactions with ward staff, as highlighted in this quote by Bateson (1979, p91)

“Interesting phenomena occur when two or more rhythmic patterns are combined, and these phenomena illustrate very aptly the enrichment of information that occurs when one description is combined with another.”

With the systemic premise of interventive interviewing (Tomm, 1987) in mind, the processes of asking questions, reflecting on feedback, and eliciting new information to hypothesise has the potential to create change within the team, and between the team and client systems (Dallos and Stedmon, in Johnstone and Dallos, 2014).

Systemic team formulation, as a psychotherapeutic intervention can provide a reflective space (Kustner, 2019):

1. For teams to use the language of relationships to describe and understand behaviour, beliefs, and feelings, particularly in a context where the dominant discourse is biomedical.
2. To observe interactions between staff and inpatients that could mirror interactional patterns between inpatients and their families. Problems that people face in their respective systems may often be mirrored and maintained through circular processes in their daily interactions with ward staff too.
3. To think strategically about addressing interactional patterns with each other as a team, and with patients, carers, and the wider mental health system.
4. To explore interactional dynamics and to think curiously about patterns and possible interventions or ‘differences that make a difference.’

Based on the differences and common factors in therapeutic models of formulation identified by Johnstone and Dallos (2014), I will describe what I mean by systemic team formulation according to the following aspects: the key principles of systemic team formulation and the explanatory, core systemic theoretical concepts that underpin them; the emphasis on reflexivity; the stance it takes with regards to adopting a collaborative vs expert position; the position it takes on psychiatric diagnosis; the position it takes on truth vs. usefulness; the manner in which the formulation is facilitated, shared and used.

I propose that there are three broad, key principles which systemic team formulation should include:

- a focus on language and meaning.
- encouraging widening the perspective.
- and reflecting on relational reflexivity.

Within these broad principles, I also suggest sub-concepts that which are linked to systemic thinking and practice principles (see figure 2.2).

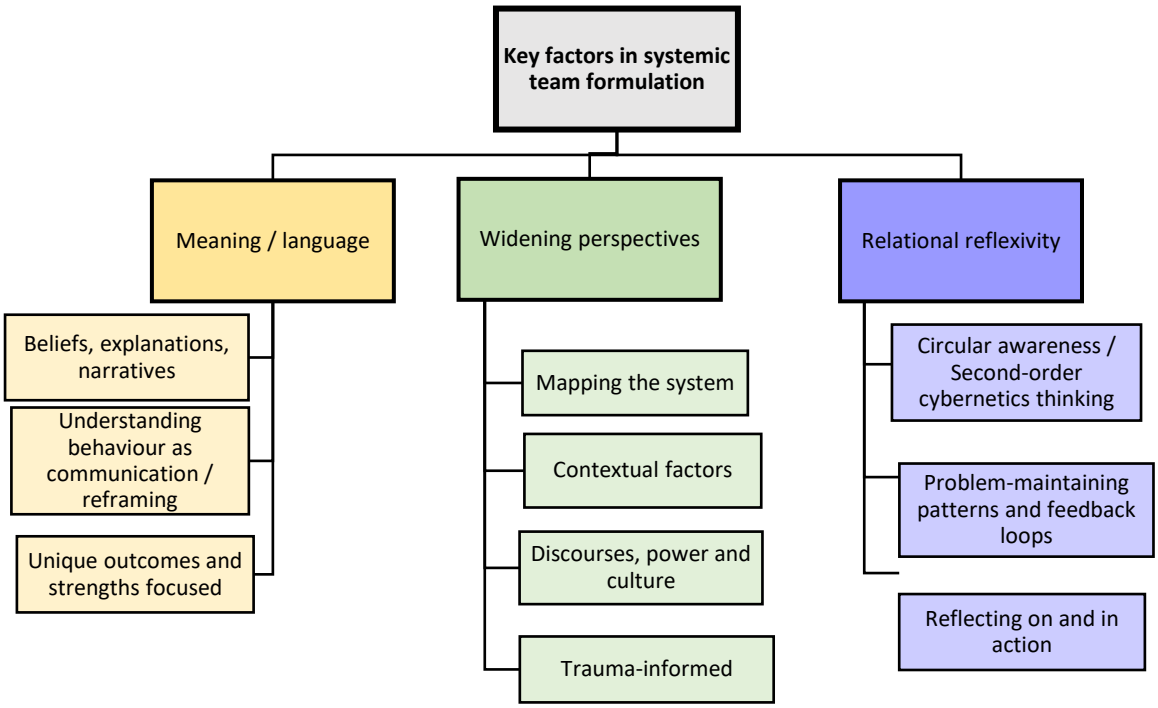


Figure 2.3 - Key principles in systemic team formulation

Overarching these key principles is the systemic view that formulations are iterative, and as such, systemic formulation (and interventions) are never a 'once-off' process but are rather continuously changing and evolving with information and hypotheses that are collaboratively and dynamically developed, evaluated, and reformulated (Dallos and Stedmon, in Johnstone and Dallos, 2014; Vetere and Dallos, 2019, Butler, 1998; Whomsley, 2010). This process of 'reformulation' is key in ensuring that hypotheses can adapt to new information and the changing needs of the client system (ACP-UK, 2022). Throughout the history of systemic theory and practice, another enduring and pivotal systemic concept is based on the view that an individual's problems often occur because of interactional and communication dynamics in the individual's system/family. In addition, a crucial systemic perspective is that all aspects of therapy are interactional and collaborative, meaning that the therapist is also part of the system. Cause and effect are thus often viewed as a circular process,

maintained through ineffective interactional feedback loops in relationships (Dallos and Stedmon, in Johnstone and Dallos, 2014). Systemic therapists also acknowledge the importance of considering wider systems, discourses, cultures, norms, and transgenerational processes in contextualising problems within a system.

Systemic formulation done with teams can be seen as a form of systemic consultation to help teams who feel stuck when working with a client system. According to David Campbell (2018), systemic consultations can be treated in the same way as a referral to help a family that feels stuck. Much like a family intervention, the team intervention may include hypothesising about why the problem has elicited feelings of 'stuckness;' and widening perspectives through the use of circular questions, reframing, reflexivity, internalised-other interviewing, and collaborative formulation (Vetere and Dallos, 2019). Systemic consultation (and team formulation) aims to facilitate changes in the meaning systems within wider organisations, and to help team members become systemic observers and thinkers (Vetere and Dallos, 2019).

It can also provide a space for clarifying different perspectives and meanings attributed to behaviour, so that teams can work more effectively in organisations (Campbell, 2018). Inpatient services rely on team-based models of care, and multiagency involvement, which is perhaps why the practice of team formulation has grown in these services (ACP-UK, 2022). Campbell (2018) reflects on the limitations and advantages of systemic consultation – it can be limiting in that it may be difficult to define the boundaries of the system, and it may not fully include and encompass the real impact of wider socio-political issues on people's lives. Consultation can however be advantageous in its ability to encourage collaborative team relationships. Campbell

(2018) comments on how the consultants of systemic consultation can take a unique meta-perspective on patterns and relationships in the system, as they are often both part of the system and in an observer position.

It is worth noting that some literature on team formulation suggests that there are some overlaps but also clear distinctions between individual formulation, clinical supervision, team formulation, and team reflective practice sessions. The latter being a space for teams to discuss systemic and organisational issues, as well as supporting teams to manage the emotional impact of their work (ACP-UK, 2022). Systemic team formulation from my perspective, assumes a second-order cybernetic position, in that the staff system are seen as part of the client system too. As such, the client system's formulation, the team's reflective practice and formulation, as well as the systemic consultation provided are all integral elements of systemic team formulation (see figure 2.4 below).

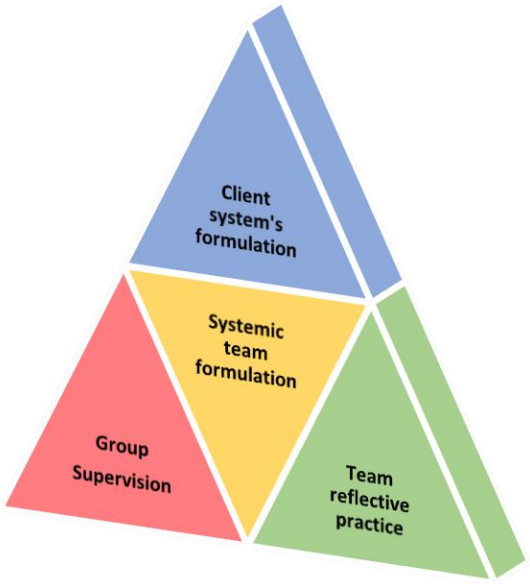


Figure 2.4: Systemic formulation as an integration of various formulations.

(Adapted from ACP-UK, 2022, p9)

2.4.1. Key principles and considerations in systemic team formulation

- **Language and meaning**

The first aspect of systemic formulation (and systemic team formulation) often involves defining and deconstructing the presenting problem. This involves exploring the language and discourses used to define the problem; reflecting on who has defined the problem in relation to what and when; examining beliefs about the problem; as well as beliefs about attempted solutions to the problem (Vetere and Dallos, 2019; Dallos and Draper, 2010; Johnstone and Dallos, 2014)

A social constructionist view maintains that meaning is created through dialogue in social interactions and is thus context dependant. The stories and narratives shared between individuals construct their reality. Language encompasses a long legacy of normative stories related to gender, class, and race. Presenting problems are thus seen to arise not within individuals but in relationships, interactions, and language between individuals. Early systemic therapists highlighted the importance of language in determining how people act (Bateson, 1979; Watzlawick et al., 1967; Hayley, 1963; Vetere and Dallos, 2019). Language thus not only reflects our reality but also shapes it. Thus, knowledge is always distorted to some extent by our perspectives, power, and culture (Forrester, 2010).

Systemic therapy focuses on both content (accounts given) and process (observations) as sources of information in communication (Vetere and Dallos, 2019). Earlier schools of family therapy placed high emphasis on communication and saw behaviour as a form of communication and exchange of information between people

(Watzlawick et al., 1967). This concept can still be a useful way of reframing challenging behaviours as unmet needs, in mental health settings. Beliefs are a way we make sense of the world, and they organise our behaviour, thus it is important to explore the client system's, the team's, and agency-wide beliefs to better understand patterns of relationships (Vetere and Dallos, 2019).

The contexts where team formulations usually take place, such as inpatient hospital settings, often adopt a dominant biomedical discourse with regards to treatment and care of client systems. It is important to create a space where staff can use the language of relationships to describe, understand and hypothesise about behaviour, beliefs, and feelings. Thus, systemic team formulation changes the lens on the 'problematic patient' to the problems being a product of interactional dynamics within the client system and with the wider system, including the health contexts where client systems are cared for and treated. (Dallos and Stedmon in Johnstone and Dallos, 2014).

Working with client systems, including thinking relationally with groups about how teams are embedded in the system too can be a complex process, with a lot of contextual, relational, and personal information to hold in mind. It is thus crucial to reflect on beliefs, explanations, and narratives, and how language is used to describe these (Dallos and Draper, 2010; Vetere and Dallos, 2019).

The use of progressive working hypotheses in systemic team formulations can be useful as (Johnstone and Dallos, 2014):

- Starting points to try meaningfully organise information in relation to psychological theory.
- A way of collaboratively eliciting new information from a position of creative curiosity.
- A means of openly stating biases and assumptions, which might affect the therapeutic relationship
- A way to highlight agreements and disagreements in teams. Which might negatively affect teamwork and/or therapeutic relationships
- Encouraging curiosity and tentativeness from the facilitator and team members, rather than aiming to get a 'correct formulation'

Systemic formulations and progressive hypothesising, first proposed by The Milan school of family therapy (Palazzoli et al., 1980), should always be open to changes and revision, as maintaining a position of curiosity is central to systemic practice. Hypotheses are thus always held lightly and mindful of multiple narratives (Johnstone and Dallos, 2014). They are measured in terms of their usefulness in eliciting change, rather than for their accuracy.

Systemic team formulation is a co-constructional and dialogical process which is an intervention to perturb and change the team system. Thus, the process of how the formulation takes place, the language and questions asked, when and how they are asked and by whom, all have the potential to create a change in the system. (Dallos and Stedman, in Johnstone and Dallos, 2014). Another systemic (and cognitive) technique, which draws on the power of language to elicit change, is reframing. Teams can often have linear beliefs about team challenges and challenges with patient care.

Reframing can be used to help teams redefine problems from a relational perspective, which can then change team beliefs to enhance patient care and team working. Reframing uses language to identify possible positive motivations in people's behaviour and uses active language to highlight personal agency (Vetere and Dallos, 2019).

It can also be helpful to focus on strengths, expectations, and unique outcomes in systemic team formulation. Drawing from the third wave schools of family therapy, such as Narrative therapy and solution focused therapy, reflecting on exceptions to the problem can help teams think about ways in which the team and client system have been successful in overcoming problems and can help to build stories of competence and success, in an often problem-saturated milieu (Vetere and Dallos 2019).

- **Widening perspectives**

An individual's presenting problem and distress is a multifaceted, iterative issue that should be understood in terms of relational dynamics at various levels of contextual understanding (Vetere and Dallos, 2019). Based on the systemic formulation model for individuals, a systemic team formulation would include the following elements: context (current, historical, developmental, social, cultural); a genogram indicating family relationships and dynamics; traumas, transitions and attachments; support sources, coping strategies and protective factors (Vetere and Dallos, 2019). A widened perspective also entails thinking about wider contexts and agencies; families and relationships; beliefs and discourses; lifespan development and trauma; power and culture, and intersectionality.

Much like a reflecting team helps family members to hear different perspectives, team formulation can also allow team members to hear and internalise different stories and explanations. As Bateson (1980 in Vetere and Dallos, 2019) reflects, teams are thus 'learning to learn' and are being encouraged to be more curious and creative in their explanations about themselves, client systems, and each other.

It can be useful to use visual representations of wider systems when doing team formulation sessions, such as genograms and ecomaps. Genograms are helpful as both assessment tools and therapeutic interventions, as it can help inform the team of the wider family system and track intergenerational relationships, boundaries, and events in a client system (Vetere and Dallos, 2019). Ecomaps can also be used to show multiagency involvement in the care of a client system.

- **Relational reflexivity**

The focus of systemic team formulation, in contrast to other team formulation models, is that its main focus is relational. Viewing individuals' concerns and problems as happening between people rather than just within people, which stems from the systemic principle of circularity (Vetere and Dallos, 2019).

One of the first schools of family therapy research, the Mental Research Institute team (Watzlawick et al., 1974; Haley, 1963) proposed the idea that difficulties can often arise from repeatedly applying failed solutions to problems (Dallos and Stedmon, in Johnstone and Dallos, 2014). Systemic team formulation would thus include reflecting collaboratively on possible problem maintaining patterns and feedback loops (Dallos

and Draper, 2010). In addition, and importantly, systemic formulation also includes asking questions about how team members, including myself, may reinforce or shift these patterns and feedback loops. This process of asking relational questions about relational processes, Burnham (2018, p3) defines as relational reflexivity – he states that it involves “initiating, responding to, and creating opportunities to reflect, explore and experiment with the ways in which we relate to others.”

In systemic team formulation, a relationally reflexive discussion is held about possible circular patterns of interaction that may occur between team members and patients, and how these interactions may or may not mirror interactions that patients may have with their families and support systems. Problems that people face in their respective systems may often be mimicked and maintained through circular processes in their daily interactions with ward staff too creating unhelpful feedback loops. Similarly, studies from a psychodynamic approach have also explored how staff members’ countertransference feelings can be used to inform and develop the formulation, to better understand and respond to the client (Lieper, 2006). Psychodynamic approaches acknowledge these complex, relational psychological phenomena as parallel processes, projective identification and repetition, and some team-based studies have explored this aspect (Bloom and Farragher, 2011; Lewis-Morton et al., 2015).

Examining the circular and recursive patterns of behaviours, beliefs and feelings between staff and service user is key, as the inpatient ward environment can often become a microcosm of the service user’s familial system. Examining circular systems of causation was a key proponent of Gregory Bateson’s (1979) cybernetic

epistemology. Bateson, an anthropologist, social scientist, and cyberneticist, is often credited with providing the epistemological foundation and language for systemic theories. Cause and effect are thus circular in nature, whereby problems are maintained through iterative cycles of unhelpful feedback (Dallos and Stedmon in Johnstone and Dallos, 2014). Circular causality is a core principle in systemic therapy and implies mutual influence in that behaviour and emotions occur and are shaped by recurring interactional patterns (Stedmon and Dallos, 2009).

Hypotheses can then be explored about different ways in which staff could interact with patients more effectively on the ward. Studies have indicated that team formulation sessions can provide a systematic framework for hypothesising about relational and systemic problems (Cole et al., 2015). The Milan team suggested that these reflections should be seen as working hypotheses, in that information should always be open to revisions as new information emerges. This process of progressive hypothesising is a form of ongoing formulation, and according to the Milan team are inextricably linked to therapy (Johnstone and Dallos, 2014).

The third wave schools of systemic therapy influenced more heavily by social constructionism, argued that social contexts, language, and power should also be considered more carefully when formulating, as well as placing emphasis on being curious about the therapist's own background, culture, class and gender positions is key (Stedmon and Dallos, 2009).

- **Secure base**

One of the most important aspects of a therapeutic process is the therapeutic alliance between therapist and client system. Given that systemic team formulation invites attention to staff members feelings, it is imperative that the facilitator endeavours to create a secure base in the formulation sessions, and attachment perspectives can be drawn on to do this (Dallos and Vetere, 2021). This could involve building working relationships with team members over time within the system, and emphasising safety and validation in the team formulation sessions, encouraging a context where negative or distressing feelings are seen and validated (Dallos and Vetere, 2021). Systemic team formulation should thus provide a necessary space for ward staff (including myself, as the therapist and researcher) to become aware of their own thoughts, feelings, and reactions towards patients in crisis; and towards each other in the team. They can reflect on their positioning, with regards to professional status, gender, class, ethnicity, age etc, and how these may impact in the care they deliver to client systems, especially as the work context is often highly emotive. It provides a space where intense relational feelings between staff and patients are acknowledged, shared and normalised. It also creates a shared formulation space whereby staff can take a wider perspective (a meta) on the relationships and dynamics between staff members within the team, and with the wider hospital and mental health system too. Reflexivity should be seen as a key aspect of formulating as it encourages collaboration, flexibility, sensitivity, and self-awareness, and discourages a problem-saturated diagnostic style of formulation (DCP, 2011).

Another key aspect to be considered in formulation is the relationship the facilitator /therapist has with the team and/or the client system. As well as the relationship the

team has with the client systems. These interactional dynamics can sometimes show similar patterns, splits, and divisions in the formulation about how the client system interact with each other. Important to note that the facilitator of the team formulation sessions brings their own personal and professional experiences to the process of formulation, which should also be considered reflectively (Johnstone and Dallos, 2014).

2.4.2. Reflective practice in teams

The term ‘reflexion,’ which is the French translation of reflection, refers to a process of hearing something, taking it in, thinking it over, and feeding back those thoughts to others (Vetere and Dallos, 2019). Reflections can also be analysed at various levels of understanding, from intrapersonal processes to relational thoughts, as well as reflections about the team and wider contexts (Stedmon and Dallos, 2009). In my practice of systemic team formulation, I encourage teams to ‘start with self’ - Team members are encouraged to self-reflect on and share their own feelings, beliefs, and responses towards about a patient, and to identify how this may affect how the patient may feel and respond back to staff members.

Reflective practice often involves creating opportunities for teams to reflect on practice and processes; to build their knowledge by sharing experiences; to share different perspectives; to contextualise their practice in wider socioeconomic and political systems; to reflect on self and the impact of self on others and on practice (Onyett, 2007). Reflective practice can also be seen as a continuous process of reflecting and

re-reflecting on transformative and significant events and activities, drawing from multiple levels of interpretation (Stedmon and Dallos, 2009).

Reflection in action refers to the immediate act of reflecting in the here-and-now and may include self-reflections. This process of self-awareness usually occurs spontaneously when a significant realisation is consciously thought of. Reflecting *on* action involves looking back on events retrospectively and taking a meta-perspective on these events in relation to theory and hypotheses (Schön, 1983 in Stedmon and Dallos, 2009). These types of reflections are often a more focused process of sense-making and learning. Both types of reflection are evident and important in team formulation sessions. As Vetere and Cooper (in Stedmon and Dallos, 2009) note, the Swedish language has various words for reflection, which captures the complexity of the concept – they distinguish between a mirror reflection when looking at oneself in still river water, and the ability to reflect on the stones at the bottom of the river too.

From a systemic perspective, team formulation is not something that the therapist does for the team but is rather a socially constructed process created with the team. This can be seen in the extensive use of reflective teams and reflecting processes in systemic practice (Anderson, 1987). The therapist and teams come together to explore and reflect on a formulation of not only the client system's problems, but also possible interactional problems between team members and client systems. The reflective process is thus prompted through social engagement via dialogue and hearing other people's thought processes. Reflective practice is thus seen as an *inter*personal phenomenon occurring within and between people (Stedmon and Dallos, 2009).

Multiple perspectives can foster new reflections for team members and create a space to think about change. This concept of eliciting multiple perspectives is a cornerstone principle of systemic therapy and is reflected in various systemic techniques such as reframing, circular questions, future/miracle questions (Stedmon and Dallos, 2009). Campbell (in Barrett et al., 2018) notes that team members in organisations often hold beliefs and perspectives not about themselves, but about how they position themselves, and are in turn positioned in their relationships. This systemic understanding is made explicit in systemic team formulation sessions.

Chapter 3: Methodology and Methods

"Advances in scientific thought come from a combination of loose and strict thinking".

- Bateson, 1941, p55

This chapter summarises my personal and professional journey of research, methodological tensions, and learning as I progressed through this practitioner-based, systemic research study. I will describe the research design and methodology, with reference to the systemic, constructionist, relational, and hermeneutic epistemological frameworks that informed my research methodology (discussed in chapter 3.2). In chapter 3.3. I will describe the adaptations I made to my data analysis methods using IPA for focus groups.

3.1. Methodology

I chose a qualitative approach using IPA (Interpretive Phenomenological Analysis) with focus groups for this study as I thought it would be well suited to explore and understand team members' experiences of an under-researched phenomenon, that being significant and transformative moments in the process of systemic team formulation.

Qualitative research also leads to richer descriptions of participants' experiences that allows for a more robust understanding of psychotherapy processes and has higher ecological validity that is often lacking in experimental research (Forrester, 2010).

This study can be viewed as a form of *change process research*, which attempts to examine how the psychotherapeutic intervention of team formulation inspires change (Greenberg, 1986). While positivist research methods attempt to determine whether a causal relationship exists between psychotherapeutic interventions and outcomes, *change process research* endeavours to ascertain the nature of the therapeutic interventions and relationships within it (Elliot, 2010). The process component thus also reflects the progressively subjective and fundamentally improvisational quality of the experience (Pinsof and Wynne, 2000), which fits with my constructivist and hermeneutical epistemological positions in this study.

3.1.1. Research aims, questions and rationale

As discussed in Chapter 1, the main aim of my study was to describe and explore significant moments of systemic team formulation sessions facilitated on acute adult inpatient mental health wards, by exploring team-identified experiences of the process. I wanted to identify and better understand what team members[5] experienced as being transformative and/or significant events in the process of systemic team formulation, and to explore why team members described their experiences of these events as being significant.

Thus, the central research questions of my study were:

1. What types of events or moments in the process of systemic team formulation do team members describe as being transformative and/or significant for them?

[5] I will refer to research participants as team members and participants interchangeably throughout the thesis for ease of reference and to indicate my position as a practitioner-researcher and fellow team member at the hospital where the research took place.

2. Why do they experience those events as being significant?
3. What are the emergent individual, relational, and /or organisational experiential themes and patterns mentioned?

My research study also aimed to explore transformative and significant moments to better understand the process of systemic team formulation, in my clinical practice. As discussed in detail in Chapter 2, team formulation has been shown to have numerous intra and inter-personal benefits for teams that engage in the process of shared formulations, as well as for the care of patients who are discussed. The literature base for team formulation is relatively new but is growing. To date, there has also been no studies done on *systemic* team formulation, so my research study is an attempt to introduce a systemic model of team formulation to the literature base of systemic psychotherapy and team formulation. My study will also hopefully contribute to the evidence base for its continued practice.

I also hope that the findings of my study can be applied within an acute inpatient mental health setting and in today's dynamic NHS mental health system, characterised by high levels of work demands, stressed and stretched staff, irate service users often with complex presentations, and rapidly changing structures and culture (Cleary et al., 2011; Bloom and Farragher, 2011; Wampole and Bressi, 2019). My research study may thus have systemic benefits for the NHS and mental health community, as well as for the inpatient mental health staff, in that the practice will be better understood in terms of its impact, benefits and drawbacks.

3.1.2. A brief summary of my epistemological position

"Our minds are half window and half mirror.

I will never be wise enough to know when I'm looking out or when I'm looking in".

Anderson, 2022, p20

Within my constructionist, relational and hermeneutic epistemological framework (discussed in more detail in Chapter 2) and in addressing my research questions, I wanted the design of my study to mirror the circular, iterative, and interactive elements of both my systemic practice (Vetere and Dallos, 2018) and the way in which I facilitate team formulation sessions as part of my clinical practice. My training as a clinical psychologist and systemic therapist was based on systemic theories and approaches, particularly the strategic and structural approaches to family therapy (from a second order perspective) and third wave systemic therapies, such as solution-focused and narrative therapy. These approaches influence my theoretical framework and clinical approach as a practitioner. They also inform the principles I try to maintain when facilitating team formulation sessions and when doing research such as this one, in that it I strive to be person-centred, collaborative, relational, and trauma informed.

In addition, acknowledging that good qualitative research design involves selecting data collection and analyses methods which appropriately answer the research questions being asked (Willig, 2009), my research design followed a qualitative, interpretive phenomenology approach, focusing on change processes and significant moments research, using focus groups as a data collection method.

Much like systemic formulation (Vetere and Dallos, 2018), phenomenological research values subjective knowledge for psychological understanding and gives precedence to the sense and meaning people give to phenomenon, as opposed to the structure of the phenomenon (Willig, 2017). The interpretive process also acknowledges the roles of both the researcher and participant in meaning-making, which aligns with the second-order cybernetics perspective I endeavour to take in my systemic practice and research. In systemic practice, a second-order cybernetics perspective implies that observers (such as researchers, like me) are also participants within the systems with which they are engaged, in contrast to the detached and objective position in conventional scientific practice (Von Foerster, 2003) and in earlier systemic family therapy approaches. This perspective also aligns with my constructivist epistemological framework in this study, as well as my insider research position, in that I am researching from 'within the system'.

Shotter (2004, p221) distinguished between actionable research knowledge that attempts to capture experiences as an objective observer, *"in another world independent of us',* in contrast to research that enables us to *'enter into another world, not independent of us, but in relation to us*." Each research position has its strengths and limitations, as discussed in Chapter 1, where I explore my position as an insider researcher, as well as the challenges and limitations of this position, and how I tried to overcome them.

Change process research attempts to examine how psychotherapy produces change (Greenberg, 1986). While positivist research methods attempt to determine whether a causal relationship exists between psychotherapeutic interventions and outcomes,

change process research endeavours to ascertain the nature of the therapeutic interventions and relationships within it (Elliot, 2010). The process component thus also reflects the progressively subjective and fundamentally improvisational quality of the experience too (Pinsof and Wynne, 2000) which again, aligns with the epistemological and systemic frameworks of this study. I discuss my epistemological position with regards to my methodology in more detail in section 3.2.

3.1.3. Systemic team formulation - context and procedure

I chose to do my study on an acute adult inpatient psychiatric ward, as studies within these units show that highly developed communication and personal skills are key for staff working with patients and each other in this challenging setting (Clearly et al., 2012; Wampole and Bressi, 2019). It has also been advocated that further research should focus on the understanding and development of conditions that enable the transfer of therapeutic interactional skills and relational awareness. (Onyett, 2007; Clearly et al., 2012; Kramarz, 2021).

For the purposes of contextualising my *practice* of systemic team formulation on the acute wards where the research took place, the process of systemic team formulation usually involves the following elements: 1) Weekly staff reflective practice groups, where team members usually identify and discuss a patient they would like to bring to the bi-monthly team formulation sessions; 2) the actual systemic team formulation sessions which usually take place a few days to a week after the initial discussion. I usually facilitate these sessions, with the assistance of trainee psychologists and assistant psychologists. Points and comments made in these sessions are transcribed

and emailed to team members who were not present; 3) if appropriate, care plans are then drawn up by the key nurse, in interaction with patients, if possible, as a result of the action points identified in the team formulation sessions. 4) Action points taken are then discussed and evaluated by team members in subsequent reflective practice groups.

In the Introduction chapter (Chapter 1), I have provided additional contextual information about how this model of team formulation emerged and evolved in my practice on the wards, and what my (and the organisation's) rationale was for putting it in place. I also give some background information on my development as a systemic practitioner, and key people and theories which influenced my practice in this regard.

I chose to research my team formulation process by asking team members from five different acute adult inpatient mental health wards to voluntarily participate in reflective, semi-structured small focus group interviews after I had facilitated a systemic team formulation session on their wards. It is important to note that I work on two of the five wards, and thus I had different levels of relationships with the various participants. This will be discussed further in the section on ethics later in the chapter.

3.1.4. Research participants / team members

My participant group were voluntarily recruited and included multi-disciplinary mental health care professionals working on five adult acute psychiatric inpatient wards in an NHS hospital in Berkshire. In total, my research participant group was 12 people (approximately 2-4 in each focus group) and included nurses, consultant psychiatrists,

support workers, occupational therapists, ward managers, ward psychologist and assistant psychologists. These team members were voluntarily but purposively recruited to participate in focus group interviews (research practice) after they had attended a team formulation session which I had facilitated or co-facilitated (routine clinical practice).

The main selection criteria for research participants was that they attended a full process of systemic team formulation which I had facilitated on the ward, together with the other team members who volunteered to be interviewed. The recruitment was purposive in that participants had to have experienced a systemic team formulation session related to this study. Thus, all participants in each of the small group interviews would have attended the same team formulation process. This was to ensure that the discussion of significant events was related to the same process.

Purposive sampling is typically used in qualitative research, where the deliberate choice of participants contributes to a better understanding of the phenomenon being studied (Willig, 2009). This sampling method is also often used when conducting research using an IPA approach (Larkin and Thompson, 2012). Participants are usually selected purposively because they can offer a valuable perspective on the topic in question. Since my research was about a specific intervention in my practice which I offered to mental health care professionals on adult acute inpatient wards, I wanted to research the experiences of team members who were involved in these sessions and thus invited, via email, all health care professionals who had attended those sessions to participate in the research study. The research group was voluntary, as participants self-selected to participate in the study. Informed consent was obtained

from participants who opted into the interviews. The limitation of this sampling method was that it may not have been representative of the population group being studied, despite the homogeneity of it being mental health care professionals being recruited. I was also limited in the number of participants in each group, with each group averaging between 2-3 team members. I did however get a range of participants in my research group, who varied by age, gender, race, culture, education, and profession. Half of my group of my participants were support staff and assistant psychologists, and the other half were health care professionals (nurses, medical and psychology staff). More than half of the participants were in the 20-30 age range. A large proportion of the participants were white British.

Participants	Occupation	Gender	Age range	Ethnicity
P1 (group 1)	Psychologist	Female	40-50 years	White British
P2 (group 1)	Support worker	Female	20-30 years	Black British
P3 (group 1)	Assistant psychologist	Male	20-30 years	White Other
P4 (group 2)	Nurse	Female	20-30 years	South Asian British
P5 (group 2)	Occupational therapist	Male	30-40years	White British
P6 (group 3)	Support worker	Male	30-40 years	Black Afro Caribbean
P7 (group 3)	Occupational therapist	Male	20-30 years	White British
P8 (group 3)	Support worker	Female	20-30 years	White Irish
P9 (group 4)	Nurse	Female	20-30 years	White British
P10 (group 4)	Psychiatrist	Female	30-40 years	White European

P11 (group 5)	Support worker	Female	30-40 years	Black British
P12 (group 5)	Assistant psychologist	Female	20-30 years	White British

Table 2 – Demographic details of the research participants interviewed

3.1.5. Data collection and research design

Data was collected from transcriptions of audio recordings of focus groups with team members after the team formulation sessions had taken place, as well as research diary notes, and post-focus group interview notes. I conducted the interviews using semi-structured interview questions (See appendix D). A small pilot study was initially conducted with some team members to trial the semi-structured questionnaire and was found to be clear and easy-to follow by team members. Data was analysed with an Interpretive Phenomenological Approach for use with focus groups. (Palmer et al., 2010; Phillips et al., 2016) with some systemic adaptations of my own.

I facilitated a team formulation session on each of the five wards as part of my normal clinical practice, and a few days afterwards I conducted small, focus group interviews with team members who had attended the team formulation sessions from each ward for research purposes. Around half of the team members who attended the team formulation sessions, volunteered to participate in the study. These semi-structured interviews took place after five, separate team formulation sessions, done at different times and with different staff, across the five wards. Focus group interviews were conducted with team members who had opted into the research study and had given informed consent to participate. Participants were informed about the research study

immediately after the team formulation sessions had taken place, and they were advised to contact me if they were interested in participating – I reassured team members that participation was voluntary and that they would be given an opportunity to give informed consent before participating.

In the focus groups, team members were asked to recall aspects of the team formulation session, and to identify and discuss their perceptions and experiences of transformative and significant moments in the systemic team formulation process that they had participated in. The open ended, semi-structured evaluative questions (see Appendix D) used for the focus group discussion were based on the Helpful Factors of Therapy form (Llewelyn, 1988) and significant moments research approach, which has been identified as a useful measure in psychotherapy process research.

The focus group discussion with the team started with general questions: the team were asked whether they could recall moments that were experienced to be significant during the session. Then team members were asked the following questions: What kind of feelings did you experience at/around that moment? What was on your mind? How did you perceive that moment and the team at/around that moment? The notes from these focus group discussions were transcribed for data analysis.

These semi-structured interviews were conducted by me, and were audio recorded and transcribed for research purposes. Process notes from the staff support groups, team formulation sessions as well as the care plans drawn up from the team formulations were used as *prompts* in the interviews to enhance team members' recall and interpretations of the team formulation process, and to allow for a more critical,

specific, and in-depth response from them. These clinical materials are gathered as part of the usual process of team formulation.

Small focus groups allowed me to capture relational responses of the group to the expressed opinions, beliefs, feelings, and experiences of group members (Howitt, 2010, Bloor, 2001), which fits with the systemic theoretical framework of the study. Focus groups also allowed me access to a more naturalistic process of communication and helped me explore detailed and nuanced experiences of team members in a group setting, mirroring the kind of relational discussions often held in a team formulation session.

I believe the data was enriched due to participants reflecting on and sharing their experiences, as well as clarifying and checking for understanding both among participants and between participants and myself. Moreover, there is some suggestion that such advantages combine to enhance rather than hinder methodological rigour - to reach a richer understanding of the phenomena studied. (Bradbury-Jones, 2009). A limitation of focus groups is that participants may feel hesitant to honestly express their views and experiences in a group, particularly if they oppose another member's views in the group (Bloor, 2001). Convening the focus groups with existing team members might have helped facilitate dialogue due to team rapport, but team dynamics can differ, so this may have been a limitation of this data collection method.

I conducted the research study as a participant-observer and a facilitator, on five acute adult psychiatric inpatient wards in a hospital in Berkshire. I work on two of these wards. Some of the systemic team formulation sessions were facilitated by me, and

other sessions were co-facilitated with other therapists. This was to ensure that I was able to sit in and observe different positions as a researcher within the study, and to allow for a wider range of responses across wards where I was a team member and where I was not. My co-facilitators, who were peer psychologists, also interviewed me after the research interviews, based on the same semi-structured interview questions. This was to allow me to reflect on my role and position as either facilitator-practitioner, participant-observer, researcher, and team member. I also kept a research diary to reflect on my experiences of the process of team formulation, as well as the research process as a whole.

3.1.6 Data analysis

An interpretive phenomenological approach (IPA) designed for focus groups (Palmer et al., 2010) was used in an innovative manner to analyse focus group-generated data in this study. I will describe the adaptions I made later on in this chapter.

IPA allows for an understanding of people's experiences of themselves and traditionally, is an idiographic approach to the study of individuals. I choose IPA as a data analysis approach above other qualitative approaches as it was consistent with my epistemological position of systemic theory, social constructionism, and interpretivism, and it was also a good fit for my research questions. IPA is a special research interest of mine, and I have developed some expertise in the method as I have used it in other research studies. The latter were also important considerations in my choice of research method (Harper, 2011). As opposed to research methodologies that focus on a descriptive account of participants' experiences

(thematic analysis); or on participants' discourses (discourse analysis); or on the cultural context (ethnography), I aimed to explore an in-depth *hermeneutic* understanding of how team members experienced the processes and significant and/or transformative moments of the team intervention, and the factors they thought facilitated possible change in the team and in their interactions with patients. In my epistemological position, knowledge was thus assumed to be created in social interaction (Harper, 2011) between myself as a researcher-practitioner and by the team members in my study, the research participants. In line with a social constructionist agenda, 'findings' were developed as the research proceeded and I analysed my data in relation to the whole, with a keen awareness of context, language, relationships, and culture.

Please refer to section 3.2. for a more detailed discussion of my epistemological position and reasons for choosing IPA as a methodology.

A recent development by Palmer, Larkin, de Visser and Fadden (2010) has however provided a more systemic approach (with a clear protocol) to analyse and interpret experiential claims in a group setting. While focus groups constitute a complex interactional environment, they allow for multiple voices to be heard and for experiential claims to be understood within a fairly complex set of social and contextual relationships (Palmer et al., 2010). This method of analysis, while complex in practice (Palmer et al., 2010) embodies the epistemological frameworks of this study, and also the systemic team formulation principles embedded in the intervention being studied. A more detailed exploration of how this method of data analysis was adapted to be

more systemic, such as the inclusion of a self-reflexivity column in the data analysis protocol, will be discussed further in chapter 3.3.

3.1.7. Considerations of validity enhancement strategies

In qualitative research, there isn't consensus on whether validity and reliability enhancement strategies, such as inter-rater analysis and member validation, are important to ensure research 'rigour'. These strategies were not employed in this study, as it did not fit with my epistemological position, which assumes that the relevant *reality*, as far as human experience is concerned, is that it is socially constructed and created relationally. I assumed that each individual's subjective experience (including my own experience as a team-member, clinician, and researcher), as well as the team members' subjective experiences of the processes in systemic team formulation, were all socially and relationally constructed. As such, inter-rater analysis would not be applicable.

My epistemology around the 'validity' of my data analysis and results is based on the phenomenological approach, which recognizes that `If the essential description truly captures the intuited essence, one has validity in a phenomenological sense' (Giorgi 1988, p. 173). As such, the findings of my analysis are subjective to *my* knowledge, practice, and context. I believe that my descriptions of the research findings are, however, plausible. I aimed to explain my data analysis approach transparently and systematically, including accounting for the steps of the analysis process (Webb and Kevern, 2001). I also tried to present my findings as reflexively, relationally, and authentically as possible (Simon, 2018). I also extended the concept of reflexivity by

also including it as a key element of the interpretive systemic phenomenological analysis process I followed in analysing my data. These were the strategies I used to ensure research rigour, in that the methodology and analysis process was clearly explained.

3.1.8. Ethical considerations

This study endeavoured to follow the ethical guidelines recommended in the Research Governance Framework for Health and Social Care (Department of Health, 2005), BPS code of human research ethics (BPS, 2014) and Health and Care Professions Council's standards of conduct, performance, and ethics document (HCPC, 2012). Ethical approval was obtained before commencing data collection from the Tavistock ethical committee, from the University of Essex, and the Berkshire NHS Foundation Trust ethical boards (see Appendix B).

One of the basic but imperative ethical principles is that of voluntary participation and informed consent. Participants that agreed to partake in this study were given accurate information about the purpose, procedures and duration of the research, and that they had the right to withdraw up until the stage of writing up the analysis chapter (approximately 3 months after data collection), and that there would not be any consequences of participating and /or withdrawing. (Howitt, 2010). Participants were informed that focus group interviews were going to be audio recorded and transcribed, but that all efforts were made to ensure confidentiality and anonymity of respondents and service users discussed. Participants were given information sheets (see Appendix C) and were asked to read and sign informed consent forms (see Appendix

C). I used participant identification numbers in replacement of names and all other identifiable information, such as service user details were omitted.

I also thought carefully about threats to internal anonymity, as I was aware that audiences from inside the study may have been likely to recognise other participants by their professions or roles within the quotes shared in the discussion chapter. This is a risk in multi-perspectival research (Larkin et al., 2019; Ummel and Achille, 2016). As such I was mindful about anonymising any sensitive information which I presented, without attribution to identifiable characteristics, to prevent group participants from identifying each other. I also ensured participants were fully briefed and made aware of this risk when discussing informed consent at the start of the data collection process.

With regards to another aspect of ethics, I was particularly aware of the power relationships inherent in conducting, describing, and interpreting research, as a team member/researcher. While the interview power relations are somewhat asymmetrical in this study, i.e. I initiated and provided the initial format for the formulation and interview; the dialogue was multi-directional in that it was between team members and myself. Due to the systemic nature of the research, the research study was instrumental to both me and to the team, as it serves the needs of both. Change process research methods encouraged team members to articulate and contribute valuable information and meanings they attributed to change processes in the intervention. The team formulation and the process of research were explicit in their nature, as team members were clear about the research agenda (Howitt, 2010). I tried to remain observant and curious about group dynamics in the focus groups and included those observations in my data analysis process. This included trying to

remain attentive to group processes amongst participants in the group, and between myself and them.

Being a team member myself may have facilitated the dialogue between myself and the focus group participants, as I have built up working alliances with some team members over the years I have worked at the hospital, and I also understand the challenges and experiences of working in that environment. A possible limitation of me being a team-member researcher could be that participants may not have felt comfortable sharing all their experiences with me, as a fellow team member and facilitator of the sessions. Conducting team formulation sessions and focus groups on a range of wards (some where I knew and worked with the staff, and others where I did not) allowed for me to experience different positions as a researcher and allowed for a varied and richer set of data to be collected.

The team formulation session is, in itself, a debriefing session, but I also engaged with team members afterwards in a mutual discussion of the nature, findings, and conclusion of the research, as a way of learning and improving practice. Team members were also given a summary of the research findings after it was written up.

All data was kept and transported securely (in a lockable case) in accordance with the Data Protection Act (1998) and with the Trust's data protection and storage policies. During transcription, electronic data was stored on an encrypted password protected device. All identifying information was removed from transcripts and pseudonyms were given to each group and participant. Data from the research study will be destroyed

once the research study is completed (after the final assessment of the thesis and submission), as permission was not gained for data to be stored for longer.

3.2. An Epistemological Exploration

"Truth is not born nor is it found inside the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogical interaction" (Mikhail Bakhtin 1984 cited in Simon and Chard, 2014).

In this sub-chapter I will outline and discuss, with reference to my systemic epistemology, the various research methods, and strategies I used in my methodology namely: change process research; interpretive phenomenological analysis (IPA); and focus groups. Systemic theory was my overarching theoretical framework and epistemology, as well as the main modality of my clinical practice. I will initially explore the epistemological underpinnings of each framework in relation to my study[6], with reference to systemic principles and theories.

I will also critically discuss how I adapted the IPA for focus groups models, proposed by Palmer et al (2010) and Phillips et al (2016) in this study. One of my adaptations included explicitly incorporating the use of self in the data analysis process. I will reflect on my experience of doing that as a practitioner-researcher in this study with reference to my systemic epistemology.

[6] My qualitative research study aimed to understand the significant moments in my practice of systemic team formulation on adult inpatient mental health wards. Systemic team formulation was a staff focused, supervision intervention which I regularly facilitated with staff on adult inpatient mental health wards in my role as clinical psychologist.

3.2.1. Epistemological underpinnings – stance or tool?

Epistemology, as a philosophical term, refers to how reality is known, and the relationship between the knower (or would-be-knower) and the known. It is distinguished from the terms: ontology (the form and nature of reality), axiology (values), and methodology (the process of finding out what can be known) (Guba and Lincoln, 1994). The purpose of epistemological traditions is to provide researchers with a set of assumptions to analyse the nature of knowledge and how it relates to notions of truth, belief, and justification.

Soini et al (2011) argue that epistemology should not be seen solely as a *stance* that is rigidly decided upon before engaging in research and literally followed, regardless of the research demands. He proposes that it be viewed as an explicitly chosen *tool* instead, to assist the researcher in their process of formulating questions, making methodological choices, and finding answers. In relation to using chosen epistemologies as tools, an understanding of what and how reality is known iteratively influences the: a) approaches used to get knowledge (theoretical perspective); b) the procedures and tools used to acquire knowledge (methodology and methods); which ultimately then impacts on c) the data that can be collected (sources). This set of beliefs that fundamentally guides how problems should be understood and addressed is known as a paradigm (Guba and Lincoln, 1994). The overarching paradigms in this research study were based on my beliefs that qualitative accounts of experientially based realities are socially, relationally, and reflexively constructed.

There has been a growing interest in alternative, qualitative research paradigms in response to a dissatisfaction with the conventional, quantitative research paradigms. However, the process of *epistemological* reflection is crucial for researchers to better understand how their contribution to knowledge production links to particular paradigms, which gives different answers to the questions raised by epistemology (de Gialdino, 2009). A reflexive researcher thus *actively* assumes a theory of knowledge. A critical understanding of epistemology in research is thus important, as it positions the relationship between researchers and participants; it considers appropriate measures of research quality; it influences voice and representation in the method; and is axiological in that it provides a basis for exploring and justifying types of knowledge that are admissible or not (Guba and Lincoln, 2011).

Trigg (1985 in Wainwright, 2000) similarly asserted that empirical social science research should always be founded on a solid philosophical base. The philosophical research paradigm, or belief system provides a platform for researchers to ascertain questions around the nature and form of reality, as well as the relationship between the researcher and this proposed reality. The latter then informs the choice of methods to pursue finding out about this reality (Guba and Lincoln, 1994). The ‘puzzle pieces’ of ontology, epistemology and methodology should thus link together, to logically inform the research study. When choosing my research methodology, design, and data analysis methods for this study, I wanted them to align with my chosen epistemological research ‘tools’ of systemic theory, social constructionism, hermeneutics, and interpretive phenomenology. Dickerson (2010) asserted that epistemology, or thinking about our thinking, provides us with an ‘invitation to position ourselves in a way of thinking so that the practices we employ and theories we follow

are consistent and congruent'. When choosing my research methodologies and approaches, I had to critically reflect on epistemologies in general, as well as on *my* epistemology, which has been partly influenced by the constant push for research within a positivist paradigm in my field of practice - clinical psychology, as well as by a systemic paradigm in my training and practice. The epistemological frameworks that most influence my research and practice are systemic theory, social constructionism, and interpretivism. As such, they will be discussed further below.

3.2.2. Systemic Epistemology

"When you are a crab scuttling along the seabed,

The ocean is your sky and the whales are your clouds." -Anderson, 2022, p27

My overarching epistemology in this research study was systemic, based on general systems theory principles, which I used as both a stance and tool throughout the study. This epistemology underpins the clinical training I have received and influences my practice, my worldview, and my beliefs.

I believe that a general systems theory approach is not just a theory of ideas, but rather a shift to a different way of seeing the world in terms of wholes and relational patterns. It is a pan-disciplinary epistemology, in that it can be used (as a stance and/or tool) across conventionally defined disciplines such as biology, computer science, engineering, sociology, economics, family therapy, medicine, or psychology. A systemic epistemology allows for the idea that 'there are things that emerge in groups of two or more parts that are not witnessed in those parts alone', hence, the whole is

greater than the sum of two parts. Gregory Bateson (1972), an anthropologist and ethnologist who greatly influenced the field of systemic family therapy, described this 'whole-world perspective as an ecosystemic epistemology, which is based on the worldview that the universe is a single ecological system made up of an infinite number of non-material (mind) and material (substance) subsystems.

Systemic thinking can be considered an epistemological shift of seeing the world in terms of relational wholes, as opposed to discrete individual pieces (Hanson, 2014). Within this epistemology, causality is seen as circular and adopts a *cybernetic* perspective to understand how systems operate and how change can be elicited. Bateson (1972) recognised that essentially, a system is any unit structured on feedback. It is an entity composed of interacting parts which influence and are influenced by each other, such that they create identifiable patterns. These observed patterns connect the various parts in a coherent and meaningful manner (Dallos and Draper, 2005).

A systemic epistemology also considers that meaning is relative to *context*, and highlights the role of historical, constitutional, and contextual factors in predisposing individuals to adopt a particular belief pattern (Carr, 2012). It offers a view of problems and phenomena as fundamentally interpersonal and inter-dependant, as opposed to intra-personal and individual (Dallos and Draper, 2005).

- **Cybernetics and circularity**

One of the key principles of a systemic epistemology is based on the science of cybernetics (in Goldenberg and Goldenberg, 2012), which originated in the 1940s in the cross-disciplinary fields of engineering, mathematics, science, and social sciences. In my early studies of systemic theory and practice, I was drawn to this principle, as I was curious about how it resonated with my observations of interactional feedback cycles in my own personal relationships, and in other relationships I observed in my practice.

Cybernetics focuses on the study of communication, with reference to regulation and control, through the operation of self-correcting feedback mechanisms (Goldenberg and Goldenberg, 2012). Bateson (1972) recognised that this epistemology could be applied to understand families as systems which maintain balance and constancy through self-regulating feedback mechanisms too. This was a significant paradigm shift in the social and behavioural sciences, as it encouraged social scientists and therapists to adopt a relational and circular outlook on phenomena. This entailed a shift from understanding psychological problems in individuals, families and other systems based solely on content (linear historical facts) to considering the importance of *process* (circular interactional patterns) as explanations for behaviour (Goldenberg and Goldenberg, 2012).

- **Second order cybernetics**

Within a cybernetic epistemology, another important systemic principle considers that it is not possible to observe and/or attempt to change a system from an objective, outsider position, as the observer is both influenced by and influences the system.

This principle is an important aspect of postmodern family and systemic therapy (Goldenberg and Goldenberg, 2012), and is an important aspect which I considered in my research practice too.

Cyberneticists emphasise that objectivity does not exist, and that descriptions of an individual's accounts are not objective, but rather a social construction that may say more about the describer than the individual. A 'family's described reality is an 'agreed-upon consensus that occurs through social interaction of its members' (Goldenberg and Goldenberg, 2012, p19). My epistemological view is that this principle could be applied to other natural social systems and groups too, such as teams and focus groups. A team, including a focus group, is composed of multiple perspectives, and the researcher has a part in constructing the experiences shared and reality being observed. A second-order cybernetic model is synchronous with theories of social constructionism and IPA, as discussed below.

3.2.3. Social Constructionism and Interpretivism in research

There are a plethora of definitions and debates about what social constructionism is, in both research and practice, so it is important that I share the definitions which most resonated with my understanding and application of the epistemology, in that it:

> *"…replaces the dualist epistemology of a knowing mind confronting a material world with a social epistemology. The locus of knowledge is no longer taken to be the individual mind, but rather patterns of social relatedness" (Gergen, 1994, p. 129).*

and that *"…our culturally adapted view of life depends upon shared meanings. The self is a construction that proceeds from the outside in as well as from the inside out" (Bruner, 2020).*

The paradigms of constructionism and interpretivism moved away from the positivist notion of ontological realism towards ontological relativism, which assumes that reality exists as intangible mental constructions, based on local experience and within specific social interactions. Realities thus, can and do change within this paradigm. Social constructionism as a paradigm is often criticised for being anti-realist in denying that knowledge is a direct perception of knowledge, but constructionists maintain that knowledge (in research studies) is created in social interaction between researcher and respondents and the research findings are created as the study proceeds.

My subjectivity as a researcher is thus, acknowledged. It is this circular and relationally reflexive process that prompted my adaptation of the IPA for focus groups methods discussed further below. Methodologies from a social constructionist perspective are thus often hermeneutical and dialectical, to allow for an inquiry into the social constructions created between and among researcher and participants (Guba and Lincoln, 1994). Thirsk and Clark (2017, p.8) advocate hermeneutic methods for research on complex healthcare interventions, to go 'behind and beyond what is said'. Knowledge from a constructionist perspective is context and time dependant and is further pursued by exploring the meanings attached to phenomena. To do this, researchers often interact with participants to obtain data, and the inquiry impacts *both* the researcher and participants (Krauss, 2005). It is also useful to allow questions to emerge as the research process unfolds.

Systemic thinkers and qualitative researchers acknowledge that phenomena are better understood when viewed relationally, iteratively, and within their contexts. In my view, an effective way to pursue understanding of phenomena is to become immersed into the culture or context being studied and experience what it is like to be a part of it – it is from this basis that I decided to conduct research within my own area and context of practice. I have reflected further on the value and challenges of conducting practitioner-based research from-within, in Chapter 1. It is worth briefly noting, that I was already immersed in the practice of systemic team formulation on the wards, and the project grew from that.

Constructionists argue that all quantification in research is limited in nature (Krauss, 2005) and that by only focusing on a small portion of a reality, the importance of the *whole* phenomenon is lost. It can also be argued that it is impossible to ever see the *whole* and that all we ever see is a partial picture. Knowledge is thus progressed through mutual understanding and is constructed within a social community through language (Gergen, 1994). Systemic thinking also subscribes to the view that people and their identities are formed in relationship processes, and systemic psychotherapy often adopts a hermeneutic position of focusing on meaning and experience in a collaborative and negotiable manner (Dickerson, 2010).

A range of research methodologies and methods allow for the pursuit of this epistemology within the fields of psychology and systemic family therapy, such as discourse analysis, narrative analysis, interpretive phenomenological analysis and ethnography. Psychological and family therapy theories that were influenced by a postmodern and social constructionist perspective include solution-focused therapy,

narrative therapy, and integrative systemic therapies. These therapies position themselves in a post-structural, social constructionist epistemology because they all view the person as “being constituted rather than as essential, as dependent on context, and as having access to multiple identities.” (Dickerson, 2010, p355) They acknowledge that problems are constructed in reaction to dominant discourses, and that the process of change in therapy is a collaborative process. Collaboration is a value which I prioritise highly in my therapy practice, and as such, it is also a key aspect of the team formulation sessions I facilitate with staff (as discussed in the literature review chapter). My data collection method of focus groups sought to create a collaborative space for sharing multiple accounts of reality in this research study.

The relevant *reality*, as far as human experience is concerned in this study, is that it takes place in each individual’s subjective experience (including my own experience as a team-member and researcher), as well as the team members’ subjective experiences of the processes in systemic team formulation. My study thus aimed to explore multiple mental and relational constructions about how team members experienced and shared the transformative and significant processes of systemic team formulation. From an ontological perspective, this view of reality corresponds with the constructionist paradigm (Guba and Lincoln, 1994). The systemic epistemology of my research study, and my formulated research questions, are based on this paradigm and pursue a hermeneutic understanding of the process of the team formulation intervention, i.e. I’m curious about the factors that facilitated *change* in the team and in their interactions with patients, and the team’s *experiences* of the intervention. I am also curious about and want to learn more about my own psychotherapy practice.

Within the paradigms of postmodernism and social constructionism, the fields of psychotherapy practice and research have been challenged to consider the following factors: multiple accounts of reality; language as an avenue for reality construction; and the primacy of social interaction (Couture and Sutherland, 2004). Systemic family therapies acknowledge this postmodern epistemological stance, but while the field of systemic therapeutic practice acknowledged the complexities of multi-levelled systems and constructions of reality, the research methods available to study them remain to be mostly linear, individualistic, mechanistic, and decontextualised (Couture and Sutherland, 2004; Burck, 2005).

Research is a way of generating and discovering knowledge and provides an opportunity to be curious about the unfamiliar, and to notice and experience uniqueness in our practice. It is a process of looking again - looking with a new perspective and from a different position. (Simon and Chard, 2014). It was thus crucial that I considered my multiple positions within the team (ward psychologist, supervisor, facilitator of team formulation sessions, researcher), and to acknowledge the potential ambiguity and ethical implications with regards to power and difference. I attempted to position myself, where possible in the role of the observer in order to place myself in an unfamiliar position. This was to try widen my own lens and to provide myself with the opportunity to ask valid questions and to increase my reflexivity.

Reflexivity allows for an examination of our research choices, as well as our multiple identities that represent the fluid self in the research setting (Guba and Lincoln, 2011). Reinharz (in Guba and Lincoln, 2011) argues that three ‘selves’ should be considered in research reflexivity: our research-based selves; our historical, social and personal brought selves; and our situationally created selves. I paid particular attention to

reflect on my how I was initially positioned in the team, how I positioned myself in the team, and how I was currently positioned by the team in my data analysis and in my write up of the findings.

Practitioners who adopt postmodern, constructionist approaches understand change as being negotiated through the conversations of therapy. With this systemic and interactive focus in mind, research conversations (interviews, focus groups etc) can be seen as an intervention, and are transformative (Couture and Sutherland, 2004). In my research study, the team formulation sessions I facilitated are in themselves a systemic, clinical intervention, and the focus groups too may have been a transformative process for staff and for me.

Team formulation sessions can be seen as an effective and emancipating means of giving voice to the team's clinical experiences and insights, it encourages a more psychosocial understanding, and provides alternative perspectives to narrow, diagnostic-based care plans. It also encourages all staff to take an active role in care planning (Johnstone, 2018). Thus, team formulations can be said to illustrate the benefits of the constructionist epistemology in a largely positivist, medical model context.

3.2.4. Change Process Research

Change process research (CPR) outlined by Greenberg and Pinshof (1986), and my intended research approach focuses on research that explores the processes that

bring about changes in therapy (Elliott, 2011). Greenberg and Pinshof (1986) offer the following definition of process research:

> *"Process research is the study of the interaction between the client and the therapist systems. The goal of process research is to identify the change processes in the interaction between these systems. It can cover all the behaviours and experiences of these systems within and outside the treatment sessions, which pertain to the process of change". (p. 181)*

Outcome-based research traditionally has strong ties to positivist assumptions, in that it concerns itself with explaining both how and why change occurs (Elliott, 2010). While positivist research methods attempt to determine whether a causal relationship exists between therapeutic interventions and outcomes, *change* process research endeavours to ascertain the *nature* of the therapeutic interventions and relationships within it (Elliot, 2010). It seeks to reveal the 'active ingredients of therapy' (Dallos and Draper, 2005). The "process" component thus also reflects the progressively idiographic and fundamentally improvisational quality of therapeutic experiences (Elliot, 2011). As such, this kind of research can be useful to distinguish differences and commonalities between therapeutic approaches.

Process research methods offer several strategies for uncovering and evaluating explanations for client change, which are more constructionist and circular in their pursuits. These studies aim to understand the nature of change mechanisms in the interaction between systems, so that outcomes from therapeutic interventions can be tentatively linked to certain processes (Goldenberg and Goldenberg, 2012).

Qualitative data on change processes can be collected by means of post-treatment interviews, post-session open-ended questionnaires, such as the Helpful Aspects of Therapy Form (Llewelyn, 1988), therapist process notes and reports, varied forms of open-ended and semi-structured recall interviews focused on significant moments (Elliott, 2011), and audio recordings of psychotherapy sessions which can then be transcribed (Elliott, 2010). These methods allow for a more subjective research focus, which is appropriate for understanding therapeutic processes and allows clients to express and contextualize elements of change that appear to be important in their own experiences of therapy.

Significant events research (Elliott et al., 1985), which is the change process research design I used in this study, is a specific approach to explore client-identified important moments (i.e., change process) in therapy. It is a form of psychotherapy process research whereby the actual event transcript, as well as the clients' and therapists' reflections on the event are the forms of data analysed. The rationale for this type of research acknowledges that significant events are the moments of the most fruitful therapeutic work in the process of therapy. These moments could be helpful or unhelpful/hindering events (Timulak, 2007). Significant events research forms part of a broader type of research known as the 'event paradigm', which intensively analyses smaller episodes of the therapeutic process (Greenberg, 1986). Those episodes could be moments identified by clients or are based on theoretically relevant episodes,

- **Change process research in context**

From a positivist and postpositivist perspective, theories of change in my field of clinical psychology therapies are often seen from an individualising epistemology,

which generally positions therapists (and the researchers) as experts (Dickerson, 2010). The psychological approach of CBT for instance, holds the assumption that logic can be used to identify and challenge false beliefs which contributes to negative emotions. Psychoanalytic theory proposes that behaviour is linked to unconscious motives, and an awareness of these drives is cathartic. Both of these therapeutic paradigms could be seen to be epistemically deterministic and based on a presupposed notion of reality.

Another good example of a positivist view on problems and change within the field of mental health was the development of the Diagnostic Statistical Manual of mental disorders, which attempts to categorise behaviours and emotions as generalisable symptoms and criteria, which are then classified as mental disorders. These classifications imply positivist assumptions of being value-free, time-free and culture-free. The field of systemic family therapy research has previously been criticised for being unreliable and biased in terms of measuring efficacy of family therapy (Stratton et al., 2015). There is thus also a strong positivist drive in this field too, to produce psychotherapy research that is evidence-based, and outcome driven. An example of this is the ongoing research pursuit of developing a self-report outcome measure (SCORE) for families undergoing systemic family therapy, in order to measure efficacy and maintain standards of practice (Stratton et al., 2015).

Positivist research was and is important for positioning systemic psychological therapies in the field of science, as it focuses on establishing the existence of a causal relationship between therapy and client change, and statistically demonstrating effective outcomes and standards of psychotherapeutic interventions. This, so-called,

gold research standard of randomised control trials still dominates peer-reviewed journals as ‘hard science’ (Goldenberg and Goldenberg, 2013), but these kinds of studies also appear to focus too narrowly on establishing an *existence* between therapeutic intervention and client change. They often fail to describe *how* and *why* those changes were brought about in therapy, including the temporal course of those changes, the context within which the therapy took place, and the influencing role of the therapist. They have also been criticised as making simplistic assumptions about the complex and nuanced nature of the therapy process (Friedlander et al., 1994).

There is already a strong and growing evidence base for systemic interventions, which includes a wide range of approaches to working with families and systems, including change process research studies (Heatherington et al., 2015; Carr, 2019; Stratton et al., 2015). Most of this process research has however, been focused on common factors, especially the working alliance (Sprenkle, Davis, and Lebow, 2013). There have also been a few studies of in-session moments that clients identified as significant (e.g., Bowman and Fine, 2000; Helmeke and Sprenkle, 2013; Strickland-Clark, Campbell, and Dallos, 2000).

In the messy context of human emotions, behaviours and relationships, therapeutic changes typically take place during and outside therapy sessions, within individuals as well as between and among them. The person and their world are thus not separate but instead are co-constituting and mutually disclosing and constructed. (Larkin et al., 2006). The latter is the epistemological position I took in this research study which led me to using change process research as an approach, and it is also one of the fundamental principles and assumptions of systemic theory and practice.

3.2.5. Interpretative Phenomenological Analysis

Interpretive phenomenological analysis (IPA) has epistemological roots in phenomenology - the study of conscious experience; symbolic interactionism, the idea that mind and self-emerge from social interactions and communication (Howitt, 2010). Husserl, founder of phenomenology, made a distinction between what is experienced (noema) and the manner or nature of the experiencing (noesis) (in Howitt, 2010, p279). Phenomenologists, like second-order cyberneticists and social constructionists, reject the idea of an objective reality. In hermeneutics, meaning is a social and cultural product, and is focused on idiographic analyses of patterns in people's meaning-making rather than on producing a model or theory of an underlying process. Texts and data are usually analysed in relation to the entirety in a 'backwards and forwards, looping process' (Howitt, 2010, p280). Hermeneutics is thus the process of understanding, studying and interpreting texts, in order to understand a person's relatedness to the world.

Hermeneutic phenomenology emphasises that phenomenology is interpretive in its implementation – observations are always made from somewhere, and that my interpretations as a researcher are inseparably influenced by my worldview, my beliefs, my educational background, and by my relationships with others. Based on the philosophical and social work of Max Weber and George Herbert Mead, symbolic interactionism means that people are continuously adjusting what they do in response to the actions of other people. This refers to the ability to interpret the actions of others in relation to our own, and to thus formulate patterns of action in advance of responding (Howitt, 2010; Thirsk and Clark, 2017). This parallels with the principle of curiosity and

a second order cybernetic perspective in systemic theory and practice. Systemic principles centre the relational.

Given my epistemological position, knowledge was assumed to be created in social interaction between myself as a researcher-practitioner and by the team members in my study, the research participants. I aimed to explore a *hermeneutic* understanding of how team members experienced the processes and significant and/or transformative moments of the team intervention, and the factors they thought facilitated possible change in the team and in their interactions with patients. In line with a constructionist agenda, 'findings' were developed as the research proceeded and I analysed my data in relation to the whole, with a keen awareness of context, language, relationships, and culture.

My epistemology around the 'validity' of my data analysis and results is based on the phenomenological approach, which recognizes that "if the essential description truly captures the intuited essence, one has validity in a phenomenological sense" (Giorgi 1988, p. 173). I believe that my descriptions of the research results are plausible, and I aim to explain my data analysis approach transparently and systematically, including accounting for the steps of the analysis process in the next subchapter (Webb and Kevern, 2001).

3.2.6. IPA in Focus Groups

Interpretive Phenomenological Analysis (IPA) research seeks to produce contextualised accounts of how an individual makes sense of their experiences of being-in-the-world, which is why it is traditionally conducted at an idiographic level of

analysis i.e., focusing on the particular as opposed to the general. Researchers thus aim to explore and engage with the individual personal accounts of people, holding in mind the relational, cultural, linguistic, and political worlds these people inhabit. These individual accounts are usually developed via a rigorous hermeneutic approach to textual analysis, and with a social constructionist framework in mind (Larkin and Thompson, 2012). IPA has however, also been found to be a useful approach when developing and evaluating therapeutic interventions (e.g., Borg et al., 2016), and when reflecting upon the role played by therapeutic, institutional, and legislative cultures (e.g., Rostill et al., 2011). IPA does not test hypotheses and is not usually utilised to develop theory, but the analysis outcomes can be used as a way of engaging with existing theories.

The IPA approach thus tends to lend itself well to systemic psychological research which focuses on personal meaning, and on the relationship between person and world, at an individual level. As IPA can be seen as a post-constructionist approach to qualitative research, it has a similar relationship to social constructionism that systemic theory does (Larkin et al., 2012) in that it is concerned with what happens between individuals and the meanings that are created in those interactions. Both systemic theory and IPA are also interested in the function of language, but neither are defined or constrained by that interest (Larkin et al., 2012). Importantly, both systemic theory and IPA acknowledge that the researcher, who is focused on understanding patterns of meaning-making in others, is doing so from a subjective position, and that their perspective is merely bringing to light an important aspect of a shared experience (Larkin et al., 2012).

A combined IPA and focus group analysis method also has immense value when data is collected from a homogenous group who share a contextual perspective on a given experience. It can, however, be limiting, as it only offers a one-dimensional view on the meaning of processes and events. Other areas of hermeneutical research where an idiographic approach might be limiting includes research on therapeutic relationships; research on how families experience therapy; and research on the impact of interventions within a specific cultural or social context (Phillips et al., 2016, Thirsk and Clark, 2017).

It can also be restrictive when the research question and area of inquiry have a strong systemic and relational focus, such as this study, which sought to understand team-based experiences. Teams, families, dyads, and other naturally occurring groups can often provide useful and interesting perspectives on shared psychosocial experiences, which still maintain a strong idiographic focus in addition to their relational analyses. (Phillips et al., 2016). These groups can remain a recognisable unit of analysis.

Palmer et al (2010) and numerous subsequent studies (which are discussed in more detail in Chapter 3.3) have suggested methods for conducting IPA in focus groups, which I think provide a more systemic approach to analyse and interpret experiential claims in a *group* setting. These methods will be discussed further in the section below. While focus groups constitute a complex interactional environment, they allow for multiple voices to be heard and for experiential claims to be understood within a fairly complex set of social and contextual relationships (Palmer et al., 2010).

Focus groups aim to bring people together to discuss and explore a specific topic based on participants' experiences, feelings, and thoughts of the subject matter. Phenomenological researchers have noted the evidence both for, and against using focus groups in phenomenological research (Githaiga, 2014; Bradbury-Jones et al., 2009; Lambert and Loiselle, 2008; Webb and Kevern, 2001). Some scholars have cautioned that IPA and focus groups are methodologically incompatible, and interaction among participants in a focus group may contaminate data on an idiographic level. However, from a social constructionist epistemology, and with reference to phenomenological philosopher Heidegger's perspective (1962), "human beings exist in a world of shared meaning and interact with other people and objects through a system of mutual interdependence". Focus groups provide spaces for interactively and collaboratively making sense of a phenomenon in a particular context, and hence can be compatible with phenomenology (Githaiga, 2014).

3.3. IPA – Systemic application and reflexivity

"Some days language is a net. Or a bucket. Or a teaspoon.

Meaning often lands on a texture spectrum from puddle-water to mashed potatoes."

Anderson, 2022, p33

In this subchapter, I will describe the IPA-based data analysis method I adapted and used when analysing data from focus groups in my study – I will call it IsPA (Interpretive Systemic Phenomenological Analysis). I will discuss the opportunities and drawbacks of using an IPA framework to analyse data from focus groups. I will describe my data analysis process with reference to IPA guidelines and will highlight the systemic principles which influenced my thinking in the analysis process. I will also

explore my positioning in this research study, as a practitioner-researcher, and will discuss the benefits and possible drawbacks of this position.

3.3.1. IPA in Focus groups – considerations

- **Opportunities**

As discussed in previous chapters, I was drawn to using focus groups in this research study as I felt it was the most appropriate method of data collection for the following reasons: I believed it would provide a relational data collection method (i.e., an interactive, dialogical, and group-based interview space) which would adequately answer my relational-based research questions. It was suitable for my participant population who regularly interacted in groups; and it mirrored the systemic group-based team formulation intervention I set out to study. This research method thus fitted the research questions asked and a group approach was congruent with my questions and research framework too.

Focus groups offer flexibility in that they are not necessarily bound to a particular epistemological positioning. There have also been numerous IPA focus group studies and articles written since Palmer et al (2010) proposed a method of IPA analysis for focus groups over ten years ago (Love et al., 2020). There is however a continued debate about the methodological tensions of using a hermeneutic and idiographic analytic method, which focuses on extrapolating individual experiences, in a group context (Smith and Fieldsend, 2021). Researchers and IPA specialists argue that the appropriate use of IPA in focus groups is dependent on the topic, the facilitator's skill, the participants themselves (such as a participant dominating the group to the

detriment of others voicing their accounts), and modifications made during the analysis.

While some researchers argue that it is the 'group' that creates the methodological tension in IPA research (Webb and Kevern 2001, Webb 2003), studies on the suitability of the IPA approach for focus groups have found that groups can enhance personal experiential accounts (Flowers et al., 2001). Groups can capitalise on the peer-to-peer interactions and rapport, especially in a homogeneous sample with shared experiences. They allow participants to hear the ideas of others, which may help them to formulate their own opinions (Krueger, 2014). Also, participants are often able to elaborate their views in response to encouragement, or to defend their claims when challenged by other group members, which offers rich hermeneutic data to analyse (Wilkinson 1998). Focus groups can also make use of the rich canvas of experiences amongst participants who are already used to discussing their experiences in a group (Sternheim et al., 2011).

Importantly for my study, focus groups provided an opportunity to conduct research in the team's naturalistic setting, where a rich conversation about experiences could be captured as different perspectives on the topic were considered (Wilkinson, 1998). It is a useful research tool to use in actively multidisciplinary work settings such as an inpatient hospital, as group discussions are regularly held between presumed peers who share a common frame of reference, as they attempt to make sense of their experiences with one another (Kidd and Parshall, 2000). Familiarity with the group setting and pre-established work groups also make focus groups an appropriate method of data collection (Mercer and Feeney, 2009), and in some contexts may even be less intimidating for participants than individual interviews (Garroway and Pistrang,

2010). I was aiming for a mirroring of the team /group aspect of team formulation, and a group-based method of researching the process.

The position of the researcher in a focus group discussion is also different from a semi-structured interview, as the researcher not only facilitates but also *observes* a discussion amongst participants and can thus be seen to be in a more neutral position.

As a researcher-practitioner and fellow team member in this research study, I felt that my role and positioning as a researcher in the focus group interviews would facilitate some distance between myself and participants than if I had done individual interviews. As a psychologist having worked on some of the wards for over 7 years and having built up working alliances, team members will sometimes engage in individual conversations with me to seek support and/or advice in my role as a ward psychologist, which contrasts with my role as a focus group (and team formulation) facilitator, where the focus is on the group discussion, and shared experiences. I also believe that being a team member myself and working in the same context as the participants may have helped facilitate alliance building with the participants. Wilkinson (2008) argues that the interactive nature of a focus group is advantageous, as it can facilitate disclosure amongst participants and can be a useful way to gain access to their life worlds. A specific population and the particular dynamics in a group can also provide a synergetic effect in dialogue (Flowers, et al., 2001).

- **Drawbacks**

One of the main drawbacks of using IPA in focus groups is that it may not be possible to gather in-depth individual experiential accounts from each participant, as one may

do in an individual interview. Smith (2015) and Webb and Kevern (2001) have similarly cautioned that IPA data collected from groups may veer too far from the idiographic commitment of IPA. A group setting might also discourage some participants from openly discussing individual experiences (Mercer, 2012), particularly if their experiences differ from group members, and/or if participants feel there is limited time to elaborate on their experiences. There is also a risk that the collective group voice dominates the individual's account (Tomkins and Eatough, 2010). Smith (2015) have sought to differentiate between shared (focus group) and individual (interview) accounts and have highlighted that there is not much differentiation between what participants share in an individual interviews compared to focus groups, as similar themes emerged from both methods of data collection in the same study (Smith, 2015). However, managing and encouraging multiple voices in a room is a skill I have developed as a psychologist and systemic practitioner, which may have helped facilitate the benefits of using IPA in focus groups in this study.

Furthermore, multiple hermeneutics are occurring adding to this complexity; as a researcher I am trying to understand how the participants' make sense of their experiences, who in turn are trying to understand how the rest of the group makes sense of their experiences (Tomkins and Eatough, 2010). The dynamics of the group may also define the line of conversation taken in the group, which could deviate from the main focus of the interview. In the focus groups, I was mindful to allow multiple voices to be heard and to not let one or two participants to dominate. I also attempted to address some of these potential group dynamic drawbacks by keeping group numbers small (2-3 participants in each group) to create, maintain and hold a safe space, and to allow space for more elaborate conversation from participants.

Studies have found that rich IPA data can be gathered from smaller groups of 2-3 participants who are homogenous and emotionally invested in the same topic of exploration (Morgan, 1997; Dunne and Quayle, 2001; Bradbury-Jones et al. 2009; Halling et al. 1994; Githaiga, 2014). Smaller groups can thus help facilitate individual responses, but also capture multiple hermeneutics. Hennink (2007) and Githaiga (2016) also found that using mini-focus groups of less than five, permitted participants to talk more in depth on their own accounts, and have the advantage of these individual experiences being preserved as they are shared while others are listening. Analysing group dynamics and interactions to extrapolate idiographic accounts and understand group processes and interactions is also much more feasible and practical with smaller numbers of participants in each group It is the quality, rather than the quantity of data that allows for insightful analyses to be developed (Larkin and Thompson, 2012).

In relation to the modified analytic process in IPA focus group studies, researchers have noted that there is often a lack of detail about how modifications to IPA were made and that the focus group dynamic was often ignored (Tomkins and Eatough, 2010). More recent IPA studies using focus groups (Githaiga, 2016; Makin, 2012; Phillips et al., 2016) illustrate that these tensions still exist, but also suggest useful and detailed frameworks about the process of analysis, which informed my analytic process in this study.

- **Aims**

The overarching aim of IPA research is to develop an organized, detailed, plausible and transparent account of the meaning of the data (Larkin and Thompson, 2012).

Thus, the aim of IPA conducted with focus groups is to research ‘worlds within worlds’, (Phillips et al., 2016) and to produce an account that takes advantage of a multiplicity of meanings and offers a plausible interpretative perspective on how the participants’ worlds interact and overlap (Larkin et al., 2019).

This need not be at the expense of idiographic data, but rather the analysis extends this search for meaning to also consider more systemic dimensions, such as the relational, intersubjective, and microsocial elements too (Larkin et al., 2014, Rostill et al., 2011). It is worth briefly noting that IPA was developed within a Western research tradition, and as such may privilege experience and approaches that do not represent marginalised communities and broader cultures.

Allan and Eatough, (2016, p.18) reflect that “IPA moves from the particular to the shared, from the descriptive to the interpretive, it maintains a commitment to understanding the participant’s point of view, and has a psychological focus on personal, couple, or family meaning-making in particular contexts”. In identifying patterns of meaning in the data, I was interested in identifying what mattered to participants, and then exploring what these things meant to participants, individually, relationally, and with reference to the context. Once I had some understanding of this, I was able to start developing an interpretative synthesis of the analytic work (Larkin and Thompson, 2012). The process for reaching that point of synthesis in IPA is iterative and inductive, much like systemic therapy.

It has been suggested that perhaps a new name might be needed for group-focused data collection methodologies which use an IPA approach, such as ‘Interpretive

Phenomenological in Group Analysis (Love et al., 2019), or ‘Multiperspectival IPA’ (Larkin et al., 2014), or GrIPA – group IPA (Mercer, 2012).

- **Evidence-base**

Multiperspectival IPA research studies are being increasingly developed and refined. These methods strive to maintain a strong link to hermeneutic, idiographic, and phenomenological concepts, but also draw on systemic concepts too. Some more systemic IPA research studies which have been done have focused on:

  - Roles within relational phenomena, e.g., spouses within a dyad (Loaring et al. 2015); or members of a family group (Burton, Shaw and Gibson, 2015).
  - Patient and health care provider relationships (Borg, Xuereb, Shaw and Lane, 2015).
  - Multi-agency perspectives, such as the experiences of foster care by young people, social workers and foster carers (Rostill et al., 2011).
  - Family perspectives (Dancyger et al., 2010), where the complex perspectives of family members are explored with regards to decision making about genetic testing for hereditary cancers, and Penny et al.’s (2009) study, which explores generational aspects of the experience of psychosis.
  - There have also been numerous methodological papers about how to adapt IPA in focus groups (Randazzo et al. 2015; Spjeldnaes et al. 2014; Sternheim et al. 2011, Githaiga, 2014) all of which draw analysis ideas from Palmer et al. (2010) and Tomkins and Eatough (2010).

These studies show that a group can constitute a coherent unit of study, and shared narratives can produce rich data. Families and other naturally occurring groups, such

as teams, can also provide insightful perspectives on shared psychosocial phenomena. In these studies, individual analyses are often compared and analysed first at the 'within-group level' and then at the 'between-group level' (Larkin et al., 2018).

3.3.2. Conducting IPA research relationally and reflexively

While it's epistemological principles are the solid foundation of good IPA research, guidelines for IPA analysis are suggested as frameworks that can be adapted and adjusted as needed (Smith, 2015), As such, there is flexibility to adapt IPA guidelines for a group context, with a broad suggestion to analyse individual sense-making and group interactions separately (Mercer, 2012), and to hold in mind a range of group level themes, such as positionality, language use, roles, and relationships, while exploring the data (Palmer et al., 2010).

Based on Larkin and Thompson's (2012, p112) suggestions for 'good' IPA data analysis, I held the following factors in mind in the process of analysing the focus group data in my study. In the section below, I highlight how these principles resonate with the systemic therapy principles I value and use in my professional and research practice too. I also explore systemic therapy principles that I believe are transferrable when conducting IPA research:

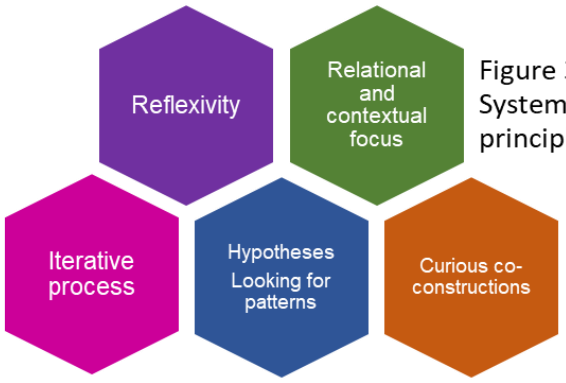


Figure 3.1: Systemic theory principles in IPA

- ***Relational and contextual focus*** – Good IPA data analysis should incorporate and develop a balanced perspective on phenomenological detail and interpretative analysis, to produce a psychologically relevant account of the participants' 'being-in-the-world'. IPA is aligned to a hermeneutical phenomenological psychology which states that our 'being in the world' is always perspectival and always in relation to something (Palmer et al., 2010, p99). As such, IPA focus group research allows for both an intersubjective, and relational/contextual enquiry. Systemic enquiry also holds a both/and position in centring relationships, interactions, contexts, and communication as the bedrock of identity and experience (Dallos and Draper, 2015).

In this study, I focused on how interactional elements of the data could be incorporated into an IPA and what these elements added. It was important for me to acknowledge the impact of the group setting on the individuals, as it contextualised the accounts shared. With my systemic and social constructionist epistemology in mind, I considered Gergen's (2009) statement that the locus of knowledge is no longer in the individual mind but in the pattern of social relatedness. I endeavoured to include contextual details in my analysis, with regards to the data, the participants, the researcher, and the

study, and as such I argue that the first step of doing IPA in focus groups should be to explicitly consider the context and to define 'caseness', which I will explain further below.

- ***Curious co-constructions and multiple hermeneutics*** – Good IPA research emphasises how experiences are understood, rather than on descriptive explanations of what happened. IPA thus moves (back and forth) from the particular to the shared, from the descriptive to the interpretive, and it should strive to maintain a commitment to understanding the participant's individual and relational experiences. It should also have a psychological focus on multiple meaning-making in particular contexts (Allan and Eatough, 2016), also referred to as multiple hermeneutics.

  This process involved me as a researcher trying to make sense of the participants trying to make sense of what was happening to them, as well as all of us trying to make sense of others' experiences within the focus group too (Githaiga, 2014). In this process of sense-making there is a systemic acknowledgement that there are multiple realities which are being created in social interaction, such that 'there are as many universes as there are willing describers' (Watzlawick, 1984 in Dallos and Draper, 2015). In my results and discussion chapter I endeavoured to provide detailed, reflective and relational accounts from participants, in order to demonstrate these multiple hermeneutics transparently.

- ***Hypothesising and looking for patterns***– Good IPA research should also open up a tentative dialogue with theory (in making sense of the analysis) and can also engage with imagery and metaphor (Larkin and Thompson, 2012). As suggested by Palmer et al (2010) it may be useful to hold some relational themes in mind when analysing IPA data in focus groups. My research analysis hypotheses were thus based on the following systemic hypotheses/themes - positionality, roles and relationships, organisations and systems, language (patterns, context, function), and stories.

  It is important to note that hypotheses and themes are not explanatory and are not a model of what is 'out there', but rather they are a representation of my analysis and hypotheses which are held lightly. (Larkin and Thompson, 2012). Thus, one of the tenants of IPA research lies in sense-making which involves using psychological theory to extend the interpretation of individual and relational accounts. This can be likened to hypothesising in the context of systemic therapy, which is a way of tentatively organising information and feedback to guide a practitioner's sense-making (Dallos and Draper, 2015).

- ***Reflexivity*** – Good IPA research should allow for detailed attention to be given to the process, including both analytic and reflexive components. It is thus inevitable that my analysis process is also an analysis from within i.e., it involves reflexivity, which is a process of monitoring and reflecting on my own actions, beliefs, values, and worldviews (Dallos and Draper, 2015) as I engage in the research process, with participants, and with the data. IPA research which has been done with focus groups encourage a process which involves

looking for ‘groupness’ in the data, clustering reoccurring group interactions, identifying interactional relationships, and incorporating group elements into an analysis (Larkin et al., 2019). These are useful prompts in widening the lens when analysing focus group data, but I believe it somewhat still excludes the researcher.

My data analysis method included an idiographic focus as I synthesised these analyses within the focus groups and between focus groups. I endeavoured to develop detailed and integrated analytic accounts by analysing and synthesising multiple perspectives simultaneously, and by attempting to explore relational conceptualisations of what was shared *between* individuals (including myself!) rather than just was shared by individuals. As such, I argue that it is important to explicitly include a column in IPA data analysis templates which allows for reflexive comments by the researcher to be included in the analysis process. This is in addition to the research diaries and separate notes which are often advocated in IPA research.

- ***Iterative process***: Good IPA data analysis should transcend the structure of the data collection method i.e., the semi-structured interview format. My whole analysis process involved an ongoing and iterative process of oscillating back and forth between individual experiences, group experiences, and contextual experiences shared, with the aim of getting an in-depth understanding of what staff experienced as significant moments in team formulation interventions. This process is known as the hermeneutic circle (Githaiga, 2014; Conroy 2003; Laverty 2003).

Systemic formulation and research practice is also iterative, in that it tends to emphasize constant comparison and involves a circular process to identify and develop themes, rather than to develop a formal theory about the phenomenon or case studied (Gehart et al., 2001).

I believe that analysing multiple voices within a transcript necessitates an iterative approach of weaving content and process, and thus additional stages of IPA analysis are often required in focus group research, which I will discuss in my analysis process below. It is important to note that while each stage is presented as distinct and separate, in practice there was an ongoing overlap. As a researcher I was thus engaged in circular sense-making (within the hermeneutic circle), going back and forth to earlier stages of consideration as the interpretation developed (Larkin, Watts and Clifton, 2006).

3.3.3. Interpretive Systemic Phenomenological Analysis (IsPA) - protocol

These are the steps I followed (as indicated in figure 3.2 and the discussion below) when analysing my IPA focus group data, incorporating additional systemic principles of considering context and caseness, and analysing the data curiously and reflexively:

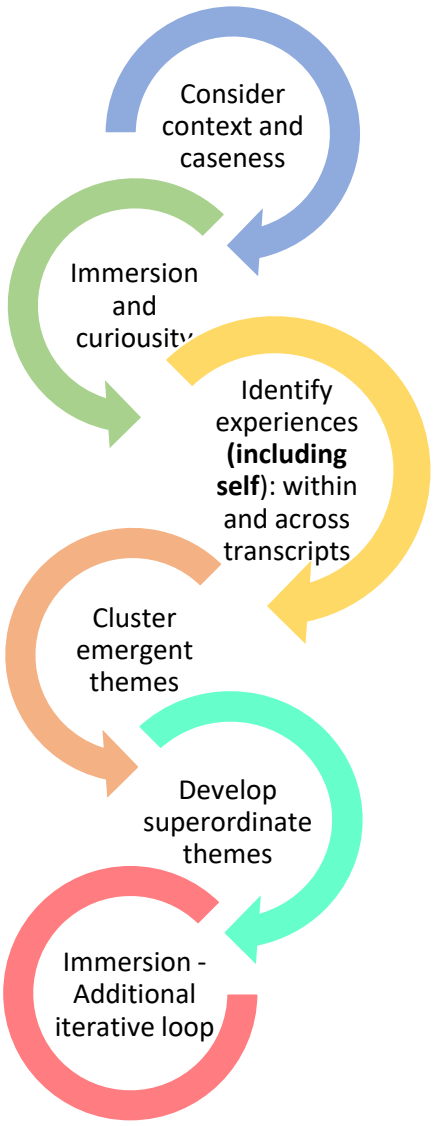


Figure 3.2. Interpretive Systemic Phenomenological analysis (IsPA) approach

- **Considering the context and defining 'caseness'**

The first step in my data analysis process was to consider the context of my research study and to define my unit of study and what I meant by 'caseness'. The context was an inpatient mental health hospital in the South East of the UK, and the units of study were the adult inpatient teams within the hospital.

In Multiperspectival IPA designs, the unit of study is the case, e.g., the person, dyad, or team (Larkin et al., 2014), thus in my analysis it was important for me to explicitly state the different dimensions of 'caseness' in analysing the focus group data. As I was exploring multiple hermeneutics in the data, I aimed to clearly define the units of study being discussed in my results and discussion chapter too.

As my research focused on a multidisciplinary team members' experience of a phenomenon, I assumed that there was a level of 'caseness' within each staff team (in each of the 5 focus groups), over and above the level of the individual case members. The research participants were also all staff members at the same hospital, so there was a level of caseness for the group as a whole too (Phillips et al., 2016; Larkin et al., 2014). Families and other naturally occurring groups such as teams can provide logical and insightful perspectives on shared psychosocial phenomena. I was aware however, that while I may have gained a particular focus on the material by defining caseness, I was also perhaps losing a wider perspective in defining the units of study in my analysis. This is also the case in family and systemic therapy when one 'punctuates' or zooms in on certain components or dynamics in the system (Vorster, 2003)

In my research and data analysis, examples of this 'caseness' was observed in how individuals discussed professional and personal alliances; in their 'we-talk;' in how they defined organisational cultures, resources, practices, and roles; in how they referred to contextual factors within the system. All of which offered significant accounts of how the various teams function as a unit and offered important information about how to make sense of participants perspectives on their experiences.

- **Context**

Based on the Heideggerian phenomenological epistemological framework of 'being-in-the-world,' there is an acknowledgment that an individual is enmeshed in the social, cultural, and practical aspects of their life. As such, it is an illusion that individuals can be detached from their cultures and systems of meaning-making, but rather meaning is derived from these systems, cultures, and contexts of experiences. (Tomkins, 2017). Given the hermeneutic perspective and procedural flexibility of IPA it can be successfully used as a framework to make sense of organisational systems, as well as individuals' experiences in these contexts (Tomkins, 2017). Even traditional idiographic approaches of IPA acknowledge the importance of considering context when analysing individual accounts (Larkin and Thompson, 2012).

Tomkins (2017) argues that IPA research should not just consider context as an add-on which provides some kind of 'background colour'. Rather it is indistinguishably embedded within, and constitutive of, the individual's experience itself. As such, even when adopting an idiographic focus, the individual should be considered in context, and wider systemic, institutional, and relational norms and practices should be considered. As such, the first subchapter of my results and discussion chapter focuses on 'context-of-ideas' (Tomkins, 2017) and provides a kind of ethnographic exploration of the inpatient mental health context where I conducted my research study. Contextual factors I considered included: the organisational structure and banding levels, history and development of the organisation, environmental factors, organisational resources, cultural factors and organisational norms, policies and procedures, roles and history of linked organisations (Dallos and Draper, 2015).

Included in my context-of-ideas section and throughout my IPA analysis, was also an exploration of discourses. A Foucauldian definition of discourses refers to sets of socially constructed and interconnected beliefs, meanings, ideas, and practices which are held in common in certain cultures and create a body-of-knowledge (Dallos and Draper, 2015; Tomkins, 2017). In IPA research conducted in organisations, it is important to try explore how organisational and wider systemic discourses shape this 'body-of-knowledge' and impact participants' sense-making. This makes for a richer interpretation which includes the experience of discourse (Tomkins, 2017). IPA research should not be seen as an either/or choice between experiential and discursive methods (Reicher, 2000).

Our experiences, particularly in organisations, are influenced by normative and professional discourses, thus it has been suggested that IPA research conducted in organisations should include 'critical sense-making' (Tomkins, 2017, Weick, 1995, Mills et al., 2010). Critical sense-making involves acknowledging that sense-making is a circular process whereby "people create their environments as those environments create them" (Weick, 1995, p.34). It considers the power of how discourses inform and shape people's experiences of themselves and their lives, and it stays true to IPA's focus on how people make sense of their worlds (Tomkins, 2017).

- **Immersion in the data and listening to transcripts curiously**

I transcribed the focus group interview data verbatim in order to immerse myself in the data. Rodham, Fox, and Doran (2015) argue that it is important that researchers listen to the audiotapes, from a curious stance and engage with the data reflexively to ensure

analytical ‘trustworthiness’. Transcription is a socio-cognitive, process-orientated task (Widodo, 2014), so I tried to remain curious in the process of transcription by looking at the data critically, reflexively, and attentively, at both a macro and micro level.

Systemic therapists often assume a curious, ‘not knowing’ position when formulating and hypothesising about clinical cases (Dallos and Draper, 2015), and are able reflect on their biases and preconceptions through regular self-reflexivity and supervision. Similarly, in this research process I undertook a self-reflexive interview before and after all the focus group interviews to reflect on my position as a researcher-practitioner, and to identify and hold in mind any preconceptions that may have been interwoven into the research process and data analysis (Dallos and Vetere, 2005).

My thoughts and views from these interviews were included in the self-reflexive columns of the actual IPA data analysis (discussed in the section below, and in table 3. Appendix E). As discussed in the previous subchapter, my epistemological framework and the phenomenological approach acknowledges that the researcher forms part of the participant’s sense-making process (Love et al., 2019), as such I kept a research diary and self-reflexive notes throughout the data collection process, which was then used in the analysis process too.

While listening to the audiotapes, I endeavoured to remain committed to engaging with the data from a “phenomenological, hermeneutic, and systemically idiographic perspective – being systemically idiographic means expanding from the usual concern with individual experiences to the experiential experiences of participants in the focus groups too (Phillips et al. 2016). Engaging the phenomenological and hermeneutic in

focus groups involves ‘zooming in and out’ to understand both the personal expressions of experience, as well as the relational experiences of participants in interaction with others and the wider system.

- **Identifying significant individual, relational, contextual, and *reflexive* experiences: within and across transcripts**

Following the standard IPA analytic process, I created a table (see Table 3 in Appendix E) with multiple columns on each side of the participant’s transcribed text. The three columns on the left were used to for preliminary stage of data analysis (step 3) to note down the following: 1) self-reflexive comments; 2) exploratory comments from a shared/group/wider experience perspective, and 3) exploratory comments from an individual perspective which included points of descriptive, linguistic, and conceptual interest.

These columns allowed me to ‘zoom in and out’ of the multiple hermeneutics, including my own (individual, relational, contextual, and self-reflexive) and to log my initial thoughts on what I thought participants were saying. I completed these three columns for all the focus groups before moving to the three columns on the right which I used for step 4 below. This entailed analysing the transcripts twice, to make initially sense of the individual experiences first before attending to the unpacking the details of the group experiences, although there was also an overlap between the two levels of analysis (Phillips et al., 2016).

This initial line-by-line analysis of experiential claims and concerns was an iterative and inductive process which necessitated a dialogue between myself as a researcher, my systemic knowledge, background and worldview, and the transcribed data. This mapping out process is also referred to as the ‘phenomenological core’ of the data. (Smith, 2015).

Tomkins and Eatough (2010) reflect on the challenges of balancing individual and group accounts when combining IPA and focus groups. In my analysis, I found it helpful to have columns on the same sheet for both individual and relational/group experience notes, as a way of ‘dynamically moving with and between both the whole and the parts’ at each level of the analysis (Tomkins and Eatough, 2010, p249). It was also useful to note that in the analysis there was often an inevitable interplay between the individual and shared accounts, demonstrating the systemic notion that neither the individual nor the group were separable units of analysis (Morgan, 1997).

In considering and identifying these interactional relationships, I held in mind the systemic conceptual model illustrated in Figure 3.1, which acknowledges the relational dynamic between participants and me as a researcher-practitioner, and the various wider systems which influence the experiences shared. When considering individual (idiographic) experiences, I particularly considered descriptive, linguistic, and conceptual concerns. When considering shared group experiences, I held in mind Palmer et al (2010, p104) relational prompts in their protocol for using IPA for focus groups, which includes: positionality, roles and relationships, organisations and systems, stories, and language.

When analysing group experience data, I held in mind Phillips et al (2016) concept of ‘looking for groupness’. They encourage looking for participant expressions that might not appear in an individual interview, such as switching between pronouns (I, we, you), which is more meaningful in a group context as it may imply inclusion or exclusion of others in the group. The following relational communication may also be observed: defending and qualifying positions; delineating personal experiences; discussing variations of experiences; agreeing and disagreeing; hedging (modulating a statement to make it less assertive).

Participants might also discuss their experiences of being a member of a different subgroup, such as their particular profession in the organisation. They may discuss wider contextual issues within their experiences and contrast this with the perceptions of others on these issues. All of these relational aspects appeared in my focus group data, and as suggested by Phillips et al (2016), I formulated a conceptual model of these interactional elements rather than including them in a hierarchy of themes, which I present in my discussion chapter later on.

Larkin and Thompson (2012) refer to this initial process as ‘free coding’, which is a consistent and systematic way of noting down preliminary thoughts while still staying close to the data. This is already the beginning of the interpretation process, as I was using the language of my everyday systemic practice to note down my summaries of what I thought participants were saying, paying close attention to the participant’s content, linguistic interpretations, as well as conceptual, relational, and contextual comments.

As the level of annotation started to thicken out, I oscillated between the analysis columns in each transcript (i.e. the individual experiences, shared experiences, and my self-reflexive experiences) as well as between the various focus group transcripts, to check and clarify that the core experiential content of the work was completed (Smith, 2015) before moving on to the step of identifying and clustering emergent themes.

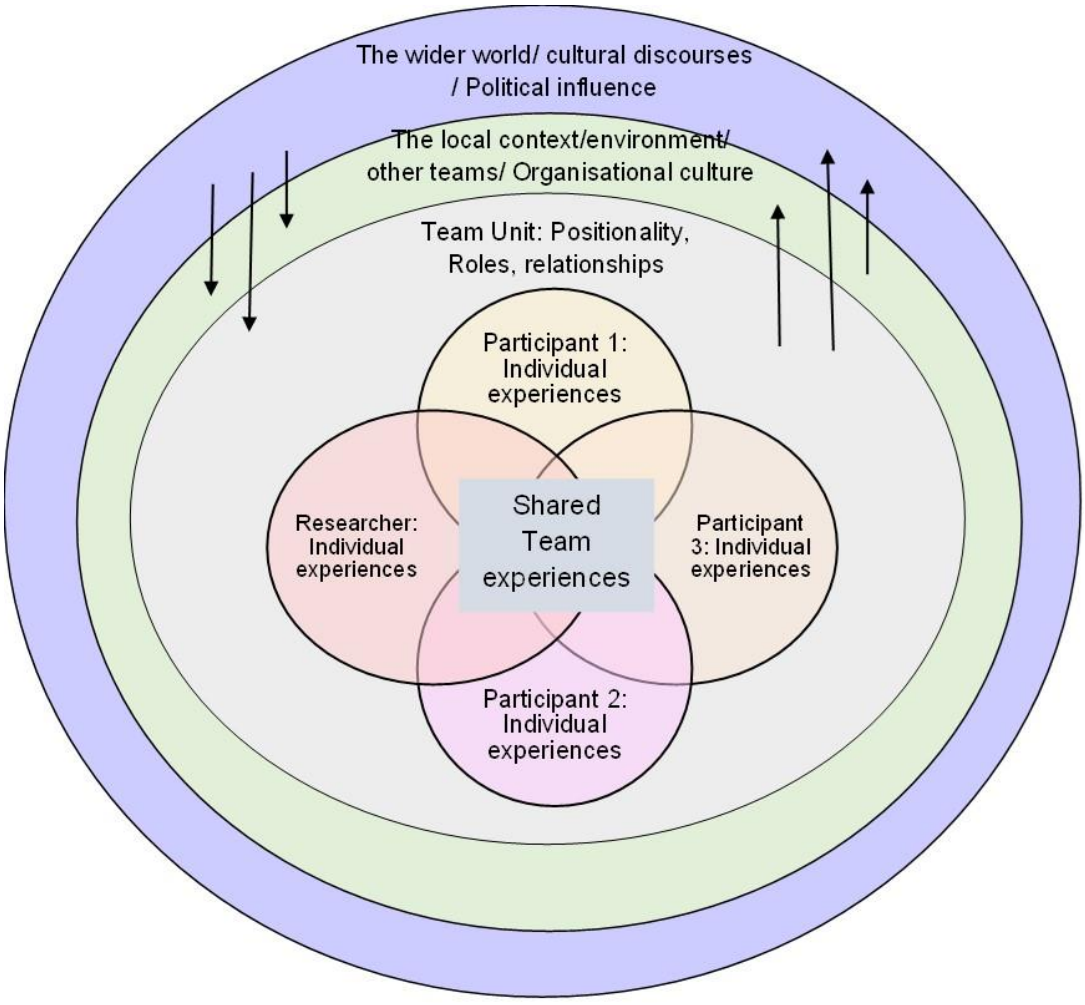


Figure 3.3: Preliminary systemic data analysis model for IsPA in groups (adapted from Phillip et al., 2016)

- **Identifying and clustering emergent themes**

After the preliminary analysis on each transcript, I then used the two main right-hand columns to develop emergent individual and shared themes, which are the building blocks of IPA. This process involved identifying segment patterns within each transcript utterance (Smith, 2007) and synthesising the line-by-line coding to develop more abstract categories (Larkin and Thompson, 2014). It required a more interrogative and interpretive approach to the coding.

This hermeneutic process of identifying emergent themes was done by linking the micro-level notes and my self-reflections (which remained close to the transcript) to more macro-level interpretations (meanings and context across the focus group). My self-reflections included my interpretations and experiences of group member's reflections, reactions, and dynamics towards each other, as well as my own biases, thoughts and emotions (Smith et al., 2021). Including self-reflexivity in the analysis was particularly important, as I was a research-practitioner, and a team member too. Palmer et al. (2010) also suggests that at this stage of the analysis it is also important to explore how the group manages and makes sense of the experiences being shared.

Clustering the meaning units into emergent themes involved identifying cumulative patterns within transcripts, and then across transcripts, by mapping patterns and connections from the initial notes taken. It was useful to number each of the meaning units to be able to locate the verbatim excerpts when the emergent themes were clustered (Githaiga, 2014). Tomkins (2017) suggests that a matrix can also be helpful when converging and clustering themes from focus group data. The matrix includes cases on one axis and themes on another, which then provides a useful visual representation of themes from multiple voices within the groups. This framework is

helpful to identify similarities and differences between and within focus groups, and to illustrate how multiple experiences converge and diverge (Larkin, 2019). It is also important to note when shared experiences by participants may have different meanings, or when shared meanings are attributed to different experiences. For example, in one of my focus groups, participants had different recollections of key people who had attended the team formulation sessions, which revealed deeper frustrations that insights from team formulations are challenging to sustain. This indicated that a significant aspect of team formulations in my work context is that it is not embedded as an essential practice to enable systemic change to happen. This became a key theme in the findings.

> *NP4: I think, yeah, maybe linked with that is the fact that in terms of the actual ward staff, very few were there, and none of the key people were there, I don't think…um?*
>
> *NP3: We had… the ward manager there, and the consultant…*
>
> *NP4: Ah yes the ward manager was there – didn't feel like it… so I guess like I know how I felt coming out of it, and I know that it's kind of as we said, made it for me, made the effort to go and talk to her more and try and understand that and in all honestly, I thought about this yesterday… that's already started to slip today, I know that's harsh, but*

These emergent themes, like systemic hypothesis in therapy practice, were seen as tentative ideas and lenses through which the data could be organised. As such, I tried not to give them titles that were too narrowly fixed in meaning, but rather used identified terms or phrases from participants as my emergent themes.

- **Identifying, connecting, and developing superordinate themes and subthemes**

Superordinate themes are identified and developed by looking for connections and patterns amongst the themes and shaping and summarising them into namely themes. This involved comparing, contrasting, and amalgamating the emergent themes across the focus group transcripts, and clustering them into mega themes, while also noting unique and distinctive themes within focus groups (Love et al., 2019; Githaiga, 2014). Tomkins and Eatough (2010) suggest that sometimes a stand-alone theme (where it is represented by one participant) should be included if it holds particular importance for just one.

This amalgamation process was more complex at a Multiperspectival level in comparison with traditional IPA research, as contextual elements, patterns and connections, as well as conflicts and differences needed to be identified between groups, dyads, and systems (Larkin et al., 2014).

In presenting my results, it was important to develop a coherent narrative about how the experiences related to one another. In my study, there were shared experiences of team formulation practice by the participants, which allowed for an exploration of how they understood the event and processes within it.

The techniques I used in the development of superordinate themes included: *Abstraction* - which involved clustering related individual themes under a single heading. *Polarization* – presenting the themes which differed from each other in a binary manner, such as positive and negative experiences of the team formulation

experience. *Contextualisation* – clustering themes around a specific shared event. These may be concrete events to psychological transitions. *Function* – involves thinking about the role played by certain themes within the participant's account of the experience, such as defending or undermining an experience (Tomkins, 2017).

I used a combination of all these methods in my analysis. Being a systematic thinker and big fan of list-making on Microsoft Word, my process of abstraction involved using multiple tables with lists of quotes and comments under hypothesised headings. I highlighted contrasting themes in different colours and cut and paste themes under clusters depending on context and function. This process was interspersed with breaks of poetry reading (such as poetry by Jarod K. Anderson, which is interspersed throughout this thesis too), which is always useful in my systemic thinking and reflection process and helped me acknowledge that *'my favourite song does not use all the notes simultaneously, and my favourite art is not all shades and hues' (Anderson, 2022, p8)* in my analysis and research process.

- **Immersion in the data again - the additional iterative loop**

Smith (2004) and Palmer et al (2010) suggest that IPA focus group transcripts are analysed more than once, so that both idiographic accounts and evidence of group patterns are accounted for, as was done in steps 2 and 3 of my data analysis process. Phillips et al (2016) and Tomkins and Eatough (2010) suggest that focus group transcripts are parsed for a third time after the superordinate themes are developed, so that a good integration of the multiple hermeneutics is achieved, and to check if the group level themes represent the idiographic experience of participants. This involved double-checking the proposed superordinate themes against each participant's

supporting quotes, along with researcher notes and self-reflexive comments, to determine whether the participant was represented in that theme, and whether that theme should be included in the data set or not (Love et al., 2019). Smith et al. (2012) propose that at least a third of participants should be represented in each theme for it to warrant inclusion in the final taxonomy of themes.

This additional iterative loop ensures that the participants' idiographic accounts are well accounted for within the thematic commonalities and divergences across the focus groups. It is an iterative process that allowed me to map out a participant's experience onto the superordinate themes. This highly detailed level of analysis is another reason smaller focus groups with fewer participants are important to consider when using IPA. These themes were also subsequently shared with some participants who were available and wanted to discuss them. This was a valuable process in having a dialogue about the themes, which participants agreed on, and recommended naming the themes after the actual words used by participants.

Chapter 4: Findings

"The sun posed a question. I didn't quite catch it.

Something about hearing all motion as music.

Something about galaxies stretching their joints after cramped quarters.

Something about vastness as a love language". – Anderson, 2022, p39

In this chapter, I will present and discuss the superordinate and subordinate themes from the IPA analysis of my data (see table 4.1 below), and I will include quotations of descriptive, linguistic, and conceptual interest by participants within these themes, as well as my self-reflections as a practitioner-based researcher and team member. I have, at times, included multiple quotations from participants when reflecting on each subordinate theme, to bring the participants' voices to light, and to try illustrate the richly dynamic nature of the focus group discussions.

'Permission to think' – Widening perspectives
•Time to think beyond the here-and-now •Understanding systemic factors •Reflecting on multiple perspectives •Team formulation can feel too open-ended
'Flicking the switch' – Relational reflexivity
•Relational awareness and awareness of communication •Building interactional confidence by learning from others •Noticing relational progress but difficult to sustain and share relational information
'Humanising the case' – The patient as a person and the professional as a person
•Validating and normalising feelings in a context that encourages emotional distance •Renewed empathy and alliance •Personal resonance •Strengths-based focus in a risk-focused /problem-saturated context
'Effective informal approach' – Challenging the notion of hierarchical professionalism
•Team support and cohesion in a hierarchical system •Informal vs. formal clinical approach •Strengths based perspective in a risk-focused and problem-saturated context •Attendance is an issue

Table 4.1 – A list of the superordinate and subordinate themes

I will then discuss each superordinate theme with reference to the literature on team formulation, by comparing and contrasting common and novel themes.

As discussed in more detail in the previous chapter, the IPA analysis involved identifying significant individual, relational, contextual, and self-reflexive experiences. This involved parsing transcripts multiple times to analyse idiographic accounts (see Appendix E, table 4.1), focus group data (see table 4.2), and then analysing across transcripts (see Appendix E table 4.3, 4.4, and 4.5). I considered the following systemic prompts in analysing the focus group data: positionality, roles and relationships, organisations and systems, stories, and language (Palmer, et al. 2010), which I will include in the presentation of findings when relevant.

It is worth noting that in my preliminary IPA analysis of emerging themes, and with reference to my systemic framework, I initially categorised and sorted subordinate themes from the focus groups based on whether participants reflections were self-focused, patient-focused, team/group-focused, or ward/practice-focused (see table 3 and transcript excerpts in Appendix E). This was inspired by Bronfenbrenner's (1977) theory of nested systems (Ryan, 2001), and from categories which appeared to be emerging from the data. There appeared to be a consistent overlap of subordinate themes across the various categories, which I then clustered as the superordinate themes discussed in this chapter (and indicated in various highlight colours). This overlap of subordinate themes relates to a systemic epistemology that individual meaning intersects and is created relationally and contextually. In my analysis process and on the table below, it was also helpful for me to note down the relevant quotes in the transcripts in relation to the subordinate themes (indicated as: s1, d1, r1 etc).

4.1. 'Permission to think'[7] – Widening Perspectives and individualising care

4.1.1. Time, space, and permission to think beyond the here-and-now

All of the participants referred to not having enough time and space to reflect on their work practice, and to adequately understand and formulate the background and needs of patients and families in their care. They expressed that a significant aspect of the process of team formulation sessions, was that it offered them protected time, space, and permission to gain a more comprehensive and systemic understanding of historical, developmental, and trauma-informed information about patients and their families. Having allocated time to think about and discuss patient care, and relational aspects of care, allowed for more mindful, holistic, and individualised care planning and delivery.

SP6: '…in some senses, we sometimes want to scroll through RIO [patient record system[8]] notes [to get to know the patient] but in reality it doesn't actually get to happen, so you get that [from team formulation] I suppose, wider insight into that persons background, what's brought them to, where they are now, why they're interacting in the ways that they are. And I think as well getting different perspectives.'

DP8: …the way the patient was looked at holistically, and that the historical things were discussed. I thought that was quite important. DP9 (agreeing with DP8): Definitely, yeah. Team formulation gives you the opportunity to explore the whole aspect of the patient.

[7] The themes are named using direct quotes from participants.
[8] Text indicated in [brackets] are my words to help contextualise the context and meaning of quotations.

It was worth noting the use of participants' language in using words such as, 'in reality', 'allow', 'grant', 'protected time' to convey a sense of time pressures and work demands being out of their control, perhaps due to the constant flux and unpredictability of the NHS inpatient mental health work context. Team formulation, and even just having the time to better understand a patient and their system, is thus seen as an 'unessential practice' and an 'opportunity' which requires 'permission' away from the imminent and essential work tasks that need to be completed.

RP1: it [team formulation] allows you to really think of the background of the person, to really understand what's gone on for them, rather than thinking about, you know the, in the heat of the, you know the acute wards and how busy it is and it gives you time to be mindful of not just what you see but what may have happened before, and understanding a lot more from their perspectives as well, how things have been developed over time.

DP8: it was also nice to have the protected time [for the team formulation session].

In my experience, working on the inpatient wards presents with the following challenges - fast pace and high numbers of inpatient admissions and discharges; the pressures of bed management; and the ever-expanding workload of form-filling and administrative tasks – all of this can make it difficult to properly review new admissions and to get an understanding of patients' history and systemic factors leading up to admission, despite the desire to want to do so in the interest of good, person-centred care.

DP8: there is so much to handover in regard to things that have been happening in the present, all the other details don't get handed over because of time restraints really.

Participants reflected on their dissatisfaction of the immediacy of the care that is often provided on the wards, which often prioritises information in the here-and-now, with little time and space to self-reflect and to understand contextual and developmental factors in patient care and teamwork. In contrast, participants alluded to team formulation being an 'enjoyable work practice', perhaps, I think, in line with the values that drew them to a healthcare profession initially. My experience of working on the wards often elicited feelings of disappointment at not being able to provide the best quality of care to patients, families, and staff, due to immense time pressures and an ever-changing patient population group, which often feels like you're 'flipping between patients', as reflected on below. This theme perhaps overlaps with the theme discussed later on in this chapter on how patients are often depersonalised in stressful and fast-paced healthcare contexts.

RP2: I quite enjoy the team formulations just in the sense that, I think with everybody's high caseloads it's quite hard to flip between patients not fully giving a patient a significant amount of time thinking about and formulating about that person. I think it's good to take a step back and have the space and that time to, say okay there's something we may need to be doing differently with this person. Instead of trying to think of those quick fixes a lot of the time, it's quite good just to grant yourself that time to reflect a bit more.

NP3: …I enjoy them [team formulations], so I think it would be good to do them every two weeks…

This rushed work pace may, in turn, impact on staff members' feelings of confidence and empathy in caring for patients with complex and challenging presentations. Participants expressed a desire to be able to offer all patients a wider perspective when formulating and considering their care needs, not only for good patient care but also to help team members understand how to provide that care better. Participants expressed how the information explored in team formulation sessions felt empowering, like, as stated by a participant - *a 'weapon' of sorts*, in being able to respond proactively when faced with challenging and confusing presentations, and to offer patients better care throughout their admission. This theme resonated amongst focus group members, as a point of agreement.

SP6: 'My things would be that you almost want a formulation for everyone. I know they happen on a weekly basis, but you do want to sit down and have that level of detail with everyone, you feel a little bit, on a selfish level, you feel more armed, you can address things more promptly and understand the individual better…'

DP9: Yes, also your point (addressing DP8) about getting the history as well, I didn't know… there's so much stuff about her I hadn't known, and things then made more sense, having a context and understanding of her younger life in her family. I felt more confident.

All of the participants shared that they felt it would be helpful to do team formulation session more often, and ideally for all patients, as they found it to be a valuable intervention.

SP7: I think if it would be possible, to actually have two. One at admission, and one maybe after, you know, post admission. I think it would be helpful.

DP9: I suppose it made me think that it's something we as [therapy team] must do more team formulations for more patients, to keep on doing it as it's so valuable

There was also a sense of the value of teams coming together to collectively formulate initial and tentative hypotheses of the 'roots' behind what patients could be experiencing in the here-and-now, which would be a good starting point of care as they got to know the patients throughout the admission. There was, however, a (shameful!) acknowledgement of the time constraints which prevents the practice of doing team formulations more frequently, and for more patients. I wondered if this dissatisfaction also reflected a deeper disappointment in feeling unable to provide good, systemic and trauma-informed patient care due to these time constraints.

RP1: not everyone [in the team] gets a chance to look at the [patient] notes, and I think that's another big thing about team formulation is actually, there's a lot of work put into it from everyone to try find out the detail really right down to the roots and it would be amazing if we could, I guess… be able to get that detail, but it's very far and few in between for all staff to do that for every patient. So, um, it allows that depth without all

that time for each individual doing it, if that makes sense, which is a shame, but … (laughing).

NP37: I think it would be good to do them every two weeks, because a month is a very long time for someone to be on the ward stagnating (sighing), especially when you have a 22-bed ward

4.1.2. Understanding systemic factors

All of the participants shared that discussing systemic factors and exploring family dynamics was a aspect of the process of systemic team formulation sessions for them. They expressed feeling enlightened and less confused about patient presentations after exploring aspects of the patients' home environments, family backgrounds, and developmental contexts.

DP9: I think it highlighted loads of stuff, particularly about the family dynamics and home environment as well, which made a lot more sense.

DP8: I always think that there is always something more to somebody than meets the eye, there's background a history that probably contributes to the way they are, so that's always been pretty how I think anyway… It's not knowing what that is, so having the knowledge to know that actually xyz, that is important.

In team formulation sessions, most of the systemic information is shared by team members (often support workers) who have perhaps had informal conversations with

patients about their families, relationships, and their contextual interests and concerns. In my experience on the wards, psychiatric assessments do not usually include questions about family relationships, histories, and patterns, beyond assessing next of kin and discharge destinations. Participant RP1 noted the importance of (and lack of!) including family members in the assessment process:

P1: I think having a family meeting before [team formulation] that would be helpful if where possible, even if possibly a phone call or something, it might make the actual risk assessment consider the whole side of it.

As such systemic and family-related information about patients, some of which can even include information about significant relational trauma events, shared in team formulation sessions can often come as a surprise to team members, but can help the team connect information in making sense about why and how a patient may be presenting, and what can help them recover.

'DP8: I think learning about the physical abuse endured by her (patient's) father was significant… that was something that we probably wouldn't have known if we hadn't had the formulation'

SP7: Prior to the team formulation, some of the things that I learnt in that moment I did not know. And it was helpful to put connections to, you know, let's say for example the physical health problems he has now. To understand from the history, from his experiences as he was growing, how some of the things have come to be, and to put connections to his mental health, physical health, and the medical interventions, such

as medication that he is having. All those things, sometimes, they don't make sense, if you don't understand the totality of the person's presentation from his upbringing side of things, so it was very helpful to get that sort of understanding.

NP4: It was quite surprising for me, that yeah, to see that [contextual] background, which me being new hadn't been aware of that, but also how much we didn't know about her.

Some participants reflected that in widening their perspectives to include a more systemic understanding of patients, it allowed some space to notice that ward teams can sometimes get wrapped up in focusing almost solely on patients' behaviour, especially if it is challenging for staff and/or evokes strong feelings. Participants shared that in those moments they can often lose sight of the patient as a 'person-in-context', and staff may actually know very little about the patient and their family system aside from the observable behaviour.

NP3: Normally the discussions on behavioural cycles is speculative so there's not much there, whereas if you recall the A3 [team formulation headings] sheets we completed on this one there was (emphasising voice tone) SO MUCH speculation on the team's feelings and impact and how we felt in the situation, partially because we knew so little about her [patient].

*RP2 (*in response to RP1 reflecting on their awareness of contextual and family issues in deconstructing the patient's presenting problem in team formulation*): 'It is good to know that there is a history there, this person isn't just acting the way he is because*

of choice or because that is how he is, there is trauma there, there's something that's causing him to be the way he is, or whatever you want to phrase it. It's a nice way to remind people to take a step back to view the person as another person and not just that person in time… um. I think [team formulation] it's good from that point of way.

NP5: I think a renewal and realisation that there are other aspects to her [patient] than being angry and hostile

4.1.3. Hearing multiple perspectives

Most of the participants shared that a significant part of the team formulation process for them, was being able to hear the experiences, feelings, and thoughts from a range of multi-disciplinary team members. There was a sense that a significant moment of the team formulation process was having the opportunity for peer reflection and team reflexivity, especially with team members who do not usually get to reflect together, due to different work roles and responsibilities (such as medical staff and support workers). This highlights the importance of creating and maintaining a collaborative space for dialogue, reflection, and engagement in team formulation sessions amongst all team members.

DP8: For myself, I think [a significant moment] it was all the contributions from all the different professionals…

NP3: I think it was useful to have you (to NP4, a support worker) and a member of the medical team there, who were more open about their experiences with the individual…

and I also think having a range of other disciplines in there, because everyone's interactions are so specific and individual, so we do all get different perspectives from different angles. Having individuals in the space who weren't familiar with the patient was very useful too. So people, who, from other teams who were reflective, trying to offer their perception objectively without a preconception was also very useful aspect of it. NP5: Yes I'd agree with that (to NP3) the range of disciplines reflected and the range of people that know the person for a while

Participants reflected that one of the values of sharing multiple perspectives was being able to learn alternative interactional patterns from others. In sharing differences and similarities of experiences, there appears to be value in discovering and co-constructing a shared formulation together. I will discuss more findings on this in the section on the theme of relational reflexivity further below.

DP9: I think just hearing everybody, like you said (to DP8) that lady who had a really good rapport… DP8: (laughing) yeah, her perspective was totally different DP9: (laughing) Yeah, totally different to mine, and my perspective and experience of her, and a lot of other people in the room, so I think having everybody there from different disciplines really helpful to gather all that information and it's really interesting what other pockets of information people knew that could come together to build a decent formulation

Despite inpatient mental health wards being structured around multi-disciplinary working, there was also a sense that relationally reflective discussions are not

normative practice in these contexts, as reflected by participant DP8, who has worked in similar settings across different NHS Trusts.

DP8: um, to hear other people's perspectives, And being new, I've never been part of anything like this before. I mean I've read about this sort of thing, but being actively involved is really positive.

4.1.4. But team formulation can feel too open-ended

There was, however, a frustrating sentiment amongst some participants that despite their value, team formulation sessions sometimes felt too open-ended, and that the sessions lacked clear objectives and outcomes. This is perhaps in contrast to other more structured ward MDT meetings, such as discharge planning meetings, where the purpose is to clearly plan possible care outcomes.

Staff can often feel stuck and confused about how to progress with patients who may present with complex and challenging behaviours, and/or who may have complex social circumstances that prolong the inpatient admission. These are the patients that are usually suggested for discussion in team formulation sessions. There is a strong sense of wanting to problem-solve and work towards outcomes that lead to progress for these patients and ward staff, and to use group meeting spaces meaningfully to do this.

NP4: (after clarifying what they had meant about the outcome being unclear) I kind of had the sense that um, maybe this was to maybe change the route that they were

thinking of going down with this case, and what the outcomes were going to be, and it became clear that it wasn't going to change anything, that they were still looking to go down that route, and a part of me wondered, why are we having this conversation if it wasn't aiming to change that outcome.

NP3: I think it's nice to come away with something very tangible and concrete, in terms of saying right I'm going to do xyz and this will definitely resolve that problem, but that's always the most difficult thing to deal with in mental health and also with team formulation. I think was chatting to you (to NP4) about it, team formulation is not about being objective, and is not always about the outcome

In response to the experience of feeling like team formulation sessions can sometimes be too focused on process, participants had numerous suggestions of how the team formulation sessions could include more structured, practical, and outcome-based reflections, some of which included embedding routine ward practices such as risk assessments into the team formulations. These reflections may also be related to a need to find time-saving strategies and use team formulation sessions to enhance essential work roles and practices. These recommendations will be considered further in the conclusion section on 'Recommendations'.

*P2: Yeah. I know we talk about it as we go, but just having a section on the triggers and coping strategies are, might be useful, I've heard from some staff on the wards, like chewing gum [as a coping strategy for patients], and they don't tend to be things that come up when I'm with those people, so worth thinking about…. [*later in the focus group discussion*] Even from my point of view, I would like to have an area of tools that*

people can use, I know we have the calm down box, but more specific ones when people come in, they can identify what coping strategies and we have something similar they can use nearby, and we can be more proactive in managing people's agitation and frustration. I know we do touch on the coping strategies, but just to have a bit more of a focus and support the other members of staff that they can use these resources and help them feel comfortable.

P1: I just thought of something as well, in saying that in terms of actually bringing up the risk assessment itself, so if we hearing things from different staff members about those examples you're sharing (to P2) that we can acknowledge that in protective factors or in the risk management plan, and then just adding that in, and going to the patient themselves, and we've heard from different staff, would these things be supportive and helpful, just to marry them together.

Some participants, who were also new staff members, reflected that they were unclear about the process and format of team formulation sessions, often just showing up to the meetings without knowing what was going to happen and who was going to be discussed. As a facilitator of the team formulation sessions, I know that sessions are usually organised on a needs-basis, usually in the weekly MDT meetings or staff support group meetings. Due to the different shift patterns of staff, not all staff are present at these meetings, so may not be informed until the day of the team formulation sessions. Emails are usually sent out to all staff about the team formulation sessions a day before it happens, but those emails may not always be picked up. In my experience working on the wards, there often isn't time to induct and orientate new staff members to all the various practices and meetings that happen in the wards, but

as a facilitator of these sessions there is more that can be done in this regard. I was aware of the tentative tone of the participants giving this feedback in a cautious and apologetic manner, which could have been related to my position as a practitioner-research, and possible discomfort in them giving me constructive feedback about my practice. This feedback will be considered further in the conclusion chapter in the section on research limitations.

NP4 (after reflecting on the value of team members being able to air their feelings in team formulation) …but I was just a bit unclear what would then kind of, not point because that's the wrong way to put it, but kind of what the outcome of that [team formulation] kind of intended to be …I kind of just showed up to the team formulation without really knowing the initial process… Sorry – I have a question - How often do you do them?

*SP7: [*when reflecting on not knowing who was being discussed in team formulation*] Um, personally, um, I don't know how helpful it can be to know ahead of time who you are going to be discussing, but having said that I have also no doubt the benefits of being told on the day who you are going to discuss, because um, it helps to harness that subconscious information, that you know you discuss, you relate, you do things, without like trying to maybe fit a certain shape, so when you are just told on the day, I mean like on the day I was told a totally different person, so when I walked in I was actually thinking of a different person, I walked in and sat down and realised we are discussing … So yeah, I can see both benefits of knowing on the day and being informed prior.*

4.2. ‘Flicking the switch’ - Relational Reflexivity

4.2.1. Relational awareness and awareness of communication

All of the participants discussed the significance of relational thinking and awareness in team formulation sessions. As discussed in the literature review, systemic formulation sessions often involve encouraging increased circular awareness and relational reflexivity amongst team members. Relational reflexivity is a systemic concept which highlights the intentional process by which individuals explicitly consider, explore, experiment with, and elaborate on the ways in which they relate (Burnham, 2018) The term was originally conceptualised with reference to the client-therapist relationship, but I am using the term more widely here, to relate to an explicitly reflective and dialogical process which considers how people reflect on how they relate to one another i.e. taking a meta-perspective on one’s ‘relational dance’ with others, and engaging in a dialogue about it.

Relational reflexivity includes circular awareness, which involves team members acknowledging that they are actively influencing and influenced by their interactional patterns with each other, with patients, and with patients’ families. Participants referred to this process of relational reflexivity as an enlightening moment of awareness in team formulation sessions, like ‘flicking a switch’ and having a ‘kind of moment’ of realisation. In systemic terms, this principle is also linked to second-order cybernetics theory, whereby staff realise that they are not just external observers of a client system but also form part of that system i.e., they influence the system, and are influenced by it. The quotations below indicate a form of relational reflexivity in staff-patient relationships, as well as relational observations between patients and their families.

SP6: Yeah, it's almost like someone flicked a switch after the team formulation, the progress after it, It was, um, I also found that one of the comments at the end to all the questions we were asked, how does that person make you feel – our emotional reaction to him, um my response was on edge, and I very quickly noticed that my interactions with him after had changed, There was still some risk, that you're almost on edge with everyone, but I noticed that I felt a lot more comfortable, the de-escalation that was required was a lot easier because I could relate it back to things in a different way, so yeah, I think that process is great in that, just even when someone is at that crisis point we can relate on a more personal level, helps to ground that … I think it was very, very beneficial.

*DP9: 'You know in terms of her doing things culturally you know, to try and put people down, upsetting them, what have you. That part of the TF really highlighted that if we're not treating her respectfully then she's not going to be respectful. And there was this kind of moment… that was quite an important bit of the formulation'. DP8: [*in response to DP9 using a reflective tone*] 'The way she treats people she respects, she treats very differently to the ones that she doesn't'*

DP8: I didn't get to go to MDT [meeting] today, but think it was interesting that the more family visits there were, the more spikes in her behaviours.

There was a realisation amongst participants that interactional responses and feedback loops between patients and staff can happen automatically as team members react to strong feelings elicited in them, especially as they attempted to manage risks. There were reflections that sometimes these interactional responses

were not in the best interest of good patient care, and having the space to become aware of, and reflect on relational responses was helpful.

SP6: and I actually just at the end when we were raising the actions and questions, um that without realising sometimes keeping people at arm's length, um because of risk, and actually we need to be thinking why are we doing that. Is it because of safety or is it because of situational factors, or are we making assumptions, um, so that's what I took away from that one…

SP6: [later in discussion with SP7] …looking at that we're phrasing it in a positive way, because it is very true that we sometimes set goals that we potentially think are achievable in the way that we work that may not be so positive, and obviously that individual specially around such behaviours like public masturbation, targeting female members of staff, obviously our desired goal is for our benefit as well. We don't want that to make us uncomfortable, but I suppose why are we actually putting that goal in place, what's the impact? That's a moment that stood out for me. It was nicely broken down to reflect both sides

Participants also reflected on the significance of relational reflexivity when considering how team members relate to one another, and to client systems. Being aware of the similarities and differences of circular interactional patterns which team members have with each other and with patients, helps normalise the range of care responses between staff and patients. This may increase team empathy, support, and cohesion, and may offer a space to learn and build interactional confidence between team systems and client systems, as discussed in the next superordinate theme below.

RP1: I think it allows us to kind of be open in our team about how we're feeling to then almost allow a space for us as well, for our peers to understand our responses, our feelings, what we're going through, almost like an indirect way of having some kind of support. People acknowledging us in the whole situation, I think as well. Um, because you know we did have differences with how the Raul [patient] would respond to say you [to RP2], compared to Jane [another ward staff member who attended and contributed at the TF] or John [a ward staff member who attended and contributed at the TF] (laughing) because he could be quite changeable with trying to almost, you know engage with the people he wanted to in a certain way, so in saying that we all have our own experiences of our interactions with him, and so obviously causes different feelings, so its yeah, it's good to find that out for ourselves and the team.

NP3: [ward team members' attitudes] which was then altered throughout the course of the formulation anyway. And I think as we all just sort of reflected, we sort of reached that, we had our status quo beforehand and we wouldn't have spent much time with her or haven't been as receptive. NP3: I think there's been somewhat of a shift with everyone coming out a bit

There was a sense amongst participants that relational reflexivity can be useful as a tool to explore alternative relational responses, whereby team members can become active and more confident change agents in their care of patients by exploring how they might engage in more effective interactional exchanges with each other, patients, and patient families. The notion of building interactional confidence[9] will be explored further below.

[9] Interactional confidence refers to confidence in one's capability to act on or influence another.

P2: I think it's good to take a step back and have the space and that time to, say okay there's something we may need to be doing differently with this person and their system.

NP5: If it's changed the way people communicate about her, then there is a change.

4.2.2. Building interactional confidence by learning from others

All of the participants shared that a significant experience of the team formulation process for them was being able to learn from others, and particularly to learn about different ways of responding to and engaging with patients in their families. There was a sense that having a space to hear about other team members interactional responses (both effective and ineffective response patterns) helped build interactional confidence for staff to try different ways of engaging interactionally with each other, with patients, and their families. This appeared to open up avenues for renewed alliance-building with client systems.

*[*In interaction with DP9, reflecting on how another team member had a good alliance with the patient due to her informal approach with her] *DP9: I think just hearing everybody, like you said (to DP8) that lady [team member] who had a really good rapport… DP8: (laughing) yeah, her perspective was totally different. DP8: Yeah, and if it's effective, we can try mirror that can't we? DP9: yeah, definitely, and that was some of the things we included in the care plan, and then sharing that with the wider team. That's really important to make sure that everyone else [in the team] understands.*

NP5: Nodding. It's people that don't seem to be moving along or making any progress. I know I found that an issue with this lady [patient] - I was asked to an assessment with her and have been finding it really difficult to engage with her, so I was quite keen to do a team formulation. Since then I've gone to her and suggested that we do some baking, and she didn't say a flat out no, which is good, so I will continue with that. She asked if I would go into town with her and get some food, so I jumped on that chance and got leave ready, so I can try build the rapport. Had I not had that conversation with her after the team formulation I don't think that would have been suggested.

This kind of relational information appears to be best shared in dialogue with others, as opposed to just shared on notes or via email, as described by the participants below.

P1: I know it's quite a far-fetched benefit, and were getting better at it I think, but I don't think we always considered the differences in engagements and observations we all have and collecting it, to allow us to make more sense as a kind of combination rather than just, yeah, because you know if we write our notes for our patient from a nursing side I guess as well, if you write our notes from one shift to another, the difference in what people write around somebody's mental state can be completely different and our tolerances, and certain behaviours and actions, so I'm hoping it will allow people to communicate a bit more outside of team formulation and Space [support groups] and stuff.

SP6: …I find it very really interesting when you're doing group settings, when you bring people together, the way people bounce off each other, um the way that questions get

raised without actually realising that someone you're working with very closely, might have the answer to it, or more of an understanding that you just don't get from reading notes.

Continuing with the theme of team members valuing the team formulation space to learn from others, the support worker participants in particular, highlighted the significant value of having a relational learning space, as they spend a large part of their working time engaging with patients and their families. In my experience working on the wards, the support worker staff are often positioned as the key workers on the ground, and thus do not have many opportunities to attend other staff group meetings on the ward beyond informal chats with peers while working. There is a sense from SP7 and DP9's responses below, that their work can often feel overwhelming, isolating, and confusing, and having a space to 'bounce off' relational ideas with others is invaluable.

SP7: Yeah, it's almost like you are presented with an unlimited learning opportunity because um, all people are different. For myself, I like to learn by observing other people as well, and then putting those skills together, because there's not one answer to addressing mental health problems, so when you are presented with a patient, and then you see that there is always a bouncing of ideas where you see what somebody else is doing, and I look at myself and say, oh, I am weak in this area, maybe I can borrow this idea that SP6 is using, I can be able to use it and combine it with what I have done, it makes me a better support worker, so in a group setting has a lot of benefits because you learn diverse way of, you know approaching any given scenario …you realise it helps to drive conversation with patients, it helps to like, sort of narrow

down some of the areas we need to, you know assist our patients with, and to understand them as well, because if you understand what they've been through, what they're going through then it's easier to help them better to assist them along the journey to recovery.

DP9: I think it was motivating to actually try and do something differently with [patient], wasn't it [seeking validation from DP8], cause yeah, we've been banging our heads against a brick wall, really…

Participants discussed becoming aware of their circular influence when engaging with patients, and how interactional interventions could be implemented immediately, thus giving team members a sense of agency in trying to create change with patients, regardless of their position and power. Noticing changes in relational behaviour indicated a sense of relational awareness.

SP7: I think, um, I … simply because since that team formulation, there are things that we discussed there that were implemented immediately, so if you talk in QMIS terms, it was like a quick win, so um you know things like just preparing his colostomy bags ahead of time so that we don't have to wait, and having him having the things he needs around him, and if you look at his presentation prior to the team formulation, and now, there's a like a, marked improvement in his relationship with us … he is going for section 17 [leave], which he wasn't doing before and, you know, he is almost like easier to relate to him, and you can see that even though he is still a little bit uncomfortable getting help to deal with things, he now sometimes relaxes and asks for help and not just shut people off, so I think there is good progress that we are having with him.

4.2.3. Noticing relational progress

Most of the participants reflected that sustaining new ways of relating was sometimes difficult, as it meant having to respond in ways that were unfamiliar, but participants valued thinking about the relational benefits for patients, staff, and families, and how these relational ideas could influence the care pathway for patients too.

P1: …I think it gives us the confidence as a team to feel like okay, we've really thought about this now, and actually this is not us being harsh, it's the balance, and so, I think it's an empowering kind of thing to do. … it helps us with our burnout – consistency – and his benefit entirely as well. And it can completely change the dynamic the family have with us, and the care pathway, completely, which we've kind of seen now as well… that was one of the big ones [significant moments]. We had the formulation on the Mon, but the Sunday just before we had the son shouting at the staff. And so the difference since that meeting has really showed a lot of change. The incident on the Sunday with the son, the family meeting then the team formulation really just came together, like wow.

SP6: …it's looking at the patterns of formulations we have had in the past. People do seem to benefit from them, either directly or indirectly, but that person seems to progress after the formulation has happened. Which is better looking back on it. I wonder why we haven't done them sooner. I definitely think there is a pattern of people progressing after they have been done.

4.2.4. But it is difficult to sustain and share new relational ideas and progress

Despite sharing that they were able to see the relational progress of their circular awareness, all of the participants shared that sustaining effective relational feedback loops on the wards between team members, and between team members and patients was challenging. There was a sense of the strong homeostasis in the system to revert to old patterns of behaviour, perhaps due to poor attendance of key staff at team formulation sessions, and the difficulties of handing over relational information and ideas from the team formulation sessions with others. There was also a sense that team formulation sessions were experiential and transformational, and as such, difficult to share ideas and learning that came from it with others who weren't in the sessions.

NP3: it's [team formulation] focus is a bit more nebulous; its content is not a tick box exercise … is how long its followed through for. As a ward we know it's not always easy to keep that information handed over and to maintain the energy level, when we've got new people coming from different environments every day. Staff level of investment dissipates over a period of time. So initially there's a surge for a couple of weeks, maybe a month and then you see it peeter away. I suppose that's what my concern is and what could be improved moving forward. It's only been a week since…

NP4: because all of those things we have said are true – it can be frustrating and hard, I just kind of thought well at least I've done that [team formulation] and I've kind of understood her a little better, but none of the other staff were part of that and actually how many are going to read it [team formulation notes] and actually experience what

you get out of it by being in it [team formulation]. So I guess it's not the process but who needs to be part of it.

Participants suggested recommendations of what might better facilitate the communication of relational ideas and information from the team formulation sessions. They described using existing ward routines and processes to try embed some of this information. Again, there was a feeling that sharing information from the team formulation sessions via notes would not be as effective as sharing them in person and in dialogue with others, given the relational nature of the information. These suggestions will be explored further in the recommendations section in Chapter 5.

DP9: Maybe making sure that it [team formulation reflections] is shared more actively, maybe that's the way forward, now the weekend has gone by you know. Obviously the assistant psychologist is going to write it up [team formulation notes], but it needs to be much more… that information has to get out to the team as soon as possible. DP8: That would be valuable. And then probably feeding that back via handover, that information discussed in the TF being transferred in the handover so the information gets shared to next lot of people coming on shift.

NP4: (to me) Could you have a follow up session… even if it was just a short one, like 15 minutes, like time for a reflective thing, maybe in two weeks to ask how things have changed. NP5: (Nodding). Also, hypothesis testing, has it worked, is it still perpetuating, what can we do different….

There were some reflections from the participants about the team formulation notes that are usually written up and shared via email with all team members after the team formulation. There was agreement that those notes are sometimes difficult (and dangerous!) for others to read without context or having attended the session, and that team members often do not have time to read notes unless they are looking for something specific, or if it is presented in a more visually appealing way. Participants shared the importance of highlighting the tentativeness of formulation ideas and reflections on the notes and being mindful of where they are shared.

NP4: [when discussing the team formulation notes] …but the reflections and action points at the end, I don't know, it's a small thing but just to display that differently. It just looks like a bunch of text that's not going to get read at the end, so I don't know, even if the reflections are written in speech bubbles and bullet point the action points. That's all. Sorry. <laughing>

P2: Just in terms of the TF notes that are sent out – I would read them more so out of, I would only read them if there is something specifically I was looking for, trying to find a quick reference, but I haven't read them through in the sense that reading what we discussed again, but it's definitely useful to send out to staff – I suppose it's if they have a priority to read them, but it is very useful in terms of having a map of what could be going on for a family

DP9: And in terms of the information not being used out of context (pause) putting question marks next to hypotheses, or just the action plan.

NP3: Yes and no, we don't want information to be used dangerously and inappropriately out of context. It's discussed at the MDT and the reflections points are put on Rio [patient documents] so that they can be considered for the care plan.

The suggestions made above, regarding sharing information in more visual and dialogical ways, are interesting in the context of participants also sharing that an element of systemic team formulation they really valued was how the information was displayed visually. In practice, the process of team formulation entails writing up team members ideas and reflections on large flipchart papers stuck to the wall, as well as drawing a genogram and/or ecomap collaboratively with team members.

RP2: I really enjoyed the genogram and the history aspect, it's quite a good visual way of just contextualising the person.

NP4: I quite like the flipchart papers, the visual aspect seems to work.

DP8: I think it's really good that you had the posters up and different colour pens and subsections. I think that helped, I'm quite a visual learner so that was perfect (laughing).

4.3. 'Humanising the case' - the patient as a person and the professional as a person

4.3.1. Validating and normalising feelings in a context that encourages emotional distance – humanising the professional

Participants shared that a significant aspect of the team formulation process for them was being in a safe space where they could openly share their feelings about caring for patients and their families, and where these feelings could be validated and normalised by the rest of the team. Participants shared that they particularly valued sharing and debriefing negative feelings, reflecting that there was an 'unspoken rule' on the wards that personal, and especially negative feelings should not be expressed. Participants reflected on the importance of having a supportive space to share feelings, as inpatient mental health work often has significant emotional impact on team members. Team formulation sessions appear to provide team members with a space where they feel humanised.

RP2: Going on what you (to P1) were saying earlier about validating the staff's feelings, that's really important, um, I think obviously as well when you're working with people, we only do 9-5, but for support workers who work 24/7 it can be so mentally draining, just for one shift can be so tough. There is that unwritten obligation or unspoken rule you can't say out loud that you dislike a person, because obviously we have that duty of care and you know in team formulation and Space what you say won't be interpreted as saying well that person is a bad carer, cause it just gets … it's really good allowing the staff to have that forum.

NP4: for people just to be able to air how they're feeling, and I know at the end I said to you (to NP3), um, (pause) for me it was like a really good process to see that but there was, I don't know (pause) that part of me that thought this was a really good process…

There was a particular sense of surprise shared by some participants when senior professionals in the team, particularly the psychiatrists, openly shared their feelings. This again alluded to a narrative of feelings not usually being shared in ward group meeting spaces, and a strong discourse of maintaining objectivity in patient care, often role-modelled by senior team members in positions of power.

NP3: I think it was useful to have you (to NP4) and a member of the medical team there, who were more open about their experiences with the individual. The normal format of that group is always whereby there's some muttering silences and people try to be seem very professional, depending on who's attending…
NP4: Yeah, yeah (in strong agreement with NP3). Hearing the doctor talk about her feelings was really (pause), it was good to see, but not (pause) to even see that because I experience the doctor as so calm, but there was that frustration there which was obviously quite difficult for them, and I think that's not… I think if other people had seen that, it might have had a real impact on them to be honest, and I think that's been lost by them not being there.

4.3.2. Renewed empathy and alliance – humanising the patient

Participants acknowledged the transformative impact of being able to honestly identify, name, and share personal feelings elicited in patient care, as a way of improving relational and trauma-informed patient care. Thus, there was a sense that the team formulation sessions are a space where patients are humanised too.

NP4: For me, it's what you used (to NP3) the humanising of that case, actually, when I thought on that, that's what kind of really came out of it, because people were so honest in there.

Participants shared that after having had the space to reflect, they often felt a renewed sense of empathy and confidence to try rebuild an alliance with patients and families they had initially felt stuck with. This highlights the benefit of team formulation as a supervision intervention for team members. This theme of increased empathy is evident across multiple qualitative studies on team formulation, (Murphy et al., 2013; Christofides, et al., 2011; Geach et al. 2019; Priddy et al., 2021; Short et al., 2019; Berry et al., 2009, 2015; Ramsden et al., 2014) where team members identified that team formulation sessions helped them see service users more as "people" and less as "patients." Consequently, as shown in my findings too, increased empathy helped staff relate better with client systems, and was shown to improve staff-client interactions and team functioning (Christofides, et al., 2011).

P1: I think the, you know we [in team formulation sessions] always say about our feelings and stuff, and I think we do struggle with, including myself can find it challenge to name the feeling rather than the content or the context, so I think that's really important for us to really identify that to maybe manage the feelings that were feeling, and kind of avoid it coming towards responses, or manage the responses that we have or may have.

NP5: Um, I just realised I have been to three not two (laughing). I think for me it was useful to hear, I guess and feel validated in I how I was feeling, I think frustrated I

suppose, a bit… maybe not putting in as much effort with this particular person like I have had in the past, Following that, I went to have a 1:1 with them, I think it kind of renewed my enthusiasm to work with them, and I actually managed to build a rapport with them again, which was very useful…

Discussing and exploring wider perspectives also led to feelings of renewed empathy for patients and their families. This appeared to be facilitated by the processes in team formulation which encourages seeing the patient as a person in context, beyond their diagnoses and behaviour.

DP8: Seeing the person more than just the diagnosis. Look at all elements of their lives, I thought that was really interesting.

NP5: Yeah, to give that kind of context that actually I'm not the only one that feels like this about her, and to give her a bit of context in terms of talking about her past. So I think I have known her for a while, but I haven't put much thought into who is this person outside of being a mental health patient, Useful.

In my experience on the wards, the dominant formulation discourse is a biomedical perspective, but understanding behaviour and emotions from solely that framework can cause confusion in team members who are trying to make sense of a patient's presentation and how they can help, as described in SP7's quote below.

SP7: I think for me what stood out the most was the fact that we are dealing with a young man who has got a multitude of things that have gone against the grain for him.

And he is still standing and here he is. He now has mental health issues. Prior to the team formulation, some of the things that I learnt in that moment I did not know. And it was helpful to put connections to, you know, let's say for example the physical health problems he has now. To understand from the history from his experiences as he was growing, how some of the things have come to be, and to put connections to his mental health, physical health, and the medical interventions, such as medication that he is having. All those things, sometimes, they don't make sense, if you don't understand the totality of the person's presentation from his upbringing side of things, so it was very helpful to get that sort of understanding.

Self-reflexivity and widening perspectives were expressed as useful experiences when team members felt stuck about how to progress with patient care. This again highlights the possible benefit of team formulation as a supervision space and intervention for staff.

NP3: I suppose the… with, this is an individual who has been with us for a period of time, and it feels so jarring to think of … If someone had to ask me if I know this person, I'd tell them I know this person very well, whereas in fact I didn't. I knew my opinion of them very well…

Participants reiterated the challenge of sustaining renewed empathy, as relational patterns can be difficult to change, and thus positive thoughts about therapeutic alliance can be difficult to maintain with some patients. This possibly highlights the need for these discussions to continue in individual supervision, which in my

experience on the wards, is often inadequately provided for staff groups who are not supervised by therapists.

NP3: I think there are pros and cons, we initially associate ourselves with the negative traits but then we may more freely associate ourselves with more positive thoughts afterwards [after team formulation] as a result. But the key is how to sustain those thoughts?

4.3.3. Personal resonance

In relation to self-reflexivity, participants also reflected that they valued having a space to reflect on personal similarities and differences between themselves and patients they were caring for. This included team members thinking about how their own personal backgrounds, beliefs, and life stories resonated or contrasted with patient life stories, which helped increase relational awareness, deepen empathy, and widen their perspectives on the formulation and care needs.

SP7: For me this a patient that, as I mentioned on the team formulation on the day, he had an operation that is almost similar to the one I had, just as my colleague has just mentioned, he lost a parent, or rather he lost both parents. I lost a parent, and you understand at that moment how heavy some of these things can weigh, but maybe we have been fortunate enough to have support structures that he didn't have when we grew up.

SP6: [in response to SP7] …So as a person who's lost their parents too, that made me empathise with that service user as well, and I actually just at the end when we were raising the actions and questions, um that without realising sometimes keeping people at arm's length, um because of risk, and actually we need to be thinking why are we doing that. Is it because of safety or is it because of situational factors, or are we making assumptions, um, so that's what I took away from that one.

DP8: Childhood was quite significant with this lady, because I think she had a… (said sadly) now days you would probably call it like a child carer review that she needed, in a sense, because she was caring for her siblings and her mother had mental health issues. I have some experience with that myself… She should've been classified as a child carer.

There was also a reflection on the usefulness of hearing about other team member's historical experiences in a group context, which enhances team support and cohesion, which will be explored further in the findings below.

SP6: …if you've got a personal connection in that you can relate what that person is going through, chances are that somebody else in the room has got some very similar. Like until last week I didn't know about SP7's background, ad you shared that in the meeting, and that makes you also support the staff member that is with them, cause they could have a personal impact or effect on that person. So yeah, I think the group way of doing it is a lot better, than trying to scroll through someone's notes

4.4. ‘Effective informal approach’- Challenging the notion of hierarchical and risk-focused professionalism

Some of the themes that emerged related to participants reflecting on how team formulation sessions helped them think about and challenge some of the dominant discourses and narratives on the wards. These included discourses around hierarchy, professionalism, risk-based practice, and the formalities of working in that context.

4.4.1. Team support and cohesion in a hierarchical system

Participants acknowledged the benefit of reflective group spaces for staff to be able to listen to and validate each other as a unified team, in a system that is hierarchical and has inherent power imbalances. Given the stressors of working in an inpatient mental health context, participants considered the significance of team formulation sessions as a supportive space for themselves, and a space for team building too. In my experience on the wards, staff are more likely to attend a team formulation group than any other staff wellbeing or support group spaces, as they are, perhaps, more able to motivate that it is a good use of work time (which as discussed in the first theme, is limited) Team formulation sessions also offer a semi-structured format for discussions, and as self-reflexivity is part of the framework, it is often one of the few spaces team members have to discuss their feelings, beliefs, and concerns in relation to patient care.

P1: I think in itself we struggle to validate ourselves or one another in the team, not… I think we are really a much better, cohesive team at the moment, we’ve dealt with a

lot, but I think it allows us to kind of be open in our team about how we're feeling to then almost allow a space for us as well

NP3: I think yeah, it's very humanising to think you possibly have your own power dynamics within ward team especially with more senior staff, being at their level, and yeah I think it's nice to have that very much unifying, we all experience the same process, we're all in the same cycle with this individual from a variety of backgrounds.

DP9: It does feel like you're part of the team much more, but it was interesting that it was you (to DP8) who were sort of second week in to the job…it felt like it was newish people who attended, and then we had psychology there, and a student nurse, a fairly new support worker, an OT student…

There was an acknowledgement by participants about the important role of the psychology facilitators in warming the room, and creating a safe, impartial space for honest discussion, where all voices are valued and heard in team formulation sessions. This will be discussed further in the recommendations section.

SP7: I think … (pause) The person leading the group, um, if they are relaxed, they make everybody else relaxed, and if everyone is relaxed and you feel like you are under no pressure to impress but all you are doing is just maybe regurgitating the things you have been doing without any afterthought and stuff like that, it's testament to the skills of those who are leading the.. session and the time that they make it such a place where you feel like you just want to pour out and pour out and pour out, and take in what you may if needs be.

Given the hierarchical nature of inpatient wards, where senior team members of higher banding staff often carry the risk and power of making decisions about patient care, there were reflections about how team formulation sessions contrasted to other ward team meetings. I noted the language used by participants in describing how they felt during team formulation sessions – 'welcomed', 'relaxed', 'no pressure', 'able to let barriers down', 'no need to impress', 'eye-opening' indicating possible feelings of comfort and safety.

NP4: I think that's the bit that was really interesting for me [when reflecting on the difference between team formulation and other team meetings], I think because, as you say being in that MDTs and stuff like that it is very formal but actually for me realising it was a space, where some of one the doctors was frank about how they felt, um and I think that was quite an eye-opener for me, to be honest. To actually just it seemed like a good space where one could just say, particularly with this case, because I think it has been a really difficult for us.

One participant in particular, mentioned that the most significant aspect of team formulation for them was having a space where their professional opinion was validated and backed up by other team members. There was a sense of epistemic validation[10] and 'support in numbers', in opposition to psychiatrists and/or senior team members who may have a strong opinion about patient formulation and care.

[10] In contrast to epistemic injustice (Fricker, 2006), epistemic validation is when an individual, who is ordinarily invalidated as a knower, is taken as one.

P2: from my side with this service user, obviously I was assessing him for his mobilities and for his transfers, erm, my next assessment was that he was able to move independently just with lots of verbal encouragement. I felt at the time, some of the other members of the MDT felt that was a bit of a harsh assessment as such, and I should be looking at him from a more medical view, so I struggled quite a lot with that, trying to get people to understand where I was coming from and it was good to have the team formulation, to have the support workers who see him everyday, to get their feedback, they have the direct 1:1 and interactions, um, I just think that everyone coming together really helped improve his mobility anyway, that everyone is taking the same approach, um. And even though his mobility might fluctuate depending on the day or the time of the day, but once everybody has that view of balancing care and encouraging independence, I think once everyone got on the same page, that helped expedite him along a bit, it was good … from my point of view it was just nice being validated in the sense that my assessment was right at the time that you know I, from my point of view.

Participants reflected about how they hoped other team meeting spaces could be approached in this manner too. In my experience on the wards and in my position of seniority as a Band 8 staff member, which allows me to sit across the range of ward team meetings, I have observed the protocol of formal professional conduct in other team meetings, which is difficult to shift. This will be discussed further in the discussion chapter.

SP6: Positive, yeah [when asked about their experience of team formulation]. One of the big things when it comes to group setting, I always find it interesting to go to

sessions run by psychology groups, like Space groups, post incident reviews, team formulations, hierarchy is out the window, doesn't matter if you're a band 2 or a band 8, everybody feels comfortable to share, everybody's knowledge is welcomed and um, not necessarily in a negative way, but compared to the MDT and CPA (both laughing), it is mainly run by the doctors and the psychologist. Obviously they have the qualifications, they've got the knowledge and maybe a bit more of an understanding of why that person can be presenting in that way, but it's nice that people can let their barriers down. That almost professional hierarchy goes out the window, and you can share your honest beliefs. It would almost be nice if we could move that to MDTs and CPAs, because it is the support workers and nurses that see the patient everyday they should be giving their feedback as well, but yeah my reflection on what's been discussed has been good. Like I say if we could have more formulations that would be positive.

4.4.2. Informal vs formal clinical approach

It was interesting to note that in all of the focus groups, there was a discussion about informal vs. formal ward practices, attitudes and behaviours, and what was perceived as professional behaviour or not. Some participants discussed the formalities of engaging with patients, and how, when they were reflecting on alternative interactional patterns between some staff and patients, there was a realisation that team members who engaged with some patients in a less clinical and more self-aware manner were able to build rapport more effectively.

DP8: Yeah, she [team member] has a good rapport with her [patient]. I think it was quite enlightening to hear, because she is quite informal in her approach
DP8: I haven't had much interaction with her [patient] since the team formulation but I just thought it was interesting for me, as a professional, to be more self-aware, not to be so clinical or formal, and to build that relationship first before going in with your objectives to be ticked off

DP8: It's nice to be part of doing things differently, like you said [addressing DP9], trying to not do things the normal way but trying to do the best for the patient really, and looking at everything is the best way to go

There was also a sense that there is a 'normal way' of doing things on the ward which perhaps relates to rigid discourses about clinical professionalism. These ward norms could relate to a sense of having to restrain and maintain emotional distance from patients, both in interaction with them and when discussing feelings that they elicit with other staff in formal meetings.

NP3: [in team formulation sessions] you have to push through that veneer of, I don't want to say anything that's perceived as inappropriate or nasty and get to that understanding that you're a person and not only a professional. And it's nice to not have to go through that awkward first 20 minutes or so.
NP3: I suppose the case was identified, um she had been mentioned in various groups, and I sometimes sit in the staff room where, people are, in a way being less professional and discussing what they are finding challenging by extension… So there was frequent mention of this individual as causing frustration and then in addition on

top of that it was often candidates for our formulations are often people who have been here for a long period of time and are stuck in stagnation, or people who are very new and are very disruptive. And in this case it was the former.

Participants also reflected on a ward norm about meetings being outcome-focused rather than process-focused, which relates to the theme about participants sometimes finding team formulation sessions to be too contrasting to other ward meetings in terms of objectives.

NP4: Yeah, And I think that's it, that's my experience from my past job, this sounds really bad, but we usually have a meeting for a point, do you know what I mean, to reach an objective and there's outcomes from it. So for me that whole dynamic was a different thing for me to reflect on. I think, yeah, I liked it though, I think it was good.

4.4.3. Strengths-based perspective in a risk-focused and problem-saturated context

Risk-focused practice on the wards also appeared to be a dominant discourse that was discussed in the focus groups, with participants sharing that reflecting on patient, family, and team *strengths* was an unusual but significant process in team formulation sessions for participants. In systemic team formulation sessions, the first aspect that is usually discussed is what is going well for patients, their families, and the team, in relation to the patient. In my experience facilitating the sessions, starting with this reflection is key in trying to help loosen the problem-saturated narrative that often accompanies cases that are requested to be discussed in team formulation sessions.

NP3: I like the layout of starting with the positive aspects first is always a nice sort of paradigm shift as opposed to going through this as problem solving exercise, it's focused on strengths, and how we've integrated with the current system, what this person brings to the interaction but also what we may be perpetuating. I think for me it's a paradigm shift, (pause) and I also think having a range of other disciplines in there, because everyone's interactions are so specific and individual, so we do all get different perspectives from different angles

Participants shared that they enjoyed this element of team formulation sessions, particularly because it often contrasts with a strong problem-saturated narrative on the wards. The inpatient mental health wards are characterised by constant crises, as they are, an A&E of sorts for mental health issues, so it is not surprising that focusing on negative behaviours of patients and families and risk is often prioritised. Having spaces where this narrative can be balanced is seen as useful.

DP9: I quite liked the bits at the start, where you do what works well, what's going well for the patient …Because it feels like it's starting on a more positive note, because it becomes very problem focused. It's quite nice to have that bit at the start where you kind of take stock of what her strengths are. DP8: It kind of stops that negative umm… and actually looks at the strengths first, and work on the strengths, a more positive approach I suppose.

DP9: yeah, you get more of a balance, don't you… DP8: …because you can get drawn into a lot of negativity and get focused on what's not going so well, when really we should be working on and looking at the positives first.

NP5: Thinking about strengths gets you in a good frame of mind, doesn't it, rather than just going in and it being a moan. NP4: laughs and nods. NP4: In an hour, you could easily sometimes, if it's a difficult patient, spend a long time talking about the negative stuff, so I think practically it makes sense to go with the more… the more difficult, but maybe the things you don't think about as much first. NP5: Yeah I agree with this particular person there are probably lots of dilemmas and challenges we talk about everyday but the positives don't come to light as much, so it's good to start with these

Participants shared that thinking about strengths also helped open up ideas about care planning for patients, which were less restrictive and medicalised, and considered family systems. Participants also mentioned how shifting to a strengths-based perspective encouraged relational reflexivity and more conscious care planning about how teams manage challenging behaviour on the wards.

DP9: …yeah, we were thinking should we move her to [the psychiatric intensive care ward] rather than [after thinking about strengths] let's think in a renewed way, maybe we can do something for her [patient] on this ward, so there was a bit more hope really by actually understanding what was going on, and actually coming up with strategies with what we could do with her [patient] and her family.

SP6: I think, one of them that stood out for me was when we started to discuss the behavioural plan that could be put in place with him. I've got a tiny bit of experience with PBS plans with learning disability settings, so it's not exactly the same, um, but I've been I suppose being part of the formulation and understanding that that is a process that's worked for him [patient], but also looking at that we're phrasing it in a positive way, because it is very true that we sometimes set goals that we potentially think are achievable in the way that we work that may not be so positive, and obviously that individual specially around such behaviours like public masturbation, targeting female members of staff, obviously our desired goal is for our [team] benefit as well. We don't want that to make us uncomfortable, but I suppose why are we actually putting that goal in place, what's the impact? That's a moment that stood out for me. It was nicely broken down to reflect both sides.

4.4.4. Attendance of senior team members is an issue

All of the participants expressed a concern with low numbers of 'key staff' attending team formulations. There appeared to be a sentiment of frustration that key staff who would most benefit from attending team formulation sessions did not want to or were not able to attend. These 'key team members' included senior nursing staff and senior medical staff, however, even when these staff were in attendance at team formulation sessions, there still seemed to be a sense from participants that some team members were missing, as indicated in NP4's quote below.

Low attendance could be due to the fluctuating shift patterns of team members and/or busier schedules of these team members, but the initial perception of participants was that team members from these staff groups were not prioritising team formulation

sessions, and/or perhaps didn't see the value of it yet. In my experience on the wards, team disagreements about patient care are often between staff sub-groups, such as between the medical team, nursing team, and therapy teams, so having them present at team formulation sessions is seen as crucial. Participants also reflected on the value of inviting staff from other supporting teams who were involved in patient care in the community, to add an even wider perspective to the team formulation.

DP9: it was interesting – where were the qualified staff, where was the key nurse? (questioning tone) DP8: yes, because everyone was invited… DP9: It's priorities isn't it. And where was the psychiatrists, which I always find interesting, is why did they not come?

NP4: I think, yeah, maybe linked with that is the fact that in terms of the actual ward staff, very few were there, and none of the key people were there, I don't think…um? NP3: We had… the ward manager there, and the consultant…

RP2: Um, it would be quite good to get more representation from the medical team I think, maybe two or three … I think they tend to have different knowledge and skills than I do, but the patients tend to tell the doctors a little bit more or less, so quite good for them to see … it's a true MDT approach. Nursing is always there, support workers are always there, therapy staff are always there, they tend to miss out a little bit. [In response to RP1 sharing that it would be helpful to invite staff from the community*] RP2: I've never thought of the CCO, that would be helpful as they tend to know a lot more than we do.*

There were suggestions made about how senior team members could be encouraged to attend, which involved a more relational approach to invitations, and strategic thinking about how changes in the system might help facilitate attendance. These recommendations will be explored further in the discussions chapter.

DP8: You could probably approach the key nurse and see what days they are available because obviously with shift patterns and timetabling that would be really useful. And the consultants were invited but… DP9: Try encourage them to recognise the value of it

DP9: Yeah, people don't always read the emails we send out inviting them. Identifying key people from the community too… that would be valuable, wouldn't it?
RP1: I was thinking as well, … because all staff can't attend these meetings, I don't know whether it may be worth having, I know we get the notes after, but having a structure where we can, you know where we discuss history and development, so staff can maybe actually have an example there and give their input on a sheet of paper beforehand, or having it in the staff room where they can write their understandings of beliefs and feelings, a space where people can contribute ways in which people who can't be there can give their input.

RP2: In terms of staff attendance, I'm not sure about the policies on the wards, but it would be good if we could swop staff with other wards so they can watch the ward for a bit while we do the team formulations, to allow all staff to attend. I don't really know the policies around moving staff, but it tends to be a bit of an issue.

Chapter 4.5 – Discussion

The most innovative finding in this research study was that the transformative power of systemic team formulation lies in it being an activity imbued with embodied emotion. The results revealed an emotive and embodied process where participants discussed the value of being able to voice negative feelings towards clients, and to be able identify, name and explore relational patterns through dialogue and sharing of multiple perspectives in the room.

Some of the key elements which participants found to be significant about systemic team formulation, were around aspects that made it specifically systemic i.e., Getting a wider understanding of systemic factors; reflecting on multiple perspectives in the team; thinking about issues of power and difference; developing circular and relational awareness and hypothesising about alternative interactional responses; and adopting a strengths-based perspective in a problem-focused context.

Participants in this study shared that team formulation sessions provided a useful and needed space to build their interactional confidence and provided them with a sense of epistemic validation. This highlights the importance of centring the team in this intervention. This may seem counterintuitive when, on the surface, team formulation is essentially a case discussion about a client system who should be at the centre of this intervention, but there are benefits in bringing teams together to engage in a structured and clinically purposeful intervention, as advocated by Johnstone (2018, 2013) too.

Hollingworth and Johnstone, (2014) noted the benefits of team formulation beyond the formulation itself, such as increased team contact, opportunities to consult with each other, and other team processes.

My central research question intended to explore what types of moments or factors in the process of team formulation team members found to be significant or transformative. It was interesting to note that in identifying significant moments of team formulation, participants alluded to the many challenges of working in an acute inpatient mental health setting, such as: lack of time to reflect on self and others; fragmented teamwork and communication; a work context that encourages emotional distance; and rigid discourses around hierarchy and professionalism. Participants' reflections on their experience of the team formulation process either contrasted or confirmed these challenges and frustrations. What they appeared to find transformative about systemic team formulation sessions was it that it provided a much-needed balancing, validating and protected space - to slow down, to think, to share, to understand, and to reflect.

There were however numerous concerns raised that the relational insights and systemic learning gained from team formulation sessions were short-lived, difficult to handover to colleagues who weren't present, too process-focused, and unsustainable in a context where time and staffing were often short, and outcomes were key. This is especially so when team formulation sessions are done on ad-hoc basis. Participants in my study echoed the findings of Kramarz et al study (2021) that follow-up team formulation discussions could be useful to emphasise the iterative nature of formulation, and to reinforce systemic and relational insights gained.

Each of the key themes from the findings (see table 4.1 on pg. 134) will be discussed in more detail below.

4.5.1. 'Permission to Think' – Widening Perspectives

It seems like a simple and unsurprising notion, that one of the key processes which staff working in overstretched and underfunded NHS acute inpatient wards find most significant about team formulation practice, is having some protected and allocated time to pause and think with others at work, about work. There have been numerous studies which reiterate that team formulation provides a dedicated time and 'space for teams to think' and reflect on their clinical work (Christofides, et al., 2011, p6; O'Connor et al., 2018; Bealey et al., 2021; Unadkat et al., 2015; Kellett et al., 2014). Much like the results in my study, participants in these research studies reflected that they often lacked the headspace to reflect on their practice and struggled to find isolated time to think about an individual client system, especially when other crises often took priority. In these studies, team formulation was seen as a unique space which specifically encouraged a deeper discussion of an individual client system (Bealey et al., 2021; Unadkat et al., 2015; Johnstone, 2013).

In the study on team formulation by Christofides et al (2011) staff reflected that chaotic work environments with limited resources and time, such as acute care wards, blocked the team's capacity for thinking about formulation. This happened particularly in forums such CPA (care programme approach) meetings where staff reflected that care planning outcomes, which should be collaboratively developed by services and client systems, were often predetermined. In relation to this, staff have also reflected that

there is a major challenge of protecting time for team formulation sessions too, often requiring difficult negotiations with the wider team to be available to attend (Wood, 2016; Johnstone, 2015). This has been my experience too, as I initially struggled to embed team formulation as a regular practice on the wards I worked on, due to constant staff shortages and reports from staff about lack of time to attend. In time however, and with consistent perseverance to offer regular and frequent team formulation sessions on the wards where I worked, ward staff and management started seeing (and feeling!) the benefits of attending these sessions, which then became more prioritised as essential ward practice. Some ward managers at times, put out shifts for extra staff members on team formulation days to cover staff shortages, which also helped attendance numbers. There is an acknowledgement in the literature of these challenges, and multiple recommendations that perseverance, tact, and persistence are integral in ensuring that team formulation becomes an embedded practice amongst the whole MDT (Johnstone, 2013; Dexter-Smith, 2015).

In the UK, there are ever-increasing numbers of NHS mental healthcare staff who leave the service every year due to high workloads, work-related stress, burnout, and poor work-life balance (Johnson et al., 2018; Dreison et al., 2018). Reasons cited for causes of stress and burnout include lack of support, poor leadership, and lack of opportunity for skills development (Johnson et al., 2018). In addition, NHS mental health care staff also carry the emotional load of caring for complex, mentally unwell patients, who may present with high levels of aggression and self-harm; and are often detained and treated against their will. All of this happens in the context of mental health services that are underfunded (Onyett, 2007; Johnson et al., 2018). There is often very little time for interactional and systemic thinking in a job that requires such

high levels of relational reflection. Burnout itself can be seen as a relational syndrome, as it is characterised by emotional exhaustion, depersonalisation, and a feeling that emotional capacity is depleted. Systematic reviews highlight that regular and consistent clinical supervision (including group supervision) is an important protective factor against burnout and depersonalisation (O'Connor et al., 2018). Supervision is a crucial, reflective meta-space where theory-practice links can be hypothesised, and self-reflection encouraged. This is highlighted in the next process which staff found transformative and significant in team formulation practice – having the space to make systemic and psychological theory-practice links with regards to themselves, client systems, and their clinical practice.

The DCP (2011, p29) guidelines on team formulation practice recognise that there is a dominant individualising narrative in medical and (some) psychological models, which locate mental health difficulties within the individual - formulation should thus, include a critical awareness of the wider societal and systemic contexts and influences on the client system, and within which the formulation takes place too. Studies on team formulation have shown how it can shift attributions about presenting problems (Ingham, 2011; Whitton et al., 2016), by encouraging team members to consider relationships, developmental history, attachment styles, and trauma, as well as allowing staff to reflect relationally on their own feelings and responses to client systems too (Kramarz et al. 2021. Johnstone and Dallos, 2014, Davenport, 2006).

As discussed in Chapter 2: Literature Review - a systemic team formulation model encourages deconstructing the presenting problem to consider and include a language of relationships in describing and understanding behaviour, beliefs and

feelings (Vetere and Dallos, 2019; Johnstone and Dallos, 2014). A systemic approach to team formulation acknowledges that it is a dialogical and co-constructional process between team members and facilitators, which includes widening perspectives by listening to multiple voices and opinions and adopting a curious position when hypothesising formulations (Dallos and Stedmon, in Johnstone and Dallos, 2014; Vetere and Dallos, 2019; Dallos and Draper, 2005). Reflecting on multiple perspectives was seen as a transformative and significant process of team formulation practice amongst participants in this study. Research has shown that team members benefit from multidisciplinary thinking and from considering multiple viewpoints (Unadkat et al., 2015; Bealey et al., 2021) and that team formulation can be the glue that holds an MDT biopsychosocial approach together (DCP, 2011).

It is worth noting though, that some research studies also highlighted the challenge that team members in this study noted as a significant limitation of team formulation practice too, in that formulations could be either too open-ended without any clear outcomes and could be seen as making excuses for patients' challenging behaviour, or that formulations could be taken as statements of facts rather than speculations (Summers, 2006).

Johnstone (2003) cautions that there is no guarantee that team formulation will not fall into the same traps as diagnosis, by being reductive, pathologizing, and ignore social contexts and/or impose a view which the client system disagrees with. To address these challenges, the process of team formulation should strive to be collaborative, respectful of client systems views, culturally sensitive, and a reflective and curious

stance should be encouraged, to reduce the risk of using formulation in a reductive, insensitive or

4.5.2. Flicking the Switch – Relational Reflexivity

One of the key and distinguishing factors of systemic team formulation, (and systemic thinking, in general) is that it includes and encourages teams towards taking a second-order cybernetic position with regards to the staff system and client systems. A second-order cybernetic perspective acknowledges the position of the observer as part of the system. This implies that an observer cannot be objective in their attempt to understand a phenomenon, and that reality is seen as being self-referential (Becvar and Becvar, 2017). In its approach and application, systemic team formulation seeks to encourage team members (individually and collectively) to acknowledge that everything they are observing, reflecting about, and acting upon is filtered through their personal frame of reference, and that their very presence influences the context they are observing too.

From a second-order cybernetic perspective, behaviour is not discovered, it is relationally created (Becvar and Becvar, 2017). As such, relational reflexivity in systemic team formulation is fundamental to the process and was recognised as a particularly transformative and significant process by team members in this study too. Team members spoke about experiencing a 'lightbulb moment' when circular awareness occurred, almost like 'flicking a relational switch' when they realised that their own feelings, thoughts, and actions had an impact on how client systems responded. Multiple studies (DCP, 2011; Sweeney et al. 2018; Bloomfield et al., 2020;

Wampole and Bressi, 2019; Hollingworth and Johnstone, 2014; Cole et al., 2015) have advocated the importance of using a relational, trauma-informed approach in team formulation, more especially to recognise the possible role services and staff can play in perpetuating and exacerbating trauma responses and difficulties, through coercive and disempowering practices. This notion assumes that staff teams are part of the system, and can indeed, prolong and aggravate presenting problems within the client system, and vice versa.

A study which explored staff views of CAT-based (cognitive analytic therapy) team formulation sessions (Russell et al., 2022), similarly showed that a relational reformulation helped teams view challenging behaviour differently, by providing staff a space to reflect on their own feelings, to be able to relate more compassionately with themselves and with others. This resulted in relational interventions aimed at understanding and changing behaviour on an interactional level rather than addressing challenging behaviour punitively (or pharmacologically!) to reduce it. Understanding behaviour and building relationships enables dialogue and compassion. CAT formulation studies (Priddy et al., 2021) recognise that creating a safe space to share information, uncertainty, and curiosity is helpful, and revising relational patterns of client systems with staff members is helpful too.

Teams that are relationally reflexive are more able to reflect on the impact of their interactions with client systems and build their *interactional confidence* in intervening as their perceptions of client systems shift. Interactional confidence refers to confidence in one's capability to act on or influence another. Based on the findings from this study, the key process which facilitates and encourages team members to

reflect relationally and build interactional confidence is being able to learn from each other through dialogue. In my practice on the acute mental health wards, I have experienced and witnessed the frustration of useful relational and contextual information about client systems often getting lost in the haystack of digital notes on the patient record system, which staff members often do not have the time to read thoroughly.

Team formulation sessions thus provide an important opportunity for teams to engage with, and learn from, each other dialogically, which can create helpful shifts in staff perceptions of service users (Hollingworth and Johnstone, 2014; Berry et al., 2011; Priebe & McCabe, 2008) and can be useful in team building. Across psychological treatment modalities, the primary mechanisms of change suggest that increased levels of self-awareness and a greater ability to consider alternative perspectives are associated with favourable therapeutic outcomes (Gibbons et al., 2009). Similarly in team formulation, the principal mechanism of change is related to a shift in understanding the client system (and the self!), as well as exploring alternative perspectives on behaviours and needs, which is key (Ingham et al., 2011; Turner et al., 2018).

Studies show that the efficacy of therapeutic mechanisms of change, rely heavily on the therapeutic alliances between staff and client systems, and that team formulation creates an integral supervision space for teams to consider their relationships with client systems and with each other (Berry et al., 2011; Priebe and McCabe, 2008; Hollingworth and Johnstone, 2014; Vetere and Dallos, 2019; Hartley et al., 2020). This is particularly important when working with client systems with complex mental health

needs, as therapeutic alliance is a key predictor of relapse and recovery (Hartley et al., 2020). In team formulation sessions, the team are in effect the client system too, thus therapeutic alliance between facilitators and the team is also key. High levels of relational reflexivity could also contribute to more cohesive and compassionate interactions and communication between team members too, which is integral in challenging the strong notion of hierarchical professionalism, which will be discussed in the last superordinate theme.

Wider contextual, social, and relational factors, such as transference and countertransference, ethnic and cultural factors, and social factors such as class, privilege, power relations, are sometimes neglected or downplayed in mainstream psychological formulations (Hollingworth and Johnstone, 2014), and are often not even considered in psychiatric formulations. Systemic team formulation may provide an opportunity for teams to think about and engage with client systems (and each other!) in a more inclusive and culturally sensitive way. Studies are advocating for formulation models to prioritise considering issues of power and difference (McCelland, in Johnstone and Dallos, 2014; Fernando, 2010; ACP-UK, 2022).

It is crucial that team formulations acknowledge the presence of dominant ideologies and discourses, which may according to McCelland (in Johnstone and Dallos, 2014) serve to reinforce established power balances by masking and minimising inequalities. This is especially important in the inpatient psychiatric setting where I conducted my research, where the dominant discourses of diagnosis and pathology hold a lot of power with regards to patient care. Team formulation sessions could be used as a platform for social justice, where sense-making about a client system's problems

expands further, in attempting to understand the role of local inter-personal and cultural contexts on the 'diagnosis' being considered. Reflexivity can only truly happen using a social inequalities approach (McCelland, in Johnstone and Dallos, 2014; DCP 2011), which encourages personal and collective reflection on power, privilege, wider systems, contexts, and processes. Taking on a critical position and creating a discursive team formulation space that is inevitably, counter-cultural, can however be difficult to create, maintain, and sustain, as it often contrasts starkly to the dominant, linear discourses within a medical system.

Similarly, participants in this study and others (Johnstone and Dallos, 2014; Wainwright and Bergin, 2010) reflected on the difficulty of maintaining new interaction patterns and disseminating useful information from team formulation sessions with the rest of the team who do not, and are not able, to attend the sessions. As systemic team formulation sessions are transformative and dialogical interventions, there is also a big challenge in sharing and sustaining relational insights and interventions from these sessions with the rest of the team, particularly in acute inpatient wards which is a permeable work context of ever-changing teams of permanent, shift, and agency workers.

4.5.3. Humanising the case – the patient as a person and the professional as a person

One of the most surprising and revelatory findings for me in this study, was how almost all of the participants spoke about the significance (and novelty) of being able to talk about their own challenging feelings of client systems and their work, with their peers

in team formulation sessions, and for those feelings to be heard, validated, and normalised. Participants were particularly surprised when senior members of the team, particularly medical team members, were open and honest about their work-related feelings. Studies (Johnson et al., 2018; Dreison et al., 2018) have shown that mental healthcare staff have a strong perceived stigma of admitting poor mental health and may feel they cannot share negative work-related feelings with their peers. Alongside fears of jeopardising their careers or professional registrations, staff may also worry about being referred into a service which employs them and having to receive treatment from colleagues.

The request for team formulation is often prompted by strong feelings team members have in relation to caring for a specific client system. Teams often express feeling stuck or unsure how to make progress with these clients. Negative feelings about client systems and work-related distress have been shown to decrease perspective-taking and inhibit learning, which may result in impulsive decision making based on these immediate emotional states (Geach et al., 2019; Kahneman, 2003)

In some studies participants used psychodynamic views to make sense of their own transference and countertransference work-related feelings, which resulted in positive relational changes between staff and client systems (Christofides et al., 2011). Thinking more psychologically and reflexively about the causes of a client's distress was also recognized as emotionally challenging but beneficial amongst staff teams (Christofides, et al., 2011). As discussed in the findings, teams who can express work-related and personal vulnerability and share emotional experiences and personal

resonance with each other, feel more cohesive, supportive and empathic towards each other, and express increased levels of interactional confidence.

Some studies have shown that clinical supervision for mental health nurses and support workers is often non-existent or implemented on an ad-hoc basis, and often done inadequately (Clearly et al., 2009; Clearly et al., 2010; Pack, 2014; Kavanagh, 2003). In my own practice, I have observed a glaring gap in adequate clinical supervision being provided to mental healthcare team members. When team formulation sessions are facilitated as an additional form of peer supervision, which is the approach I take in my team formulation practice, an exploration of self-beliefs, thoughts and feelings is encouraged. A study conducted by Hewitt (2008) into team formulation for staff within a psychiatric rehabilitation unit found that staff discovered how their own concerns and anxieties surrounding the patient had formed, alluding to the need for more reflexive clinical supervision in these settings. This will be discussed further in the recommendations.

The systemic team formulation model I use is based on the model of team formulation and providing psychological consultation to staff proposed by Lake (2008), a psychologist who proposed facilitating staff groups by working together with teams to create a formulation for a client system, drawing on attachment and cognitive models. I use this model as a tool from a predominantly systemic approach, to provide the team with a common language and structure from which to develop a shared, relational understanding of clients' strengths and difficulties, placing value on the varied perspectives of team members and encouraging reflective practice and awareness of

relational issues. A study by Whitton et al (2016) has advocated for these elements to be included in team formulation sessions.

Increased levels of self-awareness and having a more systemic understanding of client systems helps to increase empathy towards client systems and towards other team members, as well as increasing consistency in team views and team confidence. Teams who feel more positive towards client systems also show increased levels of optimism about recovery and treatment (Whitton et al., 2016; Berry at al., 2015). When team members feel heard and validated, they are more likely to hear and validate others.

4.5.4. Effective informal approach: challenging the notion of hierarchical professionalism

It can be argued that there is an embedded system of hierarchy in the NHS which involves use of the Agenda for Change pay banding system as a means of identifying professional accountability. When the banding system is used to define a team member's identity (i.e., 'they are a band 5'), it can also create an unhelpful formality between team members and a narrative that the value, usefulness, power, and influence of a team member's views depends on their ranking in the banding system (Coomber, 2020).

One of the final findings in this study highlighted that participants feel that a significant aspect of the process of systemic team formulation is that it provides a much-needed informal, and strengths-focused space where the voices of *all* team members are seen

as valid and useful, regardless of professional position. Participants did however reflect that attendance of a range of multidisciplinary team members is crucial.

In my practice, support workers, who often hold the least amount of influential power in the hospital system, often have the most valuable relational information to offer, as they often spend the most time 'on the ground' in interaction with client systems. Their views and perspectives, however, are often lost or unheard, as they often are not included in care planning and MDT meetings. Similarly, some team members who do attend these meetings but are of a profession that isn't biomedically informed (such as occupational therapists and psychotherapists) may also find that their perspectives on client systems are not taken seriously, as the dominant discourse in acute mental health settings is still strongly medicalised. This possibly indicates a case of epistemic injustice and power asymmetries between team members, based on hierarchical attitudes and dominant discourses. Some perspectives, particularly of those of senior medical (and higher banding) team members may be more powerful and influential with regards to patient care and organisational issues.

Epistemic injustice is a concept which relates to the link between social power and social experiences. It occurs when an individual is 'wronged specifically in their capacity as a knower' (Fricker, 2007: 18). In these cases, the voice of an individual is afforded less credibility and their perspectives are invalidated or diminished due to their particular social identity and/or being in a position identified as having less power. Epistemic injustice can also occur when experiences of others are not understood because they are influenced by dominant social norms which privilege particular types of knowledge over others (Fricker, 2007).

In contrast to epistemic injustice. epistemic validation refers to validating the views, perspectives, knowledge, and experiences of individuals who are ordinarily invalidated in their capacity as a knower, due to their social position of less power or privilege.

Other studies on team formulation sessions show that they offer an opportunity to bring a multidisciplinary group of professionals and healthcare workers together, to informally (and perhaps more safely) share information and perspectives, to brainstorm ideas about care planning, to hear from others and feel heard and validated, and to bond with the team (Summers, 2006; Wainwright, 2010). Some studies (Christofides et al., 2011) have also illustrated how discussing a client system's formulation facilitated a more cohesive team approach and practice. Team cohesion is particularly crucial in acute inpatient settings, as consistency has been shown to reduce team splitting that can sometimes occur with staff/patient dynamics (Trenworth, 2003). Team formulation can thus provide a space for epistemic validation, as well as compassionate and collaborative care (ACP-UK, 2022).

Given the strongly hierarchical nature of the NHS service and the diverse nature of team dynamics, as well as issues of power and difference with regards to inclusivity, there is however, an ever-present risk that some team members may sometimes feel unheard in team formulation sessions too. In the study by Summers, 2006) a small proportion of team members shared that contributions in team formulation sessions were still mostly from team members who felt confident and comfortable to contribute. This highlights the importance of warming the room (Burnham, 2018), encouraging multiple voices, and creating a safe space for team members to share.

Other factors that were seen as important in facilitating a safe, transformative space in team formulation sessions included: ensuring the sessions were collaborative and reflective, facilitating open dialogue, and ensuring good attendance of a range of multidisciplinary team members (Kelly and Wilkes, 2021). Similar to the findings in my study, poor attendance (particularly poor attendance of medical staff) has been seen as a key hindrance and challenge to successful team formulation sessions. Poor communication and interaction between team members as well as team dynamics and staff confidence are also factors that need to be considered when facilitating team formulation sessions (Hymers et al., 2021). In my practice, I have noted that it is crucial that team members have multiple spaces for staff support available, as negative staff dynamics can often spill over into team formulation sessions.

Another key factor of the process of systemic team formulation identified by participants, was that it provided a more balanced, strengths-focused narrative with regards to client systems, in a context where risk-based formulations and interventions are the dominant framework. As acute inpatient mental health units are often characterised by a milieu of acutely unwell patients and unpredictable behaviour and interactions, it is not surprising that accountability for patient care is often focused on an organisational need to manage risks, than on building therapeutic engagement (Rio et al., 2020). Systemic family therapy approaches, such as solution-focused and narrative therapies, as well as other postmodern and post-structural therapy approaches have advocated a strengths orientation in formulation and intervention (Allison et al., 2003; Dallos and Draper, 2015) This is particularly important in mental health care settings where pathology-based approaches are still dominant.

Interestingly, a risk-based perspective was seen by participants as being the formal approach to take in clinical practice, whereas a more relational and humanised approach was seen as being 'informal'. Further studies on this finding would be useful to determine the discourses of 'professionalism' in acute mental health settings which may facilitate or hinder good patient care.

Chapter 5 - Conclusion

"We could name each mote of snow and mourn its loss when it reaches the sea, but we understand that the water was neither lost nor diminished by the journey."

Jarod K. Anderson (2022, p.63)

In this final section, I explore some limitations of the study and what I could have done differently. I also summarise the findings of the analysis in relation to the research questions, by reflecting on some implications and recommendations for practice.

5.1. Limitations and what could I have done differently?

The following points indicate not only some of the limitations of the study, but also what I could have done differently, and as such are important insights and learnings about this study as well as my research practice. Please note that many limitations and critical reflections of the research methodology, data collection and analysis methods, as well as the study design have already been explored in some depth in Chapter 3, so please refer to that section for a detailed review of limitations with

regards to those aspects. These points below are additional musings that have not yet been discussed, and on the research study as a whole.

5.1.1. Participants - The team is greater than the sum of its parts?

One of the main aims of the research was to describe and explore significant and transformative moments of systemic team formulation sessions facilitated by me on the acute adult inpatient mental health wards where I work, by exploring team-identified experiences of the process. As such, I was keen to interview a broad and diverse range of multidisciplinary staff and was hoping for focus groups of around 5-6 team members. In reality, possibly due to participants being self-selected, I was only able to recruit around 2-4 team members in each of the five focus group interviews I did. The lower number of research participants could also have been linked to the difficulties team members often have in allocating time for tasks which are outside of their essential tasks, which is a theme discussed in the findings too.While I did manage to get a range of professions in the focus groups, with higher ratios of support staff, a large proportion of the group were in the younger age ranges and were white British (see demographics table 2 on pg. 76) As a result, the sample group may not have been diversely representative of the population group being studied, despite the homogeneity of it being mental health care professionals being recruited, and the findings may not have the richness had a variety of MDT staff been present. I could have perhaps, conducted individual interviews and/or more focus groups, to try get additional MDT perspectives, but as I analysed my data using an IPA approach, that would have needed more research time as it would have been a bigger study.

There were, however, some benefits of having smaller focus groups, as it is the quality rather than the quantity of data that allows for insightful IPA analyses to be developed (Larkin and Thompson, 2012). Smaller focus groups also allowed me to analyse the research transcripts in much more systemic depth, using the Interpretive Systemic Phenomenological Analysis (IsPA) protocol I adapted from existing IPA for focus group research protocols (Palmer et al., 2010; Tomkins and Eatough, 2010; Githaiga, 2016; Makin, 2012; Phillips et al., 2016).

Another significant gap in the research analysis and findings was that demographic information of the participants was not included in this write-up, to protect the anonymity of participants and team member colleagues they may have mentioned in the focus groups. Given the small size of the hospital staff group population and very limited numbers of certain professions, such as psychiatrists and occupational therapists, it would have been difficult to anonymise identifiable characteristics.

I was also mindful that audiences from inside the study may have been likely to recognise other participants by their professions or roles within the quotes shared in the discussion chapter. This is a common issue in multi-perspectival IPA group studies (Larkin, 2014; Ummel and Achille, 2016). As such, I was careful about anonymising any sensitive information which I presented, without revealing identifiable characteristics. I also ensured participants were fully briefed and made aware of this risk when discussing informed consent at the start of the data collection process. I acknowledge that some important contextual information may have been lost in the analysis because of this. I did however try including in the write-up as much

unidentifiable information as I could about staff roles, positioning, and power which team members discussed and explored in the focus groups.

5.1.2. Wider considerations

As with any study, there are limitations in the data that one focuses on. In my practice, there are many other elements surrounding team formulation sessions that were not included as research data in this study. There are weekly reflective practice groups where team members often discuss and decide which client system they want to put forward for a team formulation session. There are daily handover meetings and MDT meetings where plans and information from team formulation sessions are sometimes discussed. Then there are the actual team formulation sessions themselves, and written reports thereof. All of these other meetings and discussions provide important background and context around the process of team formulation, but none of these elements were directly used as points of data in this research, as the study was focused particularly on understanding team member's views of significant moments of team formulation sessions after they had taken place. Future research studies on systemic team formulation could perhaps shed light on and include these other important adjunct moments where team members come together to dialogue and discuss client systems. The study by Christofides et al (2012) has provided some initial insight on the role and value of these 'chipping in' formulation moments.

With regards to my chosen data collection method of audio recordings, I did consider whether I could do video recordings of the focus group meetings, so I could incorporate multimodal and non-verbal observations and interactions in my data analysis. This

would have given me much richer and multidimensional data to analyse. I was, however, cautious about the utility, ethical considerations, and constraints of using video recording as a data collection tool with fellow members of staff, and the added complexity that would be involved in doing an IPA analysis of video-recorded focus group data. Some research studies have noted that healthcare professionals are particularly wary of being video-recorded due to worries around confidentiality and liability (Asan and Montague, 2014). Video recordings are however a valuable method of data collection, and there are ethical reassurances and guidelines that can be put in place to reassure participants, so it is a possible avenue for further team formulation research in future.

While some team members helped me to pilot the semi-structured interview questions, and a psychology colleague interviewed me after the research process, there was limited input from multidisciplinary staff or client-systems in the rest of the research design or analysis. I could have used an action research framework for this study and did consider it, as it is a useful and collaborative research strategy to use in settings where the 'demarcation between examiner and examined are less clear than in other studies' (Stensland, 2003, p21). As discussed in the limitations of team formulation section in chapter 2, client systems were also not directly consulted in this research study, given that my research questions were focused on staff team members' perspectives of the process of team formulation. Co-developed and co-produced research with client systems is however, being seen as important in building an understanding of the impact of team formulation sessions on care and outcomes, so this is an important point to consider in future research (ACP-UK, 2022).

5.1.3. Insider research, and quality

Shotter (2004, p221) distinguished between actionable research knowledge that attempts to capture experiences as an objective observer, *"in another world independent of us",* in contrast to research that enables us to *"enter into another world, not independent of us, but in relation to us*." This means that I believe that my research inquiry was both impacted by me and impacted me. Pistrang and Baker (2010) advocated that insider practice-based research provides a useful bridge between what practitioners do, and what researchers do. Some of the main pitfalls, however, are not being aware of possible preconceptions and underestimating conflicting researcher-participant dynamics and roles (Stensland, 2003). A possible limitation of me being a team-member researcher could be that participants may not have felt comfortable sharing all their experiences with me, as a fellow team member and facilitator of the sessions. I endeavoured to adopt a both/and position in navigating the complexities of my dual clinician-insider/ practitioner-research role with participants / team members, as discussed in more depth in Chapter 1. I did this by using my skills as a therapy clinician (Helps, 2017), my alliance with participants as a team member, as well as using the containing ethical tools of research, such informed consent forms and research ethics, to create a safe space for team members to share their perspectives and experiences. This ethical process is seen as being a dynamic and evolving process and required me to adopt a dynamic relational and reflexive ethics of care throughout the whole research process (Helps, 2017). This position was also one of the main reasons I explicitly incorporated the use of self in my data analysis process too.

Conducting team formulation sessions and focus groups on a range of wards (some where I knew and worked with the staff, and others where I did not) also allowed for me to experience different positions as a researcher and allowed for a varied and richer set of data to be collected. I was aware of the sometimes-tentative tone of the participants giving me feedback in a cautious and apologetic manner, which could have been related to my position as a practitioner-research, and possible discomfort in them giving me constructive feedback about my practice. This is a limitation in the study.

Another limitation of focus groups is that participants may have felt hesitant to honestly express their views and experiences in a group with fellow team members, particularly if they opposed another member's views in the group. Convening the focus groups with existing team members (and being a team member myself) might have helped facilitate dialogue due to team rapport, but team dynamics can differ, so this may have been a limitation too. I considered relational dynamics in my data analysis, but I could have perhaps paid closer attention to ward team dynamics in the data analysis too.

With regards to issues of reliability and validity of my data analysis and findings, the relevant *reality*, as far as human experience is concerned in this study is that it is socially constructed and created relationally, and also in each individual's subjective experience (including my own experience as a team-member, clinician, and researcher), as well as the team members' subjective experiences of the processes in systemic team formulation.

My epistemology around the ‘validity’ of my data analysis and results is based on the phenomenological approach, which recognizes that `If the essential description truly captures the intuited essence, one has validity in a phenomenological sense' (Giorgi 1988, p. 173). As such, the findings of my analysis are subjective to *my* knowledge, practice, and context. I believe that my descriptions of the research findings are, however, plausible. I aimed to explain my data analysis approach transparently and systematically, including accounting for the steps of the analysis process (Webb and Kevern, 2001). I also tried to present my findings as reflexively, relationally, and authentically as possible (Simon, 2018). I also extended the concept of reflexivity by also including it as a key element of the interpretive systemic phenomenological analysis process I followed in analysing my data.

5.2. Concluding remarks and Implications for practice, training and research

In this concluding section, I attempt to weave the findings of this study in relation to the research questions, and explore implications for practice, training, and research. In line with my epistemological framework, I do not intend to explain what the findings mean, but rather what they mean to my contextual practice and suggest possible broader recommendations for future practice based on these findings.

5.2.1. Taking a step back from quick fixes - Embedding team formulation as an essential practice in its own right

Participants reflected that it would be beneficial if these significant and embodied aspects of the team formulation process were somehow embedded in regular and essential ward practices, such as handover meetings, care plan approach meetings, risk assessments, and MDT meetings. Participants felt that sharing information from the team formulation sessions via notes would not be as effective as sharing them in person and in dialogue with others, given the relational nature of the information. Other studies on team formulation have echoed this need, highlighting that good continuity of care involves ensuring that care plan strategies discussed in team formulation sessions are implemented consistently by staff teams (Kramarz et al., 2021; Whomsley, 2010; Ingham, 2015, Wood, 2016)

It has been suggested that templates and forms on digital patient record systems could perhaps be used strategically to incorporate formulation-based care plan checklists as routine patient care (DCP, 2011; Kramarz et al., 2021). This could perhaps then inform teams which strategies have been implemented and provide efficacy data (Foley and Woollard, 2019). Risk assessments could be conducted with aspects of team formulation in mind (Kramarz et al., 2021). Team formulation ideas could be used in supervision and mentoring sessions too (Ingham, 2015). In health settings where time is limited and staff shortages are ever increasing, there is a risk that team formulation sessions are seen as a substitute for clinical supervision, but this should be advocated against. Team formulation sessions can indeed provide an additional and useful peer learning and peer supervision space, but good quality individual clinical supervision should still be a high priority for services to pursue.

While all of these ‘embedding and time-saving’ suggestions in my study’s findings and others appear useful, they also point to a worrying systemic issue of services and teams constantly looking for a ‘team formulation quick fix’ for the ‘quick fixes dilemma’ they find themselves in. Team formulation, in and of itself, is a valuable (and beneficial) systemic intervention which counters the dominant discourses of linear and outcome-focused thinking and provides team members with a crucial space to connect and reflect in the pursuit of good practice, and as such, should be promoted as an essential ward practice, *in its own right*.

Christofides et al., (2012) and Whomsley (2010) agree that team formulation is most effectively done separately from existing meetings, at an allocated time. Like Summers (2006) however, I have found that team formulation works well when it is robustly linked to care planning, which is an embedded ward practice. This could perhaps be a future avenue for research to consider.

Johnstone (2018), Unadkat et al., (2015) and Dexter-Smith (2015) have noted that major systemic changes are needed if formulation is to be integrated into all levels of services. It is crucial that psychological practitioners advocate for and align with senior leadership teams on the importance of team formulation as an essential practice. Management should ensure time to attend team formulation sessions is protected and scheduled on rotas (Kelly and Wilkes, 2021). In some inpatient services, team formulation is prioritised as a “cornerstone of the workforce strategy”, whereby staff are trained in team formulation and are using it to strengthen MDT work (Roycroft et al., 2015). On the wards where I work, team formulation started as an ad-hoc meeting provided sporadically to some ward teams, and over the 9 years I have worked on the

wards and advocated for it with the help of my supervisor, management, and colleagues, it has started embedding itself as an essential, standalone routine psychology practice on all the wards. Attendance can, however, still be an issue, and improves when management organise stand-in and/or supernumerary staff to cover shifts on team formulation days.

Given that concrete, evidence-based research, focused on economical outcomes (such as reduced bed stays, reduced use of medication, better recovery rates, and fewer admissions) still holds a lot of power amongst commissioners and service leads (Cole et al., 2015), future research on team formulation could perhaps focus on these elements.

5.2.2. Systemically informed team formulation facilitators, training and practice

Some of the key elements which participants found to be significant about systemic team formulation, were around aspects that made it specifically systemic. Systemically informed and psychologically minded facilitators are thus key in encouraging that this approach, and these methods and techniques are used. Further training and research on a team formulation approach, which is relationally reflexive and culturally informed, would be beneficial too. Other studies have highlighted the underdeveloped area of culturally sensitive formulation, and have also advocated that culturally informed advocacy and support is available to client systems too (DCP, 2011; ACP-UK, 2022)

It has been advocated that facilitation of team formulation meetings could perhaps be shared amongst team members (Hewitt, 2008; Johnstone, 2014; Kennedy, 2008;

Whomsley, 2010) and that staff could perhaps be trained (Davenport, 2002) and supervised (Summers, 2006) to facilitate them. While this is a possibility it might be challenging to do, as it seems like a significant process of team formulation are the skills of the therapist/facilitator in holding the space, encouraging psychological theory-practice links, and managing group dynamics. The latter is particularly important in acute inpatient mental health wards, where psychological practitioners can have a positive impact on therapeutic culture and clinical outcomes, and can reduce adverse events and improve staff-patient dynamics (Man et al, 2022).

Contemporary systemic therapists acknowledge that the expertise of a therapist's abilities is key to the therapeutic process. Skills such as active listening, building a therapeutic alliance, encouraging multiple perspectives and shared understandings, as well as remaining flexible and open to feedback are crucial (Stedmon and Dallos, 2009; Hartley et al., 2020). There was an acknowledgement by participants in my study about the important role of the facilitators in warming the room, and creating a safe, impartial space for honest discussion, where all voices are valued and heard in team formulation sessions. It is also important for facilitators of team formulation to adopt a curious and second-order perspective, by acknowledging that they are part of the system under observation, and as such are also influenced by the discussions held in the room, and by cultural norms, stereotypes, and biases (Vetere and Dallos. 2019). Best practice guidelines (DCP, 2011) for team formulations recommend many of these systemic elements discussed above. The guidelines suggest that team formulations: are compiled from information which is gained from comprehensive assessment; are culturally sensitive; shared in language that is accessible to all team members; are trauma informed; considers the personal impact and meaning of medical diagnoses

and interventions; reflects on the possible role of services in perpetuating problems; and considers wider contexts, such as organisational and societal factors. Bealey et al., (2021) also advocated that future team formulation research should consider the researcher's impact on the data collection and engagement with participants, as studies showed that a safe working alliance between the facilitator and team members is key to open and honest discussions in the sessions.

The therapeutic processes in most models of team formulation have been identified as similar to processes in individual therapies (Dexter-Smith, 2015) and the process of team formulation, at times, involves psychological therapy techniques such as Socratic questioning and meaning making (Ingham, 2011). Psychological formulation is viewed as a skilled process that merges scientific principles with reflexivity (DCP, 2011). It has many purposes in psychological work with individuals, families, teams, and organisations, and can potentially develop and enhance the core aspects of clinical work across various roles and positions too. It is also useful in linking theory with practice and ensuring interventions are evidence-based. As such, psychological practitioners are well-placed to promote its use through practice, teaching, supervision, consulting, and research (DCP, 2011)

Based on the findings in this study and in relation to wider literature on team formulation, the following therapeutic skills and qualities are thus important to consider in systemic team formulation:

- Role modelling openness and curiosity – a team formulation facilitator that can role model reflection-in action can be helpful in encouraging team members to

do the same. Reflection in action includes being attuned to our own feelings and thoughts and to the microlevel aspects of verbal and non-verbal communication in others (Stedmon and Dallos, 2009).

- Balance between prepared and shared discussion points – Reflection on action is a more considered form of reflection that attempts to make sense of behaviour and communication at a macro level (Stedmon and Dallos, 2009). In a team formulation session, it can often include the pre-formulation hypotheses and psychological formulations that a facilitator brings to the session to discuss and explore with team members. Team members bring their own hypotheses and reflection to reflect on too – these shared accounts of meaning can be viewed as a 'sea of stories' (Rushdie 1990 in Stedmon and Dallos, 2009) which draw on cultural templates, beliefs, and language. Aiming for a balance between prepared and shared discussion points is key in maintaining a collaborative discussion and sharing psychological insights and hypotheses.
- Building and sustaining multiple alliances with the team – conditions for team formulation can be optimised by building positive relationships with a range of team members, and drawing on the collective knowledge of team members by inviting multiple multidisciplinary perspectives (Geach et al., 2019)
- Focusing on the team's feelings and emotional responses as a priority, to create a safe and open thinking space for relational reflexivity and widening perspectives.
- Widening perspectives on 'presenting problems' by considering organisational constraints too.

5.2.3. The team as a client system - Centring team members

Participants in this study shared that team formulation sessions provided a useful and needed space to build their interactional confidence and provided them with a sense of epistemic validation. The latter is often missing in overstretched services (Onyett, 2007) and as indicated by participants in my study. Future research using validated measures of staff wellbeing, teamwork and therapeutic relationships before and after participating in case formulation could allow for a more systematic investigation of the impact of team formulation on staff wellbeing, which is a recommendation echoed by Kramarz et al. (2021).

Viewing the team as a client system also fits with a systemic perspective of working therapeutically with wider systems, which then ripples down to better client care. The study by Geach et al., 2018 highlighted the role of team formulation as a brief intervention for staff development and support, which had positive implications for good practice, such as reducing restrictive practices. Team formulation as a collaborative, nonjudgement, reflexive, and discursive space can facilitate the latter. Good attendance of varied and key staff is thus crucial. Ways of improving staff attendance and improving team interactions should also be considered as part of the future development of team formulation meetings and could perhaps be an interesting avenue for future research too.

5.2.4. Including service users in the team

A constant tension in team formulation research and practice revolves around the direct inclusion of service users being discussed in the session (Cole et al., 2015; Bealey et al., 2021). As a systemic therapist and client-centred practitioner, I am mindful of the importance of *doing with*, and *not doing to* in my practice, particularly in an acute inpatient setting where patients may often feel they lose their sense of autonomy. Johnstone (2018) argues that team formulation should be seen as a hypothetical and speculative exercise when there is not direct service user involvement and advocates that future research and practice should involve experts by experience to develop a more collaborative way of directly incorporating team formulation in client care. Ideally, working collaboratively and openly with service users and their families to gain a shared understanding of issues and relationships is good practice, but can be very challenging on acute ward settings where patients are often in times of crisis and may not be willing to engage.

In my practice, teams have found some ways of including service users in the team formulation process by ensuring (when possible) that care plans and documentation are co-produced. Team formulation notes which are shared amongst the team are also always highlighted as being *tentative* and provisional consultation or supervision notes from team discussions, in line with the guidelines suggested by ACP-UK (2022). The ACP-UK also recommend that families, carers, and other services involved in care are consulted for their views on care plans, whenever possible. Indeed, participants in my study reflected on the benefits of including families and carers in formulations and care planning. There is perhaps an opportunity to consider an open dialogue approach in team formulations (Seikkula and Arnkil, 2013), which could perhaps be investigated in future research and practice.

“Language is amazing,

But it compresses huge, messy concepts

Into tidy signifiers like overstuffed pockets.

Unpack the common words.

See what’s hiding inside. -Anderson, 2022, p40

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Appendices - Appendix A – Example of team formulation template

Kustner, C (2018). Relational Team Formulation. Adapted from Lake, N. (2008) BPS Clinical Forum186

PRIVATE AND CONFIDENTIAL

The following information is NOT to be shared with the service user without permission of the author of this report.

The following information is a record of a team discussion which took place on _____on _____.The purpose of the discussion was to gather together information about _____ so as to have a shared understanding of them. The discussion is an opportunity to explore different perceptions and understandings of the service user and of staff's experiences of working with them. The two sections "Questions/Dilemmas" and "Reflections" are a record of staff's thoughts and perceptions and therefore may not be shared by all staff working with the service user. This also means that some of the information are hypotheses and not factual. Where the information is a hypothesis this will be indicated by being written in *italics* and enclosed within brackets, e.g. *(…)*.

Report written by:

Things that are going well

Challenges / Dilemmas

Kustner, C (2018). Relational Team Formulation. Adapted from Lake, N. (2008) BPS Clinical Forum186

HISTORY

Genogram & relationships / Ecomap

Developmental/school/employment history

Trauma

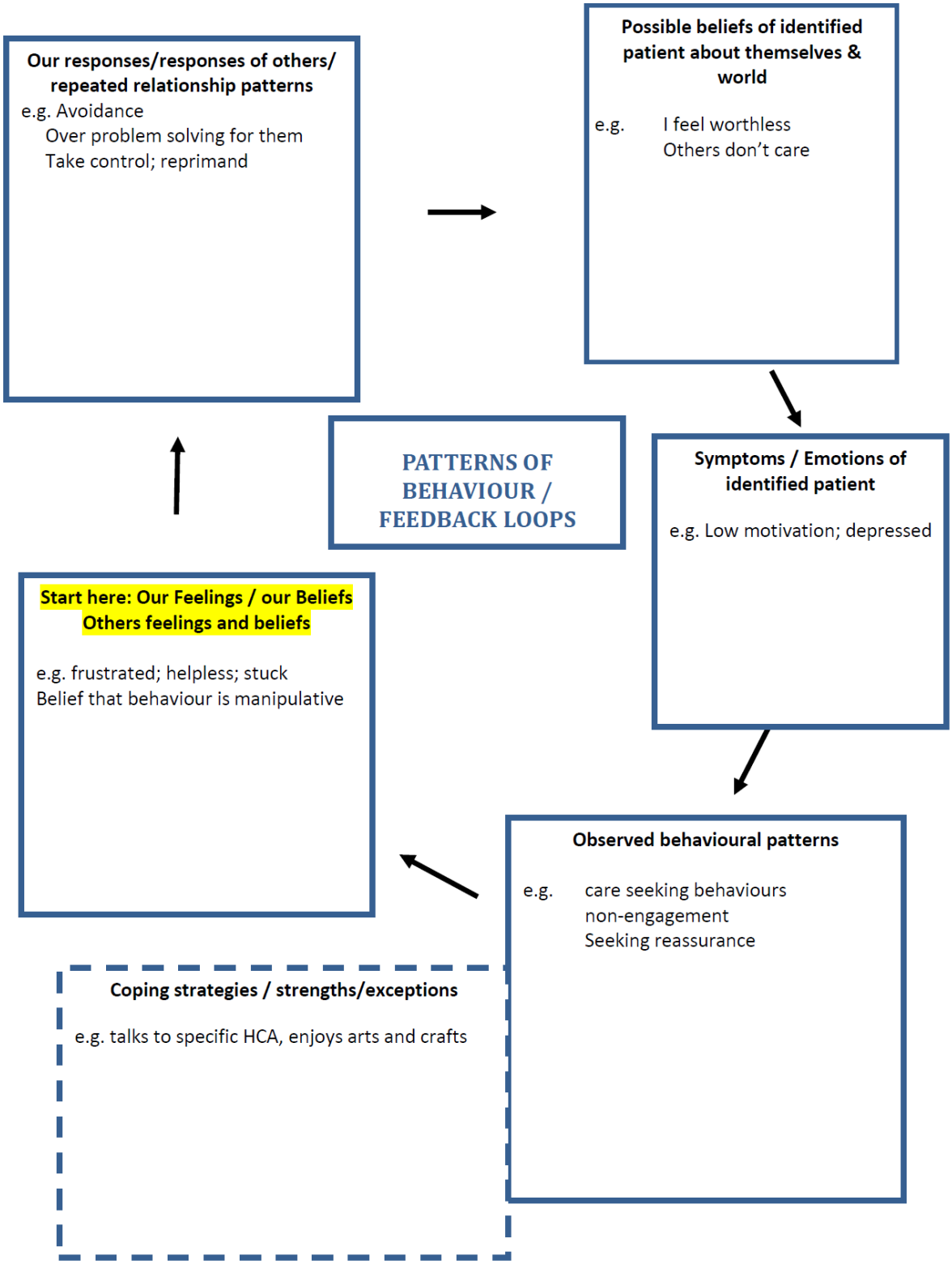
Cultural factors

Home / contextual factors

Issues of power and difference

Temperament

Kustner, C (2018). Relational Team Formulation. Adapted from Lake, N. (2008) BPS Clinical Forum186



Kustner, C (2018). Relational Team Formulation. Adapted from Lake, N. (2008) BPS Clinical Forum186

REFLECTIONS

We discussed as a team how it might be best to support and encourage _____ in the future. The following points are the team's suggestions:

Appendix B – NHS Trust Ethical Approval

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Claudia Kustner
Acute Adult Inpatient Ward
Prospect Park Hospital
Reading
RG30 4EJ

Research & Development
Psychology Department □ University of Reading
Whiteknights Road □ Earley □ RG6 6AL
t: **0118 378 5650**
f: **0118 378 5705**
e: **research@berkshire.nhs.uk**

3rd September 2018

Dear Claudia,

Title of the Project: Staff experiences of significant moments in systemic team formulation in acute adult inpatient mental health wards

The Research and Development department has carefully reviewed the different aspects of your proposed project from the proposal form submitted by yourself.

Your proposal does not warrant review by the Research Ethics Committee, nor management under the Research Governance Framework as it is a Service evaluation, which is designed to support service improvement.

Following review, the department has approved the project as an evaluation; subject to the following terms:-

- *A copy of the report is sent to the Research and Development department upon completion for our records.*
- *You are required to provide our R&D department with a monthly update of the number of participants taking place in this project (if relevant).*

This project has now been registered and placed onto the R&D department's database. Your unique project number is 2018SE13 and the project ends on 30th September 2019 please use this number on any correspondence you may use this will help the R&D department ascertain which project the correspondence relates to.

We wish you every success with the project.

Yours sincerely,

Stephen Zingwe
Research & Development Manager

Appendix C – Information sheets and Informed consent forms

Berkshire Healthcare NHS
NHS Foundation Trust

Information to prospective candidates

The Researcher: Claudia Kustner
Prospect Park Hospital, Rose ward, Honey end lane, Reading RG304EJ
Tel: 0118960 5202 Email: Claudia.kustner@berkshire.nhs.uk

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
Staff experiences of significant moments in systemic team formulation in acute adult inpatient mental health wards

Project Description

This study aims to explore staff-identified significant events of the process of systemic team formulation, which I will facilitate on five adult inpatient mental health wards in an NHS hospital in Berkshire. I currently work part-time, as a clinical psychologist on one of these wards.
This study has obtained formal approval from the Berkshire NHS Foundation Trust Research Committee*, as well as from the Tavistock and Portman Trust Research Ethics Committee (pending).*

Systemic team formulation in the context of my research study is a staff-focused, psychological, group supervision intervention that encourages the ward staff to develop a shared understanding of a patient's difficulties and behaviours, from a systemic psychology perspective. A systemic perspective involves viewing individuals' concerns and problems as happening *between* people rather than just *within* people. It involves thinking about wider contexts and agencies; families and relationships; beliefs and discourses; lifespan development and trauma; power and culture. Systemic team formulation also encourages staff to reflect on themselves, and to reflect on the way they relate to others (patients and other staff), when considering the case being discussed.

In this research study, I will be conducting five semi-structured, small group interviews with 3-5 staff members on their experiences of the team formulation sessions and on the processes and events that they found significant in the sessions. This will be done across five adult inpatient wards. Significant refers to any events that staff may have found important, helpful and or/ unhelpful in these sessions. These small group interview sessions will occur shortly after my facilitation of the systemic team formulation session on each ward, and at a time when research participants can all attend. The location for the interviews will be a quiet room in the hospital. Interviews will be audio recorded and transcribed for data analysis purposes.

The main selection criteria for research participants are that they attend a full process of systemic team formulation on the ward, together with the other staff members who volunteer to be interviewed afterwards. Thus, all participants in the small group interviews would've attended the same team formulation process. This is to ensure that the discussion of significant events is related to the same process. I will also be interviewed about the systemic team formulation process by another team member, to give my own perspective on the sessions.

Data will be analysed qualitatively, using an interpretive phenomenological analysis framework for small groups. Participants will also be given a summary of the research findings once they are written up. The research findings may also be reported and disseminated at conferences and in publications, but all information shared will remain anonymised.

Participation in the research interviews is voluntary, and participants can choose to withdraw at any stage of the process without any consequences.

If needed, participants will also be offered the opportunity to speak to me individually after the interview, should they experience any distress as a result of the interview, or if they wish to debrief after the interview. Staff who may request or need further counselling will be signposted to the Trust's employee wellness counselling services – CIC Employee Wellness (Contact nr: 02079376224)

Confidentiality of the Data

The team formulation sessions and interviews will be audio recorded and transcribed, but all efforts will be made to ensure confidentiality and anonymity of respondents. Confidentiality is limited where disclosure of imminent harm to self and/or others may occur. Participant identification numbers will be used in replacement of names and all other identifiable information and participant details will be anonymised in the research report.

All electronic and paper data will be kept and transported securely (in a lockable case) in accordance with the Data Protection Act (1998). During transcription, electronic data will be stored on an encrypted password protected memory stick. Once the research is completed, both electronic and transcription data will be stored safely (in a lockable cupboard) for a period of 10 years, after which it will be undergo secure disposal.

Location

The research will take place in the daylight room at Prospect Park Hospital. The small group interviews will take place after the team formulation session has taken place, and at a time that research participants can all attend.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the research, at any time of the process, you may do so without disadvantage to yourself and without any obligation to give a reason.

if you have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Louis Taussig, the Trust Quality Assurance Officer pjeram@tavi-port.nhs.uk

Berkshire Healthcare NHS
NHS Foundation Trust

Informed Consent Form

The Researcher: Claudia Kustner
Prospect Park Hospital, Rose ward, Honey end lane, Reading RG304EJ
Tel: 0118960 5202 Email: Claudia.kustner@berkshire.nhs.uk

Project Title
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Data will be analysed qualitatively, using an interpretive phenomenological analysis framework for small groups. Participants will also be given a summary of the research findings

once they are written up. The research findings may also be reported and disseminated at conferences and in publications, but all information shared will remain anonymised.

Participation in the research interviews is voluntary, and participants can choose to withdraw at any stage of the process without any consequences.

If needed, participants will also be offered the opportunity to speak to me individually after the interview, should they experience any distress as a result of the interview, or if they wish to debrief after the interview. Staff who may request or need further counselling will be signposted to the Trust's employee wellness counselling services – CIC Employee Wellness (Contact nr: 02079376224)

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All electronic and paper data will be kept and transported securely (in a lockable case) in accordance with the Data Protection Act (1998). During transcription, electronic data will be stored on an encrypted password protected memory stick. Once the research is completed, both electronic and transcription data will be stored safely (in a lockable cupboard) for a period of 10 years, after which it will be undergo secure disposal.

Location

The research will take place in the daylight room at Prospect Park Hospital. The small group interviews will take place after the team formulation session has taken place, and at a time that research participants can all attend.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the research, at any time of the process, you may do so without disadvantage to yourself and without any obligation to give a reason.

if you have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Louis Taussig, the Trust Quality Assurance Officer pjeram@tavi-port.nhs.uk

Consent

I have the read the information above relating to the research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the research has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent, I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: …….

Appendix D

Focus group interview questions - Systemic team formulation research

1. What was your experience of this process of systemic team formulation?
(How did you make sense of what was happening? What stood out for you in the process? What will you remember about the process?)

2. What types of events would you describe as important or significant in this process of team formulation? (What was helpful, unhelpful, important and/or significant?)

3. Why did you experience those events as being significant? (What kind of feeling did you experience at/around that moment? What was on your mind? How did you perceive that moment and the team at/around that moment?)

4. What other experiences did you have of this systemic team formulation process?

- What was your experiences of support groups where the formulation case was identified?
- What was your experience of being in the team formulation group?
- What was your experience of drawing up the formulation-informed care plan?

5. What has it been like talking about this in a small group? (Is there anything you think you might have said individually that you wouldn't have said in a group?)

6. Please share any experiences of personal and professional impact that you think you may have had as a result of being part of the team formulation process (behavioural, emotional, cognitive, relational)?

Appendix E – Data analysis excerpts

Table 3: Excerpts of verbatim transcripts and preliminary colour-coded data analysis (step 2, 3 and 4 of IsPA)

My self-reflections	**Exploratory comments – group experiences (positionality, roles, relationships, language, stories, systems)**	**Exploratory comments – individual experiences (descriptive, *linguistic*, conceptual)**	**Original transcript**	Unit	**Emergent themes – individual experiences**	**Emergent themes – shared experiences**
I was struck by the comment, as I know some of the staff at times feel intimidated by the doctor due to her being direct and flippant – her openness in the TF was helpful. I have a good alliance with NP3 – maybe felt safer to share this?	Having team members present with diff levels of authority helps *if* they're open. Permission to feel	Multiple perspectives – honesty valued Staff initially struggle with role shifting – positioning (especially when senior staff attend??) Medical staff attendance valuable – re-positioning?	NP3: I think it was useful to have you (to NP4) and a member of the medical team there, who were more open about their experiences with the individual. The normal format of that group is always whereby there's some muttering silences and people try to be seem very professional, depending on who's attending…	N1	Ward culture of not feeling professional when sharing the personal (inpatient – perhaps more protective of personal info?) Not safe space – if some attend? SLT? **Embodied experience – muttering**	Role positioning Multiple perspectives Professional vs personal Safety? Openness is unsafe/not allowed?
I wonder if NP4 feels safe to agree or disagree with this statement?		Humour - Acknowledges non-normative role??	NP4: Laughs	N2		
In my position - I try and role model openness in my	Masking the personal to appear	Professional role can be rigid, difficult to be	NP3: you have to push through that veneer of, I don't want to say anything that's	N3	Rules of what is appropriate. **Embodied** –	Rigid role – professionalism vs

facilitation but this may only feel congruent if I know the patient/family – am within the system – I didn't know this patient.	professional? – fear of being seen as inappropropriate or uncaring Feels relieved when a senior member of the team is open – allows for other to be	perceived/act outside that role – seen as having feelings (being human), being judged?	perceived as inappropriate or nasty and get to that understanding that you're a person and not only a professional. And it's nice to not have to go through that awkward first 20 minutes or so		'pushing through' the professional behaviour? Awkward silences. Scaffolding by senior member of staff is important to give permission for staff to 'break the norm of being professional'?	personable practice / feelings shared
Am curious whether staff may cope with complex cases by rigidly maintaining a professional outlook on the case – first order perspective – safe certainty, less overwhelming than having to process the personal too?	Was surprised at the norm breaking – new staff from another inpatient unit – wider cultural norm on leaving the personal out of the professional?	Agreeing and elaborating on NP3 Collective spaces often elicit professional role. Enlightening to acknowledge staff feelings (esp. medical staff) – role modelling Ward struggles – safe space to	NP4: I think that's the bit that was really interesting for me, I think because, as you say being in that MDTs and stuff like that it is very formal but actually for me realising it was a space, where some of one the doctors was frank about how they felt, um and I think that was quite an eye-opener for me, to be honest. To actually just it seemed like a good space where one could just say, particularly with this case, because I	N4	Relieving to find there is a safe space to share Learning experience – eye-opener? – **embodied language**	Role positioning Honest, sharing of feelings Role-modelling humanity? – positions of power Discourse – leaving the personal out of the professional in complex cases – safer to maintain a 1st order perspective

		share feelings (frustration)	think it has been a really difficult for us			
		Agreeing with both, listening	NP5: Mmm… (in agreement)	N5		
I find it more difficult to think about possible interventions with staff if I am not part of the system/know the client system – on the ward where I work, I can more easily hypothesise relational interventions with the staff as part of the formulation. Wonder if it would be helpful to discuss the benefits of self reflexivity in TF sessions?	Reflecting on reflections with others Frustrations around inaction?	Feelings often not discussed (bottled – 'air') – valuable to share Outcomes-based practice? Change process? Seeing patient and staff as humans Honesty vs professionalism ?	NP4: for people just to be able to air how they're feeling, and I know at the end I said to you (to NP3), um, (pause) for me it was like a really good process to see that but there was, I don't know (pause) that part of me that thought this was a really good process, but I was just a bit unclear what would then kind of, not point because that's the wrong way to put it, but kind of what the outcome of that kind of intended to be. For me, it's what you used (to NP3) the humanising of that case, actually, when I thought on that, that's what kind of really came out of it, because people were so honest in there.	N6	Processing vs problem solving – what now? Not enough action – felt uncomfortable just being left with the feelings? Felt confused about the purpose of sharing? Feels lighter (air) to share feelings – heavy complex cases – **embodied**! Difficult to humanise complex cases – coping? Honesty rare?	Importance of taking action – doing something differently Re-positioning rigid roles – professionalism vs honesty The facilitator being part of the system/knowing the client system – helps with hypothesising interventions – part of the system, understands /feels the relational dance
		Clarifying	C: Nodding. What do mean in terms of what was unclear about the outcomes?			

It was the first formulation session that this staff member attended – all the other meetings on the ward are outcome driven (CPAs, professional meetings, tribunals) – wonder if there is an underlying expectation around problem solving? Have often been told by RC I often tell staff that understanding ourselves and the relational dances can create change	Disappointment ? Frustration? Stuck? Looking for innovative solutions – feeling stuck? Was unclear about the process – TF wasn't explained clearly? (purpose and process)	Shared frustration, timing of the discussion Hopes for change? Purpose/value of the TF	NP4: I think it's probably just in a way down to the case itself in that one, and maybe the time that it was done, I think because, um, I guess, we were all going through it, I kind of had the sense that um, maybe this was to maybe change the route that they were thinking of going down with this case, and what the outcomes were going to be, and it became clear that it wasn't going to change anything, that they were still looking to go down that route, and a part of me wondered why are we having this conversation if it wasn't aiming to change that outcome.	N7	Ward culture of all meetings being outcomes driven/relevance – expectations of problem solving/certainty? Feelings of stuckness when new ideas aren't generated? **Embodied frustration**	Outcomes-based practice? Finding value – defining purpose of TF Discourse - Relevant and useful meetings provide new ideas?

Colour coding:

Formulation related theme
Relational theme
Reflective theme
Ward related theme
Self/embodied theme

Table 4.1. Example of idiographic analysis – emerging themes for participant NP3

Focus group 2 – Participant: NP3
Useful to have openness role modelled, especially by staff in senior positions – role positions, multiple perspectives. Permission to feel. Culture of hiding behind professionalism – safety in sharing the personal. Veneer of professionalism which is silencing/scary. There are rules about professional behaviour (don't want to be seen as inappropriate/uncaring). Scaffolding openness by senior staff gives permission for junior staff to be open. Agreed with NP5 that it was useful to have personal feelings validated – helped renew empathy for patient Helpful to realise when a lack of background systemic information about patient leads to getting drawn into unhelpful interaction patterns. Circular awareness. Illusion of 'knowing a patient' from their behaviour and feelings they elicit – assumptions. 17 The formulation changed beliefs and attitudes through collective realisations – as circular awareness developed, led to more curiosity, and noticed that others have also been more open to engaging with patient that elicited distance – (change process = time to think about interactions that worked and didn't (feedback loops, self-reflection), hearing multiple perspectives). Wards often have status quos which determine interactional patterns… Previous helpful experiences of TF but wary that different interactions are difficult to sustain in a flux system of multiple interactions – easy to revert to old patterns, communicating to all staff challenging, relational perspective is not dominant perspective on ward. Linear vs circular. Frustration. Difficulty sustaining systemic thinking in linear thinking system. Humanising experience to feel unified with staff on all levels – aware of power and hierarchy on ward – male but junior. Noticed the case was chosen as staff 'on a needs basis' felt they were being 'less professional' towards patient – strong feelings by staff – stagnation. Staff reaching out for informal support 37 Attendance is issue – time? Difficult to get senior staff to attend. Likes that TF starts with strengths focus – paradigm shift (circularity, unifying professionals, multiple perspectives). Good to have visual representations of systems and dynamics. Difficult to communicate relational information – is it ethical given the system is in flux. (info out of context is dangerous!) Important to put reflection points on Rio for care plans. Feels empowering but sometimes surprising to reflect on sad feelings and how that relates to personal values. Not professional to feel sympathy rather than empathy?

Table 4.2. Idiographic and contextual – excerpt of summary of emerging themes

Participant	Key personal emerging themes	Key contextual and self-reflexive emerging themes
RP1	Permission to think, understand and notice (and name feelings) Which allows you to understand unknown historical and contextual factors, and have empathy for complexity Gives team confidence and team validation Gives self-confidence to respond relationally/circularly Collective awareness of different relational responses Highlights importance of including families Attendance and information gets lost easily – difficult to sustain Opportunity to personalise care plans and collaboration *Time to explore patient, self, and team relational interactions to provide more system-centred care, but difficult to sustain*	In fast paced ward Beyond summary of information – no time for integration In an inconsistent ward where burnout is high In a diverse staff group with different relational backgrounds In an environment that homogenises staff groups -banding No time for active, regular, open dialogue Ever changing staff group Info is often not aligned
RP2	Work satisfaction related to good patient care and reflexive practice Time to step back to notice patterns and alternative interactions Allows for collective approach to care which balances care and independence Epistemic validation and credibility Relational thinking creates positive change Space to intervene in team disagreements Information presented visually helpful Space to acknowledge 'rocky roots' and question *certainty* Space to understand behaviour as communication/complex Space to express negative feelings Space to brainstorm individual coping strategies Frustration that medical staff don't attend – need policies *Validation of feelings- challenging epistemic power and certainty*	But not possible due to high caseloads /flipping between patients Time has to be granted Where restrictive practice is common – due to different beliefs, opinions, backgrounds of staff Professional opinions vary in power due to position – authority of voice in hierarchical context -medical discourse Info is often two-dimensional Frustration blocks curiosity Expressing feelings is not professional Reactive space

Table 4.3. Focus groups - Collation of subordinate themes in participant quotes

Ward/practice focused themes	Team/group focused themes	Patient focused themes	Self-focused themes
Risk /problem focused practice – s9, d5, d6-10, d37,	Team cohesion and support – s3, s12, d54, n32, r4, r15 (Consistency – r4-7)	Learning historical information, wider insight, holistic – s1, s4, d1, d11, d18, r1,	Validation and normalisation of feelings and opinions – n1, n3. N6, n8, n11, r7, r8, r19, r20
No time – to understand patient backgrounds/presentation – s1, s10, s11, d13, d51, d71, d73, n37, n49, n61, r1, r2, r18, r22, r27 (confusing, overwhelming – s4, s10. Reactive space – s10)	Settling disagreements and differences of opinions – r4	Understanding systemic factors/family dynamics – s3, s9, d14, d22, d72, n13, n16, r1, r3, r13, r19, r21,	Awareness of feelings – d27-28, d37, d39, n62, r12
Medical/clinical/outcome focus -d47, d53, n67	Epistemic validation – r4, r8	Seeing the person / humanising – s9, d2, n6, n11, n17, n32, n63, r15	Resonance with patient: Identifying similarities and differences (values) – s3, s5, s12, d29, d31
Keeping emotional distance from patients (formality vs informality)– s3, d39, d43, d69, n3, n4, n6, n34, r20,	Hearing different perspectives – s1, d1, d50, d53, n1, n22, n42, n43, r4	Understanding behaviour as communication – s1, d23, n12, r19	Building interactional confidence (doing things differently) – s1, s9, s11, d14, d36, d47, n10, n26, n35, n65, r7, r17
Hierarchy of power – s14, n31, n32, n59, r32	Difficult to sustain relational change – s11, n23, n26, n50	Narrow down ideas for care (team care planning) – s2, s6, d38, d45, n66	Learning from others – s3, s12, s13, d41, d44-45, d49, n4, n31, n42, r15-16
Creation of safe space to be open/honest– s14-16	Sharing relational info is difficult – d46, d65, d68, d70, n23, n28, n55, n57, r18, r30	Seeing relational progress – s2, s7, s8, s9, s10, n19, n21, n23, n65, r9-10	Relational awareness – s3, s6, s9, d15, d25-26, n48, r2, r13, r15, r19 (Awareness of communication – s6, n64)
TF can feel too open-ended – s17, n6, n7, n36, n63, n66, r23-26		Strengths focused – d3, d5, n42, n44-47	Renewed empathy and alliance – s1, s8, d38, n8, n35, n68
Poor attendance – d55, d57, d62-64, n24, n28, n58, r18, r27, r34, d59-60			Visual learning – d67, n51, n53, r13

Table 4.4. Superordinate themes

Superordinate theme	Subordinate themes
Relational reflexivity	Relational awareness and awareness of communication
	Learning from others
	Building interactional confidence
	Seeing relational progress but difficult to sustain and share
Time to widen perspectives	Hearing multiple perspectives but attendance is an issue
	Learning background info and understanding systemic factors
	Time to understand the patient is limited
	But TF can feel too open ended
Challenging the notion of formal and hierarchical professionalism	Shared vulnerability and honesty
	Team support and cohesion
	Team care planning and epistemic validation
	Hierarchy of power
	Attendance is an issue
Humanising: the patient as a person and the professional as a person	Validating and normalising feelings in a context that encourages emotional distance
	Strengths-based focus in a risk focused /problem saturated context
	Personal resonance
	Renewed empathy and alliance

Appendix F – Transcript excerpts - Excerpt of focus group transcription 1R Feb 2019

Self-reflections	Exploratory comments –group	Exploratory comments – individual	Original transcript	Unit	Emergent themes – individual experiences	Emergent themes – shared experiences
Made me think of how TF allows me enough time and space to research, assess and understand patients background – fast turnover – often take shortcuts – unsafe certainty	Historical/ contextual understanding Beyond here and now – 'heat of the moment' Time- fast pace of the wards – to think Widen perspective, patient perspective	Personal account – 'for me – stepping back to SEE and understand – self, patient, system'. Multiple perspectives Heat of the moment – crisis Allows self – gives permission	P1: I think for me, it allows you to really think of the background of the person, to really understand what's gone on for them, rather than thinking about, you know the, in the heat of the, you know the acute wards and how busy it is and it gives you time to be mindful of not just what you see but what may have happened before, and understanding a lot more from their perspectives as well, how things have been developed over time.	R1	Beyond the here and now Thinking time/slow down the pace Widen perspective (incl. patient perspective) – understand the pas	Fast paced acute wards – no time to think about the individual – past and current. Allows time to listen to patients and families. Notice developments/ patterns
I see TF as a necessary and integral intervention on the ward – do other staff see it as an enjoyable luxury? A permissible task…	Fast pace, high workload – time to think about the individual Widen the perspective – 'step back' Think about alternative practices – challenge rote practices – 'quick fixes'	Enjoys the TF (frustrated with high case loads – 'flip between patients – no dedicated time) Gives self permission	P2: I quite enjoy the team formulations just in the sense that, I think with everybody's high caseloads it's quite hard to flip between patients not fully giving a patient a significant amount of time thinking about and formulating about that person, I think it's good to take a step back and have the space and that time to, say okay there's something we may need to be doing differently with this person. Instead of trying to think of those quick fixes a lot of the time, it's quite good just to grant yourself that time to reflect a bit more.	R2	Time to reflect – a luxury, an enjoyment Noticing patterns	Slow down the pace – think from patient-centred perspective Alternative practices – difference that makes a difference Beyond normative practice

Formulation related theme Relational theme Reflective theme Ward related theme Self theme

Excerpt of focus group transcription 2D April 2019

Am aware of DP9 seeking confirmation from DP8 in this interview – I do this too to try share voice – aware of power?	Strongly agrees with DP9– dominant norm? Helped with understanding meaning and context – increased confidence ot respond - observed ward team responding more directly	'Opportunity' – luxury? Space, moment, a chance – slows down the pace Broaden understanding of systemic, family issues Collective voice – we - understanding informs practice. Seeks confirmation from DP8	DP9: Definitely, yeah. TF gives you the opportunity to explore the whole aspect of the patient. I think it highlighted loads of stuff, particularly about the family dynamics and home environment as well, which made a lot more sense, and *we've* been able to act on them a bit today haven't we? (talking to DP8)	D14	Chance to learn and pause to reflect more fully Learning new things which made sense – confidence to act? Space to hypothesise - informed interventions?	TF slows down the pace Understanding to inform practice Collective account – allows for confirmation (reality testing?) Hypotheses inform relational interventions.
MDT spaces offer some space for reflecting, but some voices can dominate – the RC, my voice, manager	Reflecting on key themes from the formulation and how they are being noticed today - observation	Responds to DP9 – unsure - MDT meetings as decision-making, practice-informing spaces? Circular observation – family interactions 'spikes in behaviour' – unpredictable, (dangerous?) ward challenges	DP8: I didn't get to go to MDT today, but think it was interesting that the more family visits there were, the more spikes in her behaviours	D15	Noticed relational aspects despite not attending MDT	Practice informing processes on the ward (MDT, TF) Circular observations Unpredictable environment (dangerous)
New information can often feel mind-shifting – strong push for certainty on the wards	Reflection – missed that due to not thinking about the system?	Agrees with DP8 – Collective revelation. Noticing/awareness – patterns?	DP9: Yeah, sort of something we hadn't really noticed or thought.	D16	Noticed gap in thinking	Collective account – noticing patterns that weren't obvious

Excerpt of focus group transcription 3S Feb 2019

Am curious whether staff may cope with complex cases by rigidly maintaining a professional outlook on the case – first order perspective – safe certainty, less overwhelming than having to process the personal too?	Was surprised at the norm breaking – new staff from another inpatient unit – wider cultural norm on leaving the personal out of the professional?	Agreeing and elaborating on NP3 Collective spaces often elicit professional role. Enlightening to acknowledge staff feelings (esp. medical staff) – role modelling Ward struggles – safe space to share feelings (frustration)	NP4: I think that's the bit that was really interesting for me, I think because, as you say being in that MDTs and stuff like that it is very formal but actually for me realising it was a space, where some of one the doctors was frank about how they felt, um and I think that was quite an eye-opener for me, to be honest. Seemed like a good space where one could just say, particularly with this case, because I think it has been a really difficult for us	N4	Relieving to find there is a safe space to share Learning experience – eye-opener?	Role positioning Honest, sharing of feelings Role-modelling humanity? – positions of power Discourse – leaving the personal out of the professional in complex cases – safer to maintain a 1st order perspective
I find it more difficult to think about possible interventions with staff if I am not part of the system/know the client system – on the ward where I work, I can easily hypothesise relational interventions with the staff as part of the formulation. Wonder if it would be helpful to discuss benefits of self reflexivity in TF sessions?	Reflecting on reflections with others Frustrations around inaction?	Feelings often not discussed (bottled – 'air') – valuable to share Outcomes-based practice? Change process? Seeing patient and staff as humans Honesty vs professionalism?	NP4: for people just to be able to air how they're feeling, and I know at the end I said to you (to NP3 and NP5), um, (pause) for me it was like a really good process to see that but there was, (pause) that part of me that thought this was a really good process, but I was just a bit unclear what would then kind of, not point because that's the wrong way to put it, but kind of what the outcome of that kind of intended to be. For me, it's what you used (to NP3) the humanising of that case, actually, when I thought on that, that's what kind of really came out of it, because people were so honest in there.	N6	Processing vs problem solving – what now? Not enough action – felt uncomfortable just being left with the feelings? Felt confused about the purpose of sharing? Feels lighter (air) to share feelings – heavy complex cases Difficult to humanise complex cases – coping?	Importance of taking action – doing something differently Re-positioning rigid roles – professionalism vs honesty The facilitator being part of the system/knowing the client system – helps with hypothesising interventions – part of the system, understands /feels the relational dance

Excerpt of focus group transcription 4L April 2019

Trying to narrow down experiences to this TF session			C: If you think about this formulation we did on Friday, what stood out for you, what will you remember about that one?			
I try and role model circular questions in the process, to encourage curiosity and to encourage staff to ask questions – a wondering how this can be enhanced further using reflective teams? PICU ward – distance is the norm, risk is heightened. Didn't share in the TF that lost parents – alliance not yet established with me?	Curiosity is insightful – reflective team approach? Vulnerability	Collective voice - we Team perspectives – cohesion? Enlightening – alternative perspectives shared, possible (invisible?) feedback loops discussed Wider perspectives – understanding family dynamics. Surprise at family information. Understanding trauma and loss – increased feelings of empathy and closeness Challenge the dominant (automatic) risk discourse – relational reflexivity? Finding value in the above	SP6: I think again, definitely the combination of people being there. I remember their questions being raised that I hadn't really thought of, um, that might be impacting things around, I suppose the family dynamics and the genogram that was done, um – not actually realising how many brothers and sisters were there. Um, that actually the troubled upbringing in the sense of losing both parents as well, so um, and the circumstances in which they passed away. So on a person who's lost their parents, that made me empathise with that service user as well, and I actually just at the end when we were raising the actions and questions, um that without realising sometimes keeping people at arm's length, um because of risk, and actually we need to be thinking why are we doing that. Is it because of safety or is it because of situational factors, or are we making assumptions, um, so that's what I took away from that one	S3	Finding personal contextual similarities – enhances closeness Distance is a given on the wards – useful to reflect on – risk? Norm? Thinking outside the individual not the norm – hidden systems?	Making invisible visible Team cohesion/ vulnerability Wider perspectives and understanding Relational distance is the norm (esp PICU)? – reflexivity. Awareness of closeness and distance – conscious relating

Excerpt of focus group transcription 5B Mar 2019

Supervision really helps me when I feel in threat mode with a patient of situation – taking a step back, acknowledging and noticing the feelings, allows space for a different relational response	Team identified progress Norms of distance and anxiety on PICU (threat response – safety)? Affects relational patterns – may increase risk and need for deesclation? Beneficial vs useful vs valuable.	The difference that makes a difference – immediate change Feelings focused space useful – relational reflexivity (awareness of feedback loops) Risk-focused interactional patterns still dominant (PICU ward?) but interactional awareness increased comfort Empathic de-escalation – humanising interactions helps in crisis Finding value in pragmatic use of formulations	S11: Yeah, it's almost like someone flicked a switch after the team formulation, the progress after it, It was, um, I also found that one of the comments at the end to all the questions we were asked, how does that person make you feel – our emotional reaction to him, um my response was on edge, and I very quickly noticed that my interactions with him after had changed, There was still some risk, that you're almost on edge with everyone, but I noticed that I felt a lot more comfortable, the de-escalation that was required was a lot easier because I could relate it back to things in a different way, so yeah, I think that process is great in that, just even when someone is at that crisis point we can relate on a more personal level, helps to ground that … I think it was very, very beneficial.	S9	Noticeable progress Being given the space to talk about feelings – significant, esp negative feelings (creates change through awareness, professional challenge?) PICU norm – feel on edge with all patients – risk – self awareness and comfort may have positive effect on risk management – importance of space for self awareness - grounding	Interactional awareness – voicing feelings can elicit awareness and interactional change – safe space to share and become relationally conscious? Risk focused vs patient focused Seeing the patient as person – personal vs professional stance Finding value – pragmatic value