A Systemic IPA Study exploring the communication-experiences of team members in an NHS Child and Adolescent Mental Health Team during an MDT Case discussion.

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Author Declaration

I, Vanja Rossberg, 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;

None of this work has been published before submission

Abstract

Communication in NHS Multi-Disciplinary case discussions is meant to bring together a variety of disciplines to consider an individual's mental health needs. Communication in multi-disciplinary case discussions has been researched from different angles, but only limited empirical research has been conducted in relation to MDT communication. Within this practice-based study, a case discussion in a Child and Adolescent Mental Health Service was video-recorded and formed the ground for participant interviews. The study aimed to understand more about practitioners' experiences of case discussion communication within their MDT case discussion and their views on what contexts impact the exchanges.

One CAMHS team was filmed during one case discussion. The video was used to allow participants an observational perspective on their case discussion and the experience of being part of the case discussion. The contributions within the semi-structured interviews constitute the data for this study. I used an IPA analysis method, combined with systemic research methods, to extract insights from participants' contributions relating to how team members experienced the MDT case discussion communication. Results in this systemic, constructivist study show that participants saw their communication as influenced by factors relating to organisational -, team-, relational- and identity- contexts.

Results show that communication between the different disciplines in the team was experienced as allowing a variety of influences; however, directed through guidelines medical model thinking and diagnosis practice was experienced as central. With less

time pressure and less risk, communication allows for more varieties in perspectives, more uncertainty in positions taken, more reflective elements; with higher risk and less time, communication becomes more focussed on diagnosis and planning action; difference between perspectives is then less negotiated, but decided through hierarchical structures. Whilst multi-disciplinary exchange is valued and experienced as enriching, it comes with challenges when aiming to synthesise difference within hierarchical structures.

When conceptualising MDT communication as multi-cultural exchange, Bateson's schismogenesis concept is applicable and offers a basis for considering helpful and less helpful cultural rituals of the different disciplines if synthesis is the aim.

Above findings inform future research and practice and the study concludes with suggestions and ideas that could be applied to work towards multi-disciplinary communication that synthesis different perspectives into holistic formulations, despite hierarchical organisational structures.

Abbreviations

BAME	Black, Asian and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Team
CBT	Cognitive-Behavioural-Therapy
CC	Care Coordinator
CMHT	Community Mental Health Team
DOH	Department of Health
FYFV	Five Year Forward View
GRACES	Gender, Race, Age, Class, Education, Sexual Orientation
ICD11	11th edition of the International Classification of Disorders
IPA	Interpretational Phenomenological Analysis
JCP	Joint Crisis Plan
LAC	Looked After Children
MDT	Multi-Disciplinary-Team
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
RTP	Reflective Team Process

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1 Introduction

1.1 Introduction to the topic

"When policy-makers call for interdisciplinarity, they often mean "synergy". Synergy is indicated when the whole offers more possibilities than the sum of its parts. (Leydesdorff 2021, p.135). Seeing added value in letting differences come together has increasingly gained attention across academic fields and faculties. This has been no different when looking at the mental health sector within the UK. Multi-Disciplinary-Teams (MDTs) are established throughout the UK NHS. They have a long history within community mental health teams and have become vital to teamwork.

Although the UK NHS mental health policies have emphasised multi-disciplinary care for a sustained period (DOH, 1995, 1998, 2001a, 2007b, 2009), there have only been a limited number of empirical studies of MDT meetings with case discussions at their heart, which can be seen as the formal mechanism for practising multidisciplinary collaboration (Nic a Bháird *et al.*, 2016).

As a response, policymakers have indicated plans for an information revolution around mental health and wellbeing (DOH, 2014, p. 11) to monitor variation in provision better. Bhaird et al. point out, "A strong evidence base documenting current practices and challenges is necessary to support such quality improvement initiatives." (Nic a Bháird et al., 2016). These authors have contributed to gathering empirical material to illustrate the status quo of the function of MDTs. Other publications have contributed with other specific aspects of communication in MDT meetings and case discussions, such as challenges and barriers to MDT working, MDT decision-making regarding referral

acceptance or -rejection, the interplay between different mental health beliefs.
All these contributions provide some basis for further exploration and thinking and highlight its need. Understanding case discussions being at the heart of MDT working and representing a significant part of the formal mechanism of MDT working (Nic a Bháird *et al.*, 2016), I focused on case discussion communication within MDT meetings when searching the literature. The gap I identified is a lack of insight into an overview of phenomena that team members experience when exchanging in their MDTs.

This study, as part of a doctoral thesis, is a Systemic Interpretational Phenomenological Analysis (IPA) study that explores NHS-Children and Adolescent Mental Health Service (CAMHs) team members' experiences of their communication during an MDT case discussion. Generally, when using the term MDT in this thesis, I am referring to NHS MDTs.
My study set out to gain insight into how team members experience communication processes during MDT case discussions with the hope to contribute
to a richer empirical basis in relation to understanding how the different individuals with their different disciplines experience their communication within a case discussion. Choosing one team and using a qualitative approach ensures that the processes within one CAMHs team are captured from an individual perspective, but also with the individuals' understandings of the meaning these processes may have on a team and organisation and vice versa.
The plan was to contribute to a more overall understanding of what is at play when multiple disciplines meet to consider individual clients, how these elements and trends

interdepend and how they are responded to. The idea was that this could contribute to recognising what may support communication that is expected to use different disciplines' insights to benefit people who access mental health services.

1.2 Introduction to NHS – MDTs

The conceptualisation of MDTs in this study refers to MDTs within the UK NHS and is based on how MDTs are referred to in NHS publications and publications of other authors which also refer to NHS MDTs (for example DOH ,1999)

Within these publications, there seems to be a shared understanding that MDTs are groups of professionals with different professional backgrounds and roles within a shared pursuit of a common purpose (Onyett, 2003). B1: The purpose is to deliver care that aids recovery in an "effective and patient-centred" way (Onyett, 2003). Within the UK, health and mental health MDT teams are a standard part of local health services. MDTs within mental health aim to deliver holistic, integrated care and should ensure that patients experience continuity in their care (DOH 1999).

"A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations." (DOH 2015, p.12)

Within UK mental health services MDTs have been a model of working since large psychiatric institutions were gradually closed (Boardman 2009). MDTs evolved gradually and not systematically, contributing to a great variety in how they are organised and what functions they may hold (Burns and Lloyd, 2004). From my

practice experience, this means that MDT working is largely determined locally in each individual service and changes over time and with the people who form the service at a time.

The resulting variations also apply to the composition of MDTs. Over the past 20 years, literature has referred mainly to psychiatrists, nurses, social workers, psychologists, and occupational therapists (Norman and Peck, 1999; Carpenter *et al.*, 2003; Nic a Bháird *et al.*, 2016) when considering MDTs within community mental health. Psychotherapists and systemic psychotherapists don't seem to feature, although we know from practice-based evidence that both professional groups would be commonly found in MDTs. When MDTs include social workers, they are often meant as an integrational factor between Social Services and Health Services.

Variations also appear in relation to how interactions within MDTs and their organisational contexts are referred to. The variations include terms like " collaboration," "coordination", "communication", "cooperation" (DOH 2002, 2007b, 2009, 2010, 2015, 2016). Within this resaerch, I was interested to learn more about how professionals, who work in MDT contexts experience what happens between them and their fellow team members. I aimed at exploring what happens between people in a broad way. That is why I framed the interactions within the word "communication", rather than compartmentalising them into for example words like "collaboration", "coordination" or "coordination".

1.3 Background to the research

1.3.1 Personal and professional interests

My interest in MDT communication comes from personal and professional experiences. Being the youngest child in my family, female, having double migration experience, living within different cultures (Serbian, Croatian, German, British), and coming from a family where values are often polarised between intellectuals/middle-class beliefs on one end of the continuum and working-class beliefs and values on the other end, I am coming with an interest, sensitivity and experiences with themes like "adaptation vs integrating difference", "equal exchange", "having a voice" and "divided loyalties" when making sense and responding to difference. Having lived for a substantial amount of time in three different cultures brought embodied insight into parallelly existing "universes". The transitions between these universes, better known as migration, presented an invite and a challenge to move between adaptation – integration – separation in a way that made sense to me and my surroundings at the time.

My systemic psychotherapist practice within several different CAMHS teams and my experiences attending MDT case discussions within these teams seem the most relevant professional experiences when considering what formed the background for this research.

I noticed a great variety in how case discussions were held. I observed and experienced the difference in impact on myself and my colleagues and our work depending on how case discussions were held.

I could relate to the idea that a conversation between different perspectives could add something valuable to our work, but I also noticed that it seemed to depend on how the different perspectives were coming together and influenced the voices that were coming or not coming forward and how they were brought in.

Practice-based evidence, the background described above, and personal experiences in life relating to encounters with multiple voices and how these went for me made me interested in insights from theory and research in this context and led to the questions I was being guided by when planning, conducting, and evaluating this piece of research.

1.3.2 My philosophical orientation

The question of philosophical orientation within different research paradigms is often addressed within the methodology section of research accounts. Within this thesis, I am addressing it in some depth in chapter 3 (methodology). At the same time, I wanted to be clear about my ways of looking and making sense of things from the beginning, as this seems an essential context for understanding this study. This is a constructivist, systemic study. I identify with a constructivist research paradigm in that my ontology is relativist, and my epistemology is transactional and subjectivist.

Although "systemic" links to various therapy approaches and ways of thinking about our social worlds, it also holds many differences and can refer to different research paradigms. A critical link between all systemic approaches is that they all pay attention to contexts (Goldenberg and Goldenberg, 1996; Lorås, Bertrando and Ness, 2017). The meaning of context in systemic thinking, as well as for this study, will be introduced in 1.3.3. To introduce my philosophical orientation, it seems more relevant to explain the

differences between various systemic frameworks and explain which ones I refer to when I describe my study as “systemic”.

One way to distinguish between different systemic theories is to divide them into first and second-order approaches. Hoffmann (1985) describes one of the main first-order assumptions as understanding the observer outside the observed. In second-order thinking, the observer is part of the observed and is understood to play an active role in how the observed appears. This shows one of the fundamental differences between beliefs under the different systemic approaches. Another one that seems central to Hoffmann’s thinking is the belief around power. Second-order approaches often argue for collaborative practice as a therapist rather than a hierarchical, expert practice and entering the therapy process with the idea of co-creation (Hoffmann 1985).

As a systemic therapist, I apply methods and ways of understanding people and systems from first- and second-order approaches, depending on what seems helpful at a time and to clients or systems. This fits me because my research paradigm is constructivist, and I acknowledge the relative truth of how I make sense of phenomena. In that way, I identify with Loras and Sundelin’s idea of a “multi-epistemological therapist” (LorAs and Sundelin 2018). Although my epistemology, whether as systemic practitioner or systemic researcher, is always transactional and subjectivist, I choose to draw on practice methods rooted in different epistemologies. For example, as a practitioner in an MDT, I may engage in diagnosis practice, which I see rooted in a positivist epistemology, as this may be necessary to ensure a client can access a mental health service. At the same time, I may not engage with a person from this place of diagnosis as the only story that can be told about their mental health struggles. Still, I would invite

participation in cocreating an additional account if this was helpful to a client.

As a researcher, I aim to stay true to my epistemology when writing this thesis and articulating my thinking when planning, conducting and analysing my study and study material.

When considering how I relate to my epistemology, I see a distinction between practice and research. Research works with mental constructions and representations of phenomena, whereas practice is rooted in mental constructions and works with experience. The difference in purpose explains the different ways of relating to my epistemology, whilst my epistemology does not change.

1.3.3 The meaning of context and the importance of noticing the surroundings

Gregory Bateson's postulation that there is no meaning without context is one of the underlying core beliefs within systemic thinking and practice (Bateson, 2000).

At a time when psychiatry and psychology were often focused on intrapsychic, biological phenomena, he drew attention to family contexts which gave meaning to symptoms when researching Schizophrenia (Goldenberg and Goldenberg, 1996).

In the 1950s Bateson and some other family theorists, researchers, and therapists like Ludwig von Bertalanffy, Jay Haley, Don Jackson, and others were some of the individuals interested in researching Schizophrenia in the context of family relationships. Their work brought the notion of context (e.g., family context or interactional context) to the forefront when making sense of symptoms and problems.

At a later stage when second-order cybernetics came into play, the thinking of context

started to include the therapist within the practice and the researcher within the research (Dallos and Draper 2015). Some theorists expanded the thinking about context even further and a political aspect became relevant which was centered around power and oppression and looked beyond the family system's boundaries when trying to understand individuals and systems and their interplay. Society, culture, gender, sexual orientation, and all aspects that came to be known as social GRACES became more and more relevant in the field (Birdsey and Kustner, 2021; Burnham, 2012).

This may give a sense, even though hugely simplified, of the systemic territories that have emerged over time and aims at illustrating some of the rich and multi-faceted ground that practitioners and researchers stand on when positioning or moving within a landscape of concepts, frameworks, paradigms, methods and so on. Whilst this richness brings huge variety in the way how systemic practice and research are applied, the significance of context seems to be shared by most and some authors see the majority of systemic therapists identify with a cybernetic epistemology (Goldenberg and Goldenberg, 1996; Lorås, Bertrando and Ness, 2017).

Epistemological differences within the systemic practice field seem to correspond to the distinction between a positivist and non-positivist paradigm within research when for example considering several things like causalities, language, and, how the impact of therapists/researchers on the therapy and research process and outcomes is understood. First-order and positivist thinking consider researchers and therapists as outside the system, whilst many non-positivist and second-order traditions consider researchers/ therapists as part of the system and as influencing process and outcome. The variety

further underlines the significance of contextualising the researcher as a person and when explaining research choices.

This corresponds well with Maturana's emphasis on the acknowledgement that whatever is said, is said by somebody (Maturana and Varela, 1987). One could add that whatever is thought and written is thought and written by somebody.

Within this study, context is understood in a second-order systemic and constructivist way, in that I considered myself as the researcher being one ingredient influencing process and outcome of the study and that the process and outcome were shaping through the interactions between everyone involved (between participants and researcher as well as between participants) and the contexts that everyone was embedded in (societal, historical, political, personal, organisational and so on). This understanding of context links to the choices made within the methodoly, for example by designing a study that involves self-reflective and relational-reflective elements as well as methods that allow inquiry of the contexts participants refer to in their meaning making of MDT communication. This are introduced in the methodology chapter in detail.

Carr (2000) also makes a link between practitioners and researchers when outlining the numerous choices that both can make within their systemic practice and outlines how some individuals believe in quantitative research when trying to look for evidence, whilst others see case studies and qualitative research as more helpful in that respect (Carr, 2000). To prepare for one of the next chapters (1.4), which addresses the NHS as an organisational context, Carr's observations of differences in how systemic practitioners look for evidence can be expanded, and one can become curious about how

other mental health disciplines look for evidence.

In summary, and as highlighted in this chapter, contextual thinking has significant meaning within the variety of systemic approaches. I don't see the definition of "context" from the variety of systemic perspectives being different to a more generic definition of context within qualitative approaches; however, as introduced in this chapter, context in a systemic second order understanding is understood as constitutional in shaping meaning to phenomena in general and mental health in particular (Nichols, 2012).

Before going into the organisational context within the NHS in 1.4, it seems important to contextualise some of the language and terms I use in this thesis.

1.3.3.1 The language to describe people who are seen in mental health services

The collective nouns or phrases that are commonly used in the UK for people who are seen in mental health services are "clients," "patients," "service users," "patients/clients," "those afflicted by mental illness," and "user/survivor" (Simmons et al., 2010).

As Dickens and Pichioni (2012) note in their systematic review of articles which considered the different terms used, there is a debate within editorial columns and letters as well as in professional communities that centres around the idea that some terms may be more stigmatising than others.

Within language, it seems impossible to avoid categorising people into groups based on shared traits. Certain features, such as skin colour, sexual orientation, socioeconomic class, and mental illness, tend to carry disproportionate weight regarding their

contribution to social perception. Many other easily observable characteristics, such as shoe size, appear less socially relevant to (Rüsch, Angermeyer and Corrigan, 2005). Labelling often entails simplifying to fit specific individual features into pre-existing conceptual categories. These categories might not always be inherently value-laden. However, stigmatisation happens when particular groups are linked to unfavourable traits because of a combination of problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination). Concerning mental health, the stigma of being classified as mentally ill can have life-altering effects, such as social isolation (Kassam *et al.*, 2008).

The arguments relating to the different terms used have often been based on etymology and the power relations that these indicated. There have been etymological arguments against some names and arguments in favour of others based on the power relationships that they indicate (Calloway et al., 2001).

The terminology used in official government literature reflects this diversity of view. To Calloway et al. (2001), it appears that this is a global phenomenon: The UK government's 10-year plan for mental health services, New Horizons (they cite Department of Health, 2009), uses the terms "service user" (23 times), "patient" (12 times), and "client" variously (5 occasions).

Dickens and Pichioni (2012), from the empirical data they found in their literature review, think that most respondents in surveys preferred “client” or “patient”, and thatseemed linked to geography (US – patient and the UK - client). They speculated that this might be related to traditions and relationships to healthcare and culture.

Covell et al. (2007) conducted a study that compared individuals’ preferences between

various names and examined links between preferences and attributes like gender, race, and diagnosis. Preferred terms were ‘client’ 39%, ‘patient’ (22%), ‘consumer’ (16%), ‘survivor’ (11%), ‘other (11%),’ and ‘ex-patient’ (1%) and they could not find a clear correlation to the social attributes listed above. Their suggestion for clinicians, researchers, programme administrators and policymakers was to be sensitive to individuals’ preferences, which seems desirable and possible in interactions with individuals but seems more complicated when considering authoring research or addressing a wider audience.

When linking to practice-based insight from the use of those terms in MDTs, professionals use the term that corresponds best with their professional identity and the traditions within this identity.

For this writing, the use of terms in the different publications seems helpful to note in that it may give orientation as to the authors’ thinking about mental health and clearer situates the contribution within broader discourse, which is why I am using the terms used by authors when referring to other people’s writing and applying “client” when making a contribution based on my own conceptualisations and thoughts. On the one hand, it takes into account that this is one of the most preferred terms for people who attend mental health services. On the other hand, it seems to leave more space for different meanings and is less reductionist than “patient” and less technical than “service user”.

1.3.3.2 The conceptualisation of communication within this study

Like many terms describing abstract phenomena, the term “communication” can hold countless meanings. Communication within this study is central and I am using this section to demonstrate how I define the word “communication” and to make clear how communication is conceptualised within this study.

I define the term “communication” as referring to exchange-processes between two or more people. This includes gestures, words, facial or bodily expressions or interactions. Rooted in a systemic-constructivist onto-epistemological perspective I applied a constructivist research paradigm and within this paradigm, systemic thinking to conceptualise communication within this study.

From a constructivist perspective, communication is viewed as a reciprocal and dynamic process between individuals that provides mutual information about each other's perception of themselves and their surroundings. It is also considered as an interaction that is affected by the participation of all involved parties. Individuals are seen as actively constructing meaning through their interactions with others. It emphasises the importance of individual agency, as each person plays an active role in interpreting and creating meaning from their experiences, based on the exchanges they have with others and the different environments they stand in (Wood, 2013). Systemic second order thinking about the conceptualisation of communication corresponds with constructivist thinking in that it highlights the context-dependent, dynamic and relational aspects of communication, emphasising the interplay between individual agency and systemic influences on shaping communication processes and their outcomes (Johannessen, 2021). Systemic thinking has been influenced by authors from

different disciplines, for example Niklas Luhman, a sociologist who developed thinking on social system theory and he employed systemic theory to different aspects of society. This also included the aspect of communication and he emphasised on communication being a mechanism through which social systems evolve and operate (Luhmann, 2008, Scott 2001).

Another example of significant influence within systemic theory and practice was Gregory Bateson, who was a British anthropologist. He saw communication as process where people exchange and make meaning under the influence of the contexts they are referring to and he emphasised that here is no meaning without context ((Bateson, 2000). Bateson also contributed to a communicational understanding of schizophrenia by placing the illness in the context of disruptions in communication and feedback processes between individuals and their environments (Bateson 1956).

Generally speaking, one can say that key contributions of systemic thinking include the emphasis on interconnectedness of elements within one communication system and the interconnectedness between the systems they are embedded in, such as societies, organisations, families and relationships (Johannsen 2021, Monge 1977). Systemic theory invites a holistic perspective on communication and aims at holding multiple lenses with flexibility. The broader context of communication is encouraged by considering power dynamics, historical influences, and cultural norms. These holistic influences are employed to capture complexity and richness in human communication. Insights from different disciplines, like anthropology, cybernetics, sociology, and psychology are welcomed to contribute to a conceptualisation of communication that holds multiple dimensions. This interdisciplinary approach is recognised as supporting

collaboration and innovation within the field of communication studies (Johannsen 2021, Monge 1977).

Since I am looking from a constructivist perspective on communication, but employing one part of a communication model that is rooted in social constructionist thinking, it seems important to further establish explicitly my position relating to the conceptualisation of communication. For this purpose, I am referring back to a wider frame within the scaffolding of my onto-epistemological perspective to explain the differences and overlaps between a constructivist and a social constructionist conceptualisation of communication.

Within the constructivist perspective cognitive processes such as perception, meaning-making and interpretation are used to develop understanding about how individuals construct their lives (Wood, 2013). “Symbolic Interactionism” (Meltzer, 2020) could be seen as an example of constructivist thinking about communication, in that it looks at how symbols in general and language in particular shape social interaction and the meaning-making-process for individuals (Wood, 2013).

Maturana can be seen as a constructivist thinker in that he acknowledged the interplay between the meaning of social context and individuals’ inner processes contributing to shaping of exchanges (Maturana and Varela, 1987). With his autopoiesis- theory, he contributed insights into how communication informs the self-organization and coordination of living systems, including human societies (Maturana and Varela, 1987)

Constructivist thinking about communication overlaps with social constructionist perspectives on communication in that both acknowledge that context is a significant ingredient in meaning -making (Wood, 2013).

Wittgenstein (Wittgenstein 1958) is one of the theorists who began to understand the meaning of communicational activities more contextually and became most known for his doctrine of "language games", which became a study of language use within its context (Levinson 1992). Pearce and Cronen are social constructionist communication theorist who applied some of Wittgenstein's thinking, when developing a communication theory called "coordinated management of meaning" (Pearce and Cronen, 1980). This theory understands communication as a co-created space that emphasises on the interplay of a variety of contexts that people sit in whilst they are having an encounter with others (Pearce 2007).

Whilst both, social constructionist and constructivist theories on communication acknowledge the roles of individuals' internal processes and the social contexts when making meanings and realities, difference lies in the balance between these two components. Constructivists tend to emphasise more the individual agency and cognitive processes whereas social constructionists focus on the socially and collective locus of making meaning (Wood 2013).

I think of my conceptualisation of communication as constructivist, in that it is relativist, it acknowledges the influence of contexts, and in terms of balance between individual- and social- , it gives more weight to individual influences on what is co-created in communication; however, I will employ one element of a social constructionist communicational framework that is often referred to in systemic practice and that I thought is helpful for the purpose of this study is the "Coordinated Management of Meaning" (Pearce, 2007). According to Coordinated Management of

Meaning (CMM) theory, people communicate in order to make sense of their social environment and coordinate their actions with others. People tell stories (narratives) to make sense of and share their experiences with others. These stories influence people's perceptions of reality and communication styles (Pearce 2007). Out of this understanding, which I see located in the intersection between a constructivist and a social constructionist perspective, I have selected the LUUTTT model to help identify and label narratives within literature and the data which theory and practitioners refer to when talking or writing about MDT communication.

The categories it offers are as follows:

Lived stories – what we did or are doing Unknown stories – information that is missing

Untold stories – what we choose not to say

Unheard stories – what we say that isn't heard or acknowledged Untellable stories— stories that are forbidden or too painful for us to tell. Story Telling— the way we communicate.

Stories Told— what we say we are doing

I had outlined in 1.3.2 my philosophical orientation in relation to the research paradigm I refer to and also positioned myself within the wide landscape of systemic practice and research.

Above I have explained how I see my constructivist research paradigm as basis for how I conceptualise communication in this study. I showed how I see the relationship between a constructivist and social constructionist perspective on communication

overlapping and I explained that my philosophical beliefs correspond more with a constructivist perspective; my critique to a social constructionist perspective and for example of the overall CMM model lies purely within my beliefs about how much of the co-construction of an interaction I see based on an individual's perspective and how much on the social contexts applying to the interaction.

In terms of design, working with the above definition and conceptualisation of communication meant that I paid attention to team members' meaning making of their communication with each other and that I was interested in exploring the contexts they were referring to when creating meaning of the communication. That is why the study is designed to collect data from interviews, rather than from my own observations. I am explaining this in more detail in the design chapter when introducing my planning of the semi-structured interviews.

Since the idea of MDTs is to allow different perspectives to influence each other with the purpose to create a richer, deeper and more individualised response to individuals with mental health struggles, communication between differences is of particular interest in this study.On the one hand, one could think of it as a very particular kind of communication; on the other hand, we can see communication always being about difference talking if we consider each person and their context as "unique" in the way John Shotter (1993) spoke about the process that happens when two unique human beings make contact. I am using a citation that refers to a two-people encounter, but I see it as applicable to encounters in general and therefore suited to define communication in an MDT context in the way I understand it.

"…unfolding process in which two unique human beings, occupying unique places of

positions in the world, with two unique biographical projects come together to make some kind of contact with each other, motivated by the very fact that, due to their differences, there is a possibility that they might fulfil in each other what singly they lack." (Shotter, 1993, p. 135)

In that way and within a constructivist-systemic conceptualisation of communication as described here, I have also thought of MDT- communication as "exchange between difference". I selected literature that is introduced and discussed in chapter 2 with orienting myself along the above described conceptualisation of communication in MDTs.

Whilst the above introduced definition and conceptualisation of communication corresponds with my onto-epistemlogical stance and emphasises subjectivity, co-construction, context-related aspects and identifies ambiguities, nuances and complexities, it is making it hard to generate hugely generalizable, cross-contextual insights. Additionally, in terms of limitations, researching communication from that perspective is resource intense.

1.4 The NHS context of this study

MDT case discussions are embedded in an organisational context based on a medical understanding of "evidence" and "evidence-based practice". The NHS NICE guidelines (National Institute of Health and Care Excellence, 2022) look at mental health through the diagnosis that is given to certain mental health struggles and give direction to what is seen as the evidence-based treatment for each of these diagnoses. The classification of diagnosis applied is the ICD11, International Classification of Diseases, Eleventh

Revision (WHO 1992).

This sets the ground for a multi-disciplinary exchange based on an epistemology that could be seen in contrast to many ways of knowing within all but the medical disciplines that are invited to form the exchange. Whilst organisational policies request an exchange between these contrasting ways of understanding mental health, they don'tseem to give much explicit guidance as to how this dilemma can be worked with, but some implicit guidance comes from setting a hierarchical structure by basing the referred evidence base and applied classifications and practices mainly on one of the epistemologies (DOH, 1999, 2007a; Wagner, 2004).

This context of a dominant medical discourse can be understood as a significant and influential part of the context in which MDTs operate. It illustrates one of the debates that have been generated over time from research and practice (Pilgrim, 2014). A historical context to this debate shows the developments that have happened over time, and whilst parts of the mental health professionals' community may experience a sense of stagnation or paralysis in relation to this debate, a wider historical perspective highlights that several possible influences, (e.g., anti-psychiatry movement and cybernetics) have already led to changes. One could see this also in NHS policies that request a variety of representations of mental health concepts to influence mental health practice and MDT case discussions (DOH 1998, 2015). The selection of concepts that are invited, are referring to bio-psycho- social aspects of human functioning when working within mental health teams. These are currently often represented by psychiatrists, nurses, psychologists, systemic psychotherapists, occupational therapists, social workers, child and adolescent psychotherapists (Pilgrim, 2014). Asking this or

similar configurations of disciplines to come together and find ways to consider a person with their challenges and find helpful ways to assist them in meeting those challenges seems a complex task. When then noting that the disciplines come with significant differences in the epistemologies they refer to (Colombo et al., 2003) and the power dynamic that comes into play when equipping one perspective with more weight than the others, one may get a sense of the ramification which seems to lie in the task of collaboration and the type of communication this requires. Moving on from this direct surrounding of NHS MDTs to a broader one, it seems significant to look at what surrounds policy making and resource distributions.

According to numerous governmental publications, the supply and demand for public mental health services within the UK seem to have been out of balance from before the pandemic (Francis-Devine et al., 2021). The Covid19 pandemic has further impacted this already existing disequilibrium (Scally, 2021).

The Health Foundation most recently (2022) released a briefing outlining these challenges and formulating the edges of this development in that they warn against the impact of insufficient mental health care on increasing mental health struggles amongst children and young people. They formulate this as a risk to society's future health and prosperity (Tinson et al., 2022). They say that addressing this needs funds and action as well as reliable data to enable services for expanding needs.

This outlines a significant pressure when looking at the context that the current societal situation within the UK constitutes and how this impacts on the NHS, embedded in this context; subsequently dealing with these pressures within individual NHS trusts and further down organisational structures within teams, as professionals.

The need for more reliable data for improving mental health services is mentioned in this wider context and corresponds with research that explored the provision of mental health services on a more specific level and relevant to the subject of interest within this study, the functioning of multi-disciplinary exchange within community mental health teams. MDT exchange is often seen as a vital part of work within clinical NHS teams but is also seen with some controversy considering limited resources being available (DOH, 2010).

According to governmental publications, MDT working in general should improve health care by including a variety of professional views within care planning (DOH, 1999, 2007a; Wagner, 2004).Some publications state that it is well established that MDT working makes mental health care more effective and highlights the need to understand better how multi- professional working can be achieved (National Institute for Health Research, 2012). Bhaird refers to this as an assumption and argues that MDT working, formalised in MDT is a resource-intensive way of working, but has not been empirically researched sufficiently and adequately to come to understand how effective they are (Nic a Bháird *et al.*, 2016).

"Case typology" within NHS Camhs Teams

Since the language that is used in NHS publications often refers to a medical perspective (Pilgrim, 2014) on mental health, the types of cases seen in CAMHS are often referred to in terms of the diagnosis that is given to a child and young person and one could see these as a typology of cases. From a constructivist perspective this may seem a reductive view on people and mental health, but I will present here a list of

diagnosis that are made and responded to within Camhs, which could be understood as a "case typology" within NHS CAMHS teams. The Statistic Manual of Mental Disorder (DSM) (APA, 2013) and The International Classification of Diseases (ICD) (WHO, 2018) are commonly used in the UK for classification of diseases, including mental health disorders and specifically child and adolescent mental health disorders (Carr, 2015).

From the above classifications, I have formulated the following CAMHS Case typology:

Neurodevelopmental Disorders

Mood Disorders

Anxiety Disorders

Behavioral Disorders

Trauma Related Disorders

Substance Use Disorder

Psychotic Disorders

Obsessive-Compulsive Disorders

Gender Dysphoria

Disruptive Disorders

Other Mental Health Conditions

In terms of the nature of the case that the team discussed as part of this study and as described in more detail in the findings chapter, is relating to a young person struggling with mood problems. In terms of above case typology, the case corresponds to diagnosis within the "Mood Disorders" classification.

1.5 My research aims, identified literature gaps and my research questions

1.5.1 Research Aims

Camhs Team Members' experiences of communication practices during MDT case discussions are the subject of interest. Within this research communication processes are conceptualised as phenomena, that participants co-construct within their different contexts, such as personal -, relational -, team -, organisational -, geographical and political surroundings.

Case discussions are an element in MDT working, where multiple professions meet within a formal forum and with more than just one other professional (unlike in supervision or informal professional exchange between colleagues) to do care-planning (DOH 2015). This is an important aspect of MDT working. The people who are involved in this practice are team members because they are the ones directly experiencing the communication practices, as well as some of their impacts and outcomes.

The aim of this research was to gather empirical material and provide its analysis to complement the current research basis in this field. Capturing team members' experiences of communication practices during an MDT case discussion and the meanings which team members attach to these can provide insight into what and how different interactional aspects are at play when cases are discussed within MDT forums. My understanding is, that exploring the meaning that team members give to these

processes in relation to themselves, others in their team,
their organisation, and service users will inevitably influence their way of interacting/ communicating in future and are therefore worth understanding more about.

1.5.2 Identified literature gaps

To demonstrate how the research questions fit within the current state of research in the field of MDT case discussion communication, I am providing a brief literature synthesis here and the research gaps I identified from it. My literature with relevant referencing is presented and discussed in more detail in Chapter 2.

As a constructivist and systemic researcher, I on the one hand sought literature aligning with a constructivist systemic conceptualisation of communication and conceptualising MDT communication as "Different perspectives talking" whilst also exploring literature that refers to narratives applying within an NHS-organisational context. My search therefor included NHS publications, which I found not being defined onto-epistomologically by their authors and it included post-modern, constructivist, constructionist, and systemic literature.

In summary, the literature documented significant heterogeneity in how MDT working is organised in different teams and that this is determined locally in each team, depending on local contexts (for example, organisational, socio-political) and influences coming from individual team members and their contexts.

The literature also spoke about a lack of evidence regarding the effectiveness of Multidisciplinary Team (MDT) methods in providing care for individuals with mental health issues and a need for more insight from empirical research.

Shaw (2007) specifically highlighted the dearth of research on negotiation processes among different professions within MDTs, suggesting a lack of clarity on communication processes applied and their impact.

I looked at what aspects of MDT communication had been explored and found insights relating to challenges and barriers to MDT working, MDT decision-making regarding referral acceptance or -rejection, the interplay between different mental health beliefs in MDTs, inclusion of clients in making meaning of their struggles with mental health, empirical examples of attempts to integrate different perspectives into a shared view on clients, leadership, power dynamics and possible meanings of hierarchy in MDT case discussions as well as relational-emotional processes in MDTs. Whilst this seems a wide range of aspects of MDT communication that had been explored, it also highlighted that a broad perspective on MDT members' experiences of the phenomena at play in their exchanges had not been inquired about. The literature I looked at addressed specifics and enquired apove the particular areas of interests (as listed above), but did not give an overview of what and if other phenomena may be experienced by team members during their case discussion - MDT communication.

In the following section I show my translation from research interest and the research-gaps identified from my literature search into research questions.

1.6 Research questions

This section introduces the research questions that I developed. They are a result of considerations relating to my research interest, the aim I had when planning and conducting this study and on my understanding of some of the research gaps of the

currently available insight relating to MDT case discussion communication.

Research aims and questions help give direction for a piece of research and also for articulating this direction to the readers (Davies, 2018). At the same they may invite linearity when thinking about this study, in that they can be suggestive of my research working towards "the answer(s)" which would be a more positivist way of working with research questions. Looking from a systemic-constructivist onto-epistemological perspective, I consider them as direction. I am aware of the limitations of framing and naming phenomena and the trap of representationalism that can come with it (Davies, 2018).

I therefore used the research questions in this study with flexibility, in that I paid attention to results that seemed to respond to the research questions, but I was also curious about results that emerged as a "by-product".

The research questions I formulated on this basis are

1. What are team members' experiences of communication practices in their MDT case discussions?
2. What contexts do MDT participants experience as relevant in their case discussions?

The first question addresses MDTs' team members' experiences directly. Due to my understanding of meaning being dependent on context, I felt it was significant to also aim at understanding what contexts participants may refer to when making meaning of their MDT-case discussion-communication.

The research design, including the questions that I used within the semi-structured interviews was set up in a way that seemed to me most promising in generating data that would bring insight into the formulated research questions and is described in more detail in Chapter 3, where I talk about methodology, including the design of the study. As indicated earlier, I took guidance from the research questions when designing and evaluating the study, but I was also curious about additional results that I had not systematically planned for. Chapter 5, which introduces my findings speaks about both areas of findings, the area that relates to the research questions and the area that came as addition and relates to insights about the use of research-methods.

1.7 Pre-existing ideas on what I may find - my experiences of what happens in MDT case discussions

Because my research interests are informed in part by professional experiences in UK mental health teams for children and adolescents, it seemed important to draw attention to, but also make transparent to the reader, what ideas I had developed about MDT case discussion communication. I worked within 6 different mental health teams, 5 CAMHS teams and one adult mental health team, 2 CAMHS teams were specialised on Looked After Children (LAC) and 1 CAMHS team was specialised on severe mental health, two were generic.

I am introducing this in form of the memories and impressions I have from my practice. It aims at illustrating what informed my understanding of MDT case discussion communication before starting this study. I find this relevant, because it shows what

defined my own MDT-context when developing curiosity about a scientific way to find out more about how MDT communication is experienced and what people see as influencing it. By defining my own influential contexts (personal and professional), I am staying true to my constructivist-systemic perspective and acknowledging myself as an active ingredient within the research process and results.

- My experience has been that every team I worked in was organising the MDTs differently in terms of attendance, frequency, length, which cases get discussed.
- One team I worked in held lots of complexity in discussions; it was a very stable team with long standing relationships and many experienced team members; reflections of process were welcomed, although time pressures were making this hard.
- One team seemed very task-oriented; I thought of the leadership level as possibly feeling threatened by debates; the leadership was mainly held by the team manager, because the psychiatrist was not present very much; the team manager was new to the team and new to the role; as a team, we felt in a dilemma to challenge the pace of case discussion and help invite reflection, because we noticed, alongside the power that the team manager held in her role, there was vulnerability through being new in that role and in the team.
- NICE guidelines and the medical model thinking seemed central in most teams, except the LAC teams, where trauma-focused thinking took precedence.

- NICE-evidence-base-discourse seemed a taken for granted knowledge in all teams; my experience was that it needed time to be available and an invite to be able to question the dominant narrative or bring alternative thinking.
- Active inviting of complexity and difference did not happen often, and I felt this was organised by time pressure.
- In one team this seemed mainly directed by how the Psychiatrist was inviting this; the psychiatrist was male/Asian and was not challenged in keeping case discussions one-dimensional and practising a directive leadership style; powerful through discipline and gender, but less identified with power through culture. And the team, similar to the other team I introduced above seemed organised by fear to challenge the power that is paired with possible vulnerability or possibly the fear that challenging this person could be placed in a context of racism.
- My experience was that time pressure through high caseloads supports task orientation and stress (fear) can become one of the main organising factors in how the case discussion was held.
- In one team I worked, the team manager and the psychiatrist seemed to be in covert and overt conflict based on a power struggle and this seemed one of the dominant factors shaping case discussions in that it was a tense atmosphere; theteam seemed organised through loyalty dilemmas; I felt it was difficult to stay focussed on the content.

- One very small team (4 team members) seemed to work in a niche, disconnected from senior leadership; the team manager and psychiatrist were not very present, but two team members through their longest membership in the team seemed to hold significant power and directing exchange in discussions whilst openly disregarding senior management. As a newer team member this seemed difficult to challenge.
- My experience has been that reflections on the process of case discussions are not very often invited or given space and it can feel like a risk to be the person to suggest this.
- Depending on a variety of team dynamics, it felt more or less exposing as a practitioner to present my cases and be seen with my practice.

In summary, my experiences have been varied and every team seemed different to other teams in terms of the teams' nature of caseload, the team constellation (regarding experience in mental health, time in the team, ethnicities, genders, ages, present disciplines, number of team members), how MDTs were organised (leadership styles, presence, chairing, which cases get discussed, frequency, length, function, how much reflection was invited), additional social differences (temperament, interests, ways to communicate and so on). From my practice experiences, I was especially interested in the influences within MDT case discussion communication that resulted in different levels of integration of different views and also in different levels of invitation to different perspectives to present their views. I was curious to investigate other practicioners' experiences of the phenomena at play in MDT case discussions within a

scientific framework, and as shown in 1.5.3 this curiosity is also reflected in my research questions. They inquire about team members' experiences of their communication during one of their MDT case discussions and what contexts they consider influencing the communication.

I have provided the insights from my literature search in a synthesised form in 1.5.2 and the next chapter presents my literature exploration in more detail.

2 Literature Review - selection of pre-existing insights

2.1 Introduction

It seems common practice within recognised research to refer to “Literature Reviews” when presenting a selection of publications that build part of the context in which a piece of research can be situated. Certain ways to select and present material for literature reviews are more or less recognised within the world of science as meeting “scientific standards”, whilst others may receive more questioning, criticism or a lack of acknowledgement (Grant and Booth, 2009); a significant feature of the more recognised ways to review literature seems to be systematisation when setting up a process of literature selection (Aveyard, 2014). It is often based on the idea of capturing reliable and sufficient data to document “the evidence” that is present (Page et al., 2021). Some understand our historical and local philosophical surroundings of science, explaining why this seems the preferred way of using pre-existing insights. They connect it to Descartes and his strong emphasis on reasoning when making sense of things and insisting on what is known as “cartesian dualism” as a principle (Brown, 1989). I can relate to the link that is made here. At the same time, one could connect it to other locally dominant influences over time, like dominant religious or political regimes, or one could as well go further back in history, and then often Greek philosophers are cited (Brown,1989). Whilst the differences seem obvious, I can see a common thread in that all see a dualistic perspective, an idea of subject and object as having a significant tradition in this part of the world.

On the one hand, this traditional way of conceptualising literature reviews, which seems

based on insight and experience throughout the history of science and may therefore deserve to be included when setting criteria for a "good literature review"; on the other hand, it may limit considerations that are related to a particular piece of research and that could benefit from applying more creativity and a wider lens to researching literature. Although constructionist and constructivist research paradigms seem to allow for more flexibility when making choices and may seem more compatible with context-aware and systemic ways of looking at things, they can come along as quite prescriptive in other ways. Concerning literature reviews, this means that depending on where researchers situate themselves, they choose how to do this research task on a continuum between reproduction and co-creation.

I have been guided by Montuori's ideas on literature reviews (Montuori, 2005), who suggests a "creative inquiry" and views a literature review as an exchange between the researcher and a certain field. The researcher is a participant in putting together an interpretation of community discourses and owning one's signature within the presented material.

Having decided to work from a constructivist paradigm (Please refer to 3. Methodology for more detail), I have constructed a literature review that pays close attention to my research aim and emphasises transparency regarding choices around data sources, search strategies, screening, inclusion/exclusion of certain articles and the selection of insights that I made when referring to certain sources. I was looking at my choices with an understanding that this was already shaping and influencing the process and the results. I aimed to use material that seemed meaningful for my research question, and that would be recognised within a contemporary local research community.

"Contemporary" as in current, "local" referring to local to the research paradigm I am applying. I am aware that this perspective may be critisised by scientists and researchers who operate from a positivist position, in that they may hold the view that research should be generalisable and would otherwise not count as research (Guba and Lincoln 1994). However, this is where the paradigms and the beliefs which are forming them don't correspond with each other and from a post-positivist perspective this is acknowledged as difference in beliefs, rather than questioned in its scientific nature (Guba and Lincoln 1994).

I am aware that the above way of selecting literature was excluding insights which may have derived from less recognised but equally meaningful sources, for example, more rooted in practice-based insights.

Another contextual aspect of literature searches is the cultures that the researcher and the local research communities are part of. Cultures relating to disciplines and fields, but also cultures relating to the geographical and political surroundings that the research is being situated in (Montuori, 2005). I would add that "situating the research" happens under the significant influence of the researcher's choices when selecting and including/ excluding certain pre-existing insights.

2.2 Literature Search

Following on from the idea of understanding a literature review as a dialogue with the relevant research community, I understood the research community to consist of bodies and organisations as well as individuals who contributed to gathering and developing insight into communication during case discussions in MDTs. I included NHS-

commissioned research alongside research supported or commissioned by other agencies and organisations and self-funded research and literature.

From there, I widened the scope of literature that spoke more generally about communication at work and between differences.

Choices had to be made in terms of relevance and with consideration of the word count. It meant I left out more macro-level contexts beyond "communication in the local and present working cultures", which would have included a more global surrounding. I also omitted some more micro-level contexts that may have been more relevant if my data were not contributions that referred to individuals' meanings but if it would have been about analysing conversations between participants.

2.3 Sources

When planning my literature search and thinking about where to look for relevant contributions, I realised that part of the search had started before my formal research journey for this study. Since my interest in MDTs is rooted in experiences in practice, I had some publications in mind that I had read over the years of practising as a systemic therapist in MDTs, which I assume had added directions and mapping within the territory of understanding that I was moving in. It seems impossible to remember them in a systematic way, but I will introduce the ones that I see as having been most influential within my practice in MDTs, in paving the grounds for my research journey and forming initial sources for my dialogue with the writing community.

One was Arlene Vetere's writing (Vetere, 2007) on how Bio/Psycho/Social models are applied within MDT-working. It highlights the significance of relationships in a

working environment. It emphasises that systemic thinking offers the theory and methods for partnership working across the boundaries of team and family relationships and the professional boundaries within teams. Her thinking seemed an invitation to me as a systemic practitioner to offer systemic thinking in MDTs. As indicated in the introduction (1.6), I found MDT case discussions in various MDT teams to be often centred around linear and medical model thinking, neglecting the meaning of circularity in interactions and neglecting to consider professionals to be part of problems and solutions. Vetere cites a DOH publication (2006) and refers to a similar observation "…we see in the UK National Institute for Health and Clinical Excellence, in their *Guidelines on Health Behaviour Change* (2006), a complete absence of any reference to the family and wider kin groups " (Vetere, 2007). She emphasises the meaning of relationships and emotions in health and mental health within all relevant systems, including families, teams and organisations. She speaks about ways systemic contributions can aid an integrated theoretical structure for formulation and practice in MDT working. It can do this without challenging preferred identities and ways of thinking (Dallos and Vetere, 2009). There is some insight from DOH investigations that helpful communication and respectful working relationships with service users are essential for healing and rehabilitation (DOH 2004).

Another reading that influenced me before starting the research journey and directed my thinking more towards the "untold and unknown stories" when considering MDT communication was "The Unconscious at Work" (Obholzer, 2019). This writing is rooted in psychodynamic theory and emphasises the significance of "emotional forces" within organisations that happen on levels that people are less "conscious" of.

Translating this psychodynamic way of framing into systemic language, I understood Obholzer's writing to be speaking about untold and unknown stories within teams and organisations and the emotions that are considered the main players in these untold and unknown stories. This writing brought my practice awareness to the emotional past and present stories that team members come with and how these influence our encounters at work and the meaning we give to them.

Both above-mentioned contributions informed my thinking about MDTs before starting the formal part of my research journey. From there, when planning my research project, I started to look for sources that would help me develop a relationship with the insight that others had gained from their research and thinking.

I started my search on EBSCO, which is an online discovery service, accessible through the Tavistock Library. It includes many databases, with a wide range of contexts that cover the areas I considered relevant for my study.

Parallel to that, I was also looking through contributions and publications which were recommended to me by my supervisor, peers, by practice colleagues and I looked up citations from the authors used within the above-described pools of existing insights. In the next section, I aim to illustrate what I was searching for and how I selected literature that I would include in my review.

2.4 Search terms and inclusion/exclusion criteria

When considering what subjects and themes were relevant to my research interests, I identified communication as a phenomenon of interest. I considered teams and

organisations to be relevant contexts to consider. I also considered communication between differences and in the context of hierarchies or power differences to be of interest, and I considered multidisciplinary working to be another relevant context.
As a constructivist, systemic researcher, I wanted to use literature and research that would correspond with this perspective. Still, I also wanted to relate these insights to the type of thinking in mental health practice and research that informs the dominant narratives in this field. This formed a search that was looking for NHS-publications and post-modern, constructivist, constructionist and systemic practice and research literature.

When looking through contributions and deciding whether to include or exclude them in this literature review, I started by looking through the contributions made to MDT communication and relevant communicational and interactional organisational structures, then looking for a wider context that would still be relevant to MDT communication, like multi-professional communication or inter-agency communication. I thought they had similar features to MDTs, in that they also included communication between different perspectives, communicating in light of hierarchies and unequal power distributions and communication at work.
When looking through empirical material on MDT-working, I looked for studies that had been conducted after 1999. In 1999 significant changes within the NHS policies were outlined in relation to the integration of services and disciplines and significantly formed some of the contexts for current MDT working (DOH 1999).
Conceptualising my literature review as "talking to the research community" and

finding writers' philosophical context relevant in making meaning from their writing made me emphasise the people and some of their background behind the writing where this was possible; however, this was not possible relating to the NHS publications, as the authors were often named research-companies, or the writing was published in the name of departments/ ministries, rather than individual people. In the next section I present a review of the reviewed NHS publications and other publications that are presented by author.

2.5 Review of selected contributions – talking to people with insight and experience

2.5.1 Introduction to the dialogue with the writing community

MDT-working is common practice within the UK NHS health and mental health teams, and this is based on a widespread idea that including a variety of perspectives in care planning will increase the quality of health care. The idea is manifested in numerous guideline documents which emphasise multi-disciplinary care (DOH 1995, 1998, 1999, 2001, 2007a, 2007b, 2009).

A lack of evidence for the level of its helpfulness in offering care to people with mental health struggles seems to have been referred to when looking through a wide range of publications in the field (Colombo *et al.*, 2003; Cott, 1998; Fay *et al.*, 2006; Galvin and McCarthy, 1994; Nic a Bháird *et al.*, 2016; Rees *et al.*, 2004; Shaw *et al.*, 2007; Simpson, 2007). The views on cost-effectiveness also don't seem to give a clear picture. Shaw (2007) points out that *"Processes of negotiation between members of different*

professions and their impact on patients remain little researched. In consequence, the effectiveness of multidisciplinary teams has not been demonstrated…." (p.22)

From the number of publications on this subject, I would argue that significant research has been undertaken, but that the picture it gives about clinical-, or cost-effectiveness is not unified, making it hard to take a polarised view on "effective or not effective". The terms "effective" or "cost-effectiveness" are often not locally and explicitly defined. They would need a more specific description of stakeholders, their expectations and investments and reference points whose effectiveness and costs are being considered. Whilst less accommodating to polarisation, the rich landscape of contributions invites looking at the phenomenon of communication in MDTs in more detail and with a local connection. It may constitute a map that can give orientation when planning and conducting the MDT exchange. The variety in this landscape may be understood as isomorphic to "difference talking in MDTs" in that each contribution is situated in the epistemology of the author(s), and the same phenomena would be understood accordingly, which then, when making the authors talk to each other may at times seem contradictive or confusing because the fundaments they stand on are different places in this landscape, like a different country that uses different language and a different culture. Nevertheless, the idea is that it will help to show some of the discourse contexts in which this study is situated and illustrate the research gap to which it speaks.

2.5.2 Contributions from within the NHS

As a response, not only to a gap in understanding and doubt concerning some ideas of effectiveness and cost-effectiveness of MDTs but embedded in answer to global

recession and austerity, policymakers have indicated plans for *"an information revolution around mental health and wellbeing"* (DOH, 2014, p. 11) and created the Five Year Forward View – Plan (FYFV) which set out to better connect primary care, community services and hospitals, to better tailor services for personalised care and through more connected communication to grow into networks of care as opposed to individual organisations. Another aim was to offer more preventative interventions that support people in improving their health and well-being through better choices. The idea was that new care models would lead to new types of MDT-working. The variety of models was captured on a continuum between uni-disciplinary to transdisciplinary working, which aimed for flexibility that allows for locally influenced structures to fit local needs (DOH 2015).

Plans specifically pertaining to MDT working were made and translated into guidelines

(DOH 2015), and as part of working toward more integrated care, a national steering group was formed (CICS for Clinical Interface Committee) "broader clinical leadership advice and guidance on integrated care." (DOH 2015, p.32)

One piece of their work was devising an MDT handbook and there a definition of MDT is provided: "A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations." (DOH 2015, p.12). Although the definition indicates communication between differences, the document does not comment on how differences can communicate and misses to acknowledge the complexity implied in this task.

As one of the attempts to implement the changes outlined in the FYFV and to create a blueprint of how the change nationwide was envisaged, the NHS invited individual organisations and partnerships to pioneer the changes and to become what was named "Vanguards" (DOH 2016) and created projects that would implement aspects of the FYFV.

The implementation of FYFV was evaluated by Cordis Bright (2018), a research company, who describe themselves as an "independent evaluator". I will introduce a few of their findings, with the aim to capture further developments in policies, their operationalisation and how they are made sense of within the NHS organisational culture, as the NHS commissioned it.

In relation to communication and interaction between professionals, the evaluators saw cultural barriers between services and between professional groups as having contributed to unsuccessful integration efforts and suggest that integration requires professionals to "put interests of service users before professional cultural norms and be prepared to work in different ways". They conclude with the need for "more effective collaboration" and state that "partnership working" is essential, as well as "accountability" in decision-making (Bright, 2018).

The evaluation seems like the original NHS guidance to lack substance on a content level, in that meanings that seem implied in terms like "effective collaboration", and "cultural barriers", remain undefined and therefore their meaning stays unclear.

Wilson and colleagues (Paul *et al.*, 2021) evaluated the Vanguard work-evaluation and commented on some similar aspects. They found that the evaluation report failed to

provide nuanced findings from the Vanguard interventions and did not contextualise it within a landscape of insights from other sources, which in their view made insights lack credibility.

Another aspect related to the level of detail that was used for the evaluation, in that it stayed somewhat vague, for example, asking for the "evaluation of everything" and that more specific questions would have made explorations more meaningful.

I agree with this view in that, to me, the guidelines stay too abstract to function as orientation and concrete guidance, support or structure for teams as to the "how?" of "effective" or "collaborative" communication in light of difference in disciplines and power imbalances that is set up through NHS guidelines on MDT structures.

When applying Pearce and Cronen LUUTTT communication model here, one could say that the writings introduced so far represent some of the NHS organisational stories that are told. From plans, guidelines, and NHS internal or commissioned evaluations introduced above, MDT communication remains an aspect of working that is referred to with little transparency around conceptual thinking. Meanings of phenomena are often given more implicitly, but at the same time with a high level of certainty in the language, implying that there is a generalised way to understand and make sense of phenomena like "communication" or "collaboration" and overlook the need to contextualise these terms in frameworks of thinking to give them meaning. This way of relating to knowledge is described as "taken for granted" knowledge in social constructionist thinking (Burr, 2015). Social Constructionist theory makes visible how the construction of knowledge that one person or group of people tell a story about, becomes an "object" of consciousness for the people the idea spreads to. The idea

becomes an objective truth and is “internalised” in the consciousness of the society or parts of society (Burr 2015).

Without contextualisation of those terms, which leaves meanings un-articulated, there can be an impression that when leading on the strategic level of policymaking, there seems little attention given to the existence of the variety of epistemologies which conceptualise relevant phenomena in fundamentally different ways whilst at the same time claiming to be integrating and inviting them on an operational level. It implies that there are stories that are not told, the stories about beliefs.

The next chapter looks at contributions that seemed conducted in a way that lets the lived organisational stories shine through some more and touches on some untold and unheard stories.

2.5.3 Contributions from other writing communities

Many of the contributions share the premise that MDT working is about bringing together different perspectives on mental health and making them work in favor of clients and in support of the teams and their work.

They acknowledge and highlight challenges and barriers they saw when trying to gain insight into how MDTs operate.

2.5.3.1 Challenges and barriers to MDT-working

Several authors make a point about challenges that come with the variety of differences that the professional groups that form MDTs encounter. On top of the general differences that there are between individuals, they mention “professional identity”

which often is linked to certain world views (Galvin and McCarthy, 1994; Norman and Peck, 1999; Ovretveit 1995); the difference in educational background (Freeman, Miller and Ross, 2000), pay (Bailey, 2004) and status (Norman and Peck, 1999). Ovretveit (1995) sees all these as holding potential for divergence or conflict and needing ways to be tolerated, communicated, integrated, negotiated, and synergised into shared and coordinated responses to people's mental health struggles. The difference in ethnicity is not mentioned, and it may be that a high level of homogeneity in ethnicities amongst therapists is reflected in "ethnical diversity: not featuring in above considerations when thinking about communication. A governmental report (Health and Social Care Information Centre from 2013) refers to England and Wales and speaks about the underrepresentation of Black, Asian and Minority Ethnic (BAME) individuals in the group of therapists. They state that BAME individuals make up only 9.6 per cent of qualified clinical psychologists in England and Wales, in contrast to 13 per cent of the population. One study (Lankshear, 2003), which looked at how team conflict around work allocation was dealt with, suggests that the differences pointed out above, alongside organisational demands, can lead to professionals becoming protective of their professional identities and using demarcation as a conflict-response strategy; other conflict-response strategies that were found were isolation, minimising difference and equalising, trying to build alliances with other individuals as well as trying to convince others in covert and overt ways of one own's views. The author warns that the rhetoric of cooperation and collaboration may overlook the above types of mechanisms that teams may employ to deal with conflict, which can result in "tribalism" (he cites Beattie 1995) or jealousy and protectionism (he cites Ovretveit 1995).

Hall (2005) also wrote about cultural differences between mental health disciplines and how they are informed by values, beliefs, attitudes, customs, behaviours, and the professional cultures developed alongside the different professions. Hall found them to reflect historical aspects of a profession and factors relating to social class or gender and that training within the different disciplines often encourages differentiated socialisation into a profession. This may form a barrier in interprofessional working as the training does not necessarily involve practising dialogue and synthesising with other disciplines as much as it reinforces certain own discipline values and corresponding language and jargon.

Some of the challenges that Angela Foster (1997) found in her practice as CMHT advisor were work-related stress resulting from working with risk as well as from the anxiety that team members may experience when working with clients where there is a risk (for example, self-harm or suicide). Foster found that the impact of stress and anxiety on communication in a multi-professional team can result in an attempt to hold on to the most familiar, which can make listening and negotiations between difference difficult, but also challenge the ability to tolerate and hold ambiguity and uncertainty about insights and understandings as well as care planning. Foster found that this may hinder a sense of team and undermine the support that teams can feel from relational emotion regulation that can bring containment for stressful feelings like anxiety or overwhelm. For individuals, this can result in a sense of isolation during stressful times. As a result of little containment from a sense of team, heightened emotions and a sense of stress may become the norm. Apart from being a major challenge to staff retention in

mental health teams (Yifeng *et al.*, 2018), stress can impact on the work with clients and the mental capacity to communicate and act in their interest and for their benefit (Foster, 1998).

Further challenges for helpful working together, which are mentioned in several studies (Kennedy and Griffiths, 2001; Norman and Peck, 1999; Onyett and Ford, 1996; Rees *et al.*, 2004), can be ambiguities in roles and responsibilities. For example, when holding multiple simultaneous roles such as care coordinator/ team manager/ therapist/ supervisor. Limited resources as well as organisational guidelines and team culture being in contradiction can add further confusion or stress to the work in general but communication in particular.

Related to limited time resources, one study by (Donnison, Thompson and Turpin, 2009) documents a perception in MDT case discussions that a lack of time can trigger impatience and then hinders a more thorough discussion of a case. The authors found that limited time resources are perceived as pressure, and staff experiencing this in the form of anxious feelings can contribute to a stressful atmosphere for conversation and be perceived collectively as "impatience".

The same authors (Donnison, Thompson and Turpin, 2009) also point out that limitations in the knowledge and awareness of other team members' theoretical or conceptual reference points make it hard for team members to understand each other, leading to disengagement or competition. Against the backdrop of these challenges, teams continue to aim for integrated care and some of the ways these attempts can look are presented in the studies that I introduce next.

2.5.3.2 MDT decision-making regarding referral acceptance or -rejection

Discussing new cases seemed one of the most applied functions of MDT meetings (Nic a Bháird *et al.*, 2016). Part of a new case being discussed is often a decision-making process to determine if a case gets accepted onto the team's caseload or rejected. I was interested to understand more about how MDT communication may look in these case discussions and how decisions were understood to come about.

Charles King (2001) did a qualitative study within a CMHT, specialising in "severe mental health", with a focus on the process of decision-making in relation to accepting or rejecting cases onto the team's caseload. He understood the contributions of team members to portraying the team's tendency to lean towards a "diagnosis practice" within this process, which the psychiatrist would lead. Each referral was looked at with the question if they met the criteria for diagnosis of those psychiatric illnesses that were considered "serious mental illnesses" under psychiatric diagnostic criteria and referring primarily to "schizophrenia", "manic depression" and "severe depression". Within the team, this led to tensions as other disciplines would have liked to see more consideration given to the biopsychosocial aspects of a person when making such potentially detrimental decisions.

King (2001) contrasted the above-described diagnosis process against a multi-dimensional way of decision-making. He acknowledged that diagnosis practice might offer a straighter way of establishing a CMHT boundary but offers a less comprehensive understanding of the case and leaves out significant factors that influence a person's mental health. The time constraints that many teams are under (Johnstone, 2018; Fay *et al.*, 2006) may be important to take into account as organising factors when thinking

about what may come in the way of realising multi-dimensional views on individuals. Additionally, to the points made above, King argues for doing this with sensitivity to the characteristics of the local population and the regional services that may or may not be available. Slade et al. (1997) seem to support this and emphasise that the interplay between the application of guidelines and finding the best-suited relationship to these guidelines through feedback from local staff and conditions is required to tailor mental health services to local needs and locally available resources.

One could argue at this point, that what King (2001) suggests is exactly what is being requested from MDTs through NHS guidelines in that the presence of multiple disciplines is supposed to ensure a holistic and contextual view of individuals.

King supports the idea of multiple perspectives adding significant value to mental health services and the people who need them. At the same time, his contribution illustrates how inviting multi-dimensional perspectives alone through having representatives of different disciplines present does not mean that multiple dimensions are being considered, applied, or synthesized. The author makes his points about how team dynamics, for example through the dominance of one perspective can come in the way. Many contributions in literature focus in one way or another on possible meanings of a hierarchical structure in MDT case discussions and will be considered further in detail later in this chapter.

However, from the contributions introduced above, team dynamics involve more than just dominant or powerful team members imposing their will on less powerful ones. The next section will look closer into that. It will focus on how the differences in epistemologies between clinicians may influence communication at a point when

making sense of clients' mental health struggles becomes relevant.

2.5.3.3 The interplay between different mental health beliefs in MDTs

Within MDTs, the idea is that there would be influence from a variety of perspectives within the communication and result in a multidimensional understanding of a person and their mental health struggles. Foster (1998) names psychiatrists, nurses, psychologists, social workers, and psychotherapists as typically represented disciplines in MDTs. These and additionally occupational therapists are mentioned also by other authors (Colombo *et al.*, 2003; Peck and Norman, 1999; King, 2001; Nic a Bháird *et al.*, 2016).

Colombo et al. (Colombo *et al.*, 2003) investigated the sets of professionals' beliefs around mental health struggles that the different disciplines hold. They found that the beliefs tend to correspond with what may be assumed for each discipline, but that each discipline acknowledges and recognizes influences from factors that are commonly associated with other disciplines. For example, social workers were found to connect mental health struggles with a response to social injustice and difficult social living conditions, whilst psychologists referred to the interplay between feelings, thoughts and behaviours combined with life experiences when thinking about the aetiology of mental health struggles. At the same time, both groups also acknowledge and pay attention to the other discipline's main reference points. Colombo and his colleagues found that "Few disagreements arise when working with patients described by all disciplines as 'clear-cut'". For example, social workers support the need for medication and hospital

care for people who pose a high risk to themselves or others, and psychiatrists generally recognise the value of psychosocial interventions as part of the rehabilitation process. "In obvious cases, there's no problem, "…but with patients somewhere on the road between distress and illness, things can become difficult" (Colombo p. 1566). Colombo and colleagues found that when discussing cases less defined by risk, communication problems arise from practitioner groups maintaining their implicit model. They say that in these moments, the difference in power between the different ideologies can become most evident and relevant and that power is used to respond to conflict or disagreement, which can interrupt a synthesising communication process (Colombo *et al.*, 2003).

2.5.3.4 Inclusion of clients in making meaning of their struggles with mental health

When considering MDTs, there is also a debate about how far clients could and should be integrated into the process of making sense of their mental health difficulties and Brunet (2022), a practising GP, talks about the impressions, that he took from seeing patients following a mental health assessment. He describes individuals' experiences of this and how on a fundamental level, patients did not feel heard or really seen within the assessment, but rather on the receiving end of a group of professionals who speak amongst themselves and then share a result that patients report to not fitting to their experience of themselves. This, he sees as results in a lack of trust in mental health services. Whilst insights within this contribution seem based on impressions, they bring practice-based insight and correspond to a study that was conducted concerning shared decision-making between professionals and patients (Farrelly *et al.*, 2016). The study introduced a model of shared decision-making called the Joint Crisis Plan for Psychosis

(JCP) as a response to the psychosis-related crisis and included professionals and patients. The findings suggest that the idea to include patients in the making sense process in the form of the JCP seemed to come with barriers for professionals, for example, being critical of patients' choices or not being trained to facilitate communication that fosters empowerment and choice-making but being socialised into a professional culture that expects knowing and certainty from professionals. These are just some of the barriers that lead to little success, and patients did not feel that their views and understandings of themselves had been helpfully integrated into care planning.

Oborn et al. (2019) conducted a study where they integrated peer workers into MDTs, who were individuals with experience of mental illness and accessing mental health services in the past. I saw the strength of this study in bringing and testing novelty in the practice of MDTs by experimenting with the idea of inviting people with experience of mental health struggles to the MDT discussion.

Oborn and his colleagues speak about the different "ontologies of knowing" and that when professional knowledge meets the knowledge of experience, one can see this as two ontologies meeting; one type of knowledge is seen as objective and related to "knowing about" a person's struggles with mental health and the other is subjective and related to "knowledge within" a supported person who struggles with mental health. Peer workers were part of MDT conversations. They were also part of the service that was offered to supported persons, functioning as a link-person between the professional team and the supported person. The idea was to integrate subjective and objective knowledge in making sense of a person's mental illness, planning, and delivering care.

They saw the tacit and experiential knowledge that peer workers came with to be embedded in unique socialisation, which then allows shared interactional space with supported persons. They understood this knowledge to hold insights that aligned embodied and local insight with care trajectories. They found that peer workers' unique interactional expertise and subjective way of knowing were distinctive and, at the same time, complementing contributions from professionals.

"Shared experiential knowledge of living with mental ill health could act as a point of connection between peer worker and supported person, earning the PW trust, and building rapport on which to base a therapeutic relationship. PWs' differential understandings of mental health challenges that people were facing – from a perspective grounded in their own experiential knowledge – complemented the formal expertise brought by the clinical team. PWs' embodied experiential knowing about living well with mental health offers further therapeutic potential as role models and by validating the way in which the people they sup- ported experienced and came to know their own mental health. Finally, peer workers' tacit knowledge was in part acquired through their experiences of receiving care and as such the multiple ways of knowing they brought could act as a bridge between the healthcare team and the people they supported. "

Integrating clients in MDT communication could be seen as adding another discipline with its own epistemology.

2.5.3.5 Empirical examples of attempts to integrate different perspectives into a sharedview on clients

Some papers described the different models that MDT teams may use to produce

assessments in form of formulations and/or diagnoses.

Within this section of the literature review I introduce specific authors and their studies in more detail to be explicit about what they looked at and what designs they applied. These are writings that are significantly embedded in practice and their strengths lies in testing communication-methods in MDTs that were experimented with. Whilst these are not large-scale studies and may not have brought about generalisable insight, they provide insights that can be built on or used for orientation when planning further research.

Strathdee and Jenkins (2000) say that many CMHTs have operated in a way that the different discipline groups have been undertaking separate discipline assessments and Colombo (2003) found that as well, but from other contributions, it seems that this has changed in many teams by now and may continue to exist more as a cultural legacy, rather than formal structures. From the literature, it seems difficult to gather an impression of to what level the integration of disciplines is being realised generally as it would require establishing to what level the different perspectives feature in assessments or formulations.

However, looking at individual pieces of research may help to illustrate how the implementation looks in different teams and how through the studies, different insights were gathered, which may help to identify more and less helpful features.

Donnison et al. (2009) found that using team formulation was one way that allowed teams to integrate a variety of perspectives. She also found that clinicians felt that responses to clients could be better tailored to their needs by being able to draw on

several different ways of working and a number of different views. Because the process of team formulation in this team was recursive in that it integrated feedback from the client, it seemed to further help the tailoring to individual clients' needs.

Shaw et al. (2007) examined the meeting and communication of different disciplines in a forensic mental health team when developing an assessment and applied a symbolic interactionist perspective to highlight the complexity of this task. They analysed structures and processes from the idea of 'intersections of multiple meanings' to illustrate the depth of difference that is at play within an MDT encounter. Symbolic interactionism originated mid last century in the US based on social science ideas influenced by for example William James, and Charles Cooley. It works with an understanding of a dialectical view of the relationship between the individual and society, in that individuals and society are constituted by each other (Meltzer 2020). Shaw et al. (2007) argue that the rhetoric often applied in relation to multi-disciplinary working does not address the complexity of the relational processes that are part of it. They found MDT working promoted limited partnerships between individuals, and participants seemed to experience interactions predominantly with reference to the hierarchical structures within their organisation. Through their symbolic interactionist lens, they understood the communication in MDTs as a reproduction of local structures within the NHS. Their understanding is that role-taking and role-making are, on the one hand mutually constitutive, but that the distribution of social power within an organisation sets a context for these role negotiations, and they do not happen in a vacuum. The guiding principles for professions and how they organise themselves

operate within their schools of thought but may pose dilemmas when they meet other schools of thought, dilemmas that their professional socialisation has often not taught them about, and the authors see the task to collaborate between professions in decision-making forums requiring highly innovative and tentative role-making.

Mitchell and Patience (2002) looked at one CMHT team that introduced innovation by undertaking joint assessments between a psychiatrist and another discipline. This meant that conversations with the clients were held jointly. They used a form to guide the conversation, developed as a team and understood to reflect a multi-dimensional framework of thinking. Further collaboration was emphasised by inviting multiple voices when the case was presented to the wider team post-interview with the client. Before developing and applying the form, the team had shared training to develop a shared vision of process and outcomes. Results document a shift in relationship engagements between disciplines and professionals, describing a clearer understanding of what and who was in the client's life and how this influenced his/her mental health. The results reported are anecdotal and do not go much into detail about how exactly the exchanges happened and how the issue of different epistemologies was dealt with in conversation, but it helps highlight the meaning that structures (joint training to set a vision, jointly developed assessment form, joint conversation with client and emphasis on multiple voices in team meetings) can have and here in creating a shift to what could be called “more shared meaning” and presumably more shared language when considering the form that was jointly developed.

Garven's writing (2011) documents evaluations of her work as an MDT consultant from a place of practice-based evidence, and she goes more into the details of the exchange between differences. She suggests that exchanges between the different epistemologies, usually aligned to different disciplines can be influential to each other when the way how they are practised is dialogical, which she defines through contributions from Bertrando (2007), Seikkula (2003). Within dialogical communication "…..reality is open to multiple versions and to negotiation. Therapists are more likely to view their formulation as a personal construct that has been socially constructed with others. This breeds a more open dialogue as it is easier to be speculative about one's ideas in relation to those of others. As Bertrando (2007, p. 89) says: 'We may define our therapy as "dialogic" ... only if the thera- peutic conversation acquires the characteristics of dialogue as delineated by Bakhtin (see also Seikkula, 2003): that is, a polyphonic cohabitation of different discourses and different visions from which a new vision — a new language — may possibly emerge, but where the difference of discourses is accepted in any case'. "(Garven 2011, p. 286)

Her evaluations are based on experiences using a reflective team process applied to MDTs. She was interested in how this approach can help team members engage in more dialogical exchange as she argues that this allows for more influence between the different voices. She sees it as inviting participants to identify for the time of the conversation with the idea that their view is representational rather than real, which she sees as equalling a second-order position in terms of "knowing".

As a former team member and current external consultant to multidisciplinary teams, Garven has found that it can be challenging to successfully combine a variety of

competencies, roles, and philosophical paradigms. She sees one constraint as the tendency to offer one's model as a solution to a colleague's problem. Whilst this could be seen as a natural response, it can be an isomorphic process in that a colleague's thinking and practice are being shaped around one's own thinking. Garven speaks about the risks that she finds in this way of practising MDT communication and points out that it can lead to confusion as a *"….flurry of different maps and frames are offered…."* (p.284). The other risk is that it results in competition between the different models *"…as clinicians lobby for their model to become the preferred on."* (p.284).

Garven refers to Trimble's (Trimble, 2002) understanding of the group process, where he describes that even while there may be a range of opinions present, this does not necessarily mean that the conversation will reflect variations. He points out that in groups, one voice may be the most hearable and silence all others, or participants may prioritise producing a monopolistic view and subordinate their unique voices for that purpose.

Garven has been working with the idea of inviting teams into a reflective team conversation to do a case discussion and she shares how this impacted in her view: She sees is it as a method to effectively assist teams in coordinating their many talents, concepts, and duties in a multidisciplinary setting. The postmodern and dialogical context it offers can assist teams in appreciating various realities, fostering a tolerance for uncertainty, encouraging curiosity about current events, challenging accepted beliefs, and fostering patience and trust, all of which are conducive to developing dialogical quality in their conversation.

She found that teams that are unfamiliar with systemic working have embraced these

second-order concepts and positions through participation in the Reflective Team Process (RTP). However, they may come from frameworks which would generically correspond more with first-order ideas. This happened without any official education. Teams appeared to be less interested in spreading their viewpoint when they were encouraged to connect their comments, listen to phrases that seemed to have significance for the speaker, keep the discourse open, and avoid "knowing too early". Garven uses Bateson's "binocular vision" to describe one of the qualities that participants can arrive at in that the dialogic habits become ingrained (Bateson, 1973), which heightens their sensitivity to difference and piques their curiosity about other approaches to seeing, listening, and speaking. Garven: "With these added connections, it is easier to be creative, and to see new, alternative pathways out of an impasse…… Garven cites Koestler (1964): " *It (the creative act) does not create something out of nothing: it uncovers, selects, reshuffles, combines, synthesises already existing facts, ideas, faculties, skills. The more familiar the parts, the more striking the whole'.* Garven sees placing MDT case discussions in a dialogic context through the RTP may be one way of helping teams engage with this creative process.

The contributions on formulations/ assessments/ diagnosis have highlighted some of the features of communication in an MDT exchange and have highlighted potential ways how this communication arrives at a point where one can talk about a "shared understanding", but it also highlighted some aspects that may come in the way of entering a form of conversation that allows for this result. Hierarchical structures and leadership roles both hold significant influence on communication processes and have

also been considered within the literature. The next section introduces some empirical findings and some thinking in this area of research.

2.5.3.6 Leadership, power dynamics and possible meanings of hierarchy in MDT casediscussions

Leadership in MDT- teams can have many different forms and levels of leadership and it is part of a hierarchical structure within MDTs and NHS trusts. Team leadership structures can vary between trusts and locations (Nic a Bhaird, 2016). Often there is a team manager and a consultant psychiatrist on top within the hierarchical structure. Bhaird found that how these roles are taken up and how the power and leadership tasks are distributed between those two can vary. Clinical or managerial accountability and responsibilities will vary accordingly. If one was to determine team hierarchy by pay scale, then the psychiatrist is undoubtedly on the top of the ladder; team leads often but does not always go next. In some teams, team managers are on the same pay scales as other senior members in the team, who may hold special responsibility within a particular discipline (Nic a Bhaird, 2016). In terms of gender and in the context of global feminisation-tendencies in health care (Geordan *et al.*, 2019), Lantz suggests from their review of English written literature on leadership positions in health that although the number of women in leadership roles is increasing, women remain underrepresented in healthcare leadership (Lantz, 2008).

Galvin and McCarthy (1995) talk about another hierarchical structure that is set within the NHS through the NICE guidelines and relates to the mental health explanatory models and how organisational structure relates to them. They point out that when the

medical perspective is given space above other perspectives, the multi-disciplinary nature of teamwork is undermined in that the disciplines may be present but don't get to influence views and decisions.

Like in King's study, this may not only have an impact on the quality of the actual decision but also in team dynamics. On an interactional level, he found that clinicians feel their expertise is not utilised in the way it could be if the measurement of need is done in a one-dimensional way, leading to individuals not feeling valued in their profession or expertise.

Additionally, this may leave confusion around roles, in that, on the one hand, guidelines request MDT input; on the other hand, hierarchical structures do not always cater for this, and then it becomes each team's task to negotiate roles.

Griffith's (1997) study examines the social structure of two recently created community mental health teams, contrasting the relationships they have with their team psychiatrists and how their MDT is named. The study shows how an authority role within the same formal hierarchical structure was translated into different leadership styles that had different outcomes. Different approaches to "team" implementation had an impact on how mental illness was classified and how the target group for services was defined. The nature of teamwork was critically impacted by psychiatrists' attendance or absence at team meetings and if the meetings were framed as "allocation" or "review." One team obtained some autonomy by postponing the addition of "inappropriate" patients to caseloads by taking advantage of the psychiatrist's absence to fight the bureaucratic framing of its duty as "allocation." The second team had regular meetings with its psychiatrist and was given a chance to participate in clinical case

"reviews," but discussions and conclusions were mostly made by the dominant professional.

He understood the analysis of team meeting transcripts to demonstrate how the two teams created distinct discursive repertoires that are subsequently used to categorise patients. While the role of the psychiatrist in one team was taken in a team-integrated way and included psychiatrist-chaired joint negotiations around formulation and diagnosis as well as decision-making around referral acceptance or rejection, the role was taken up differently in the other team. It meant that the psychiatrist was not present in team meetings and informed the team about his/her decisions in terms of referral acceptance/rejection and diagnosis. The meeting was called the “allocation meeting” and it seems that the MDT input was reduced to putting into action what had been decided elsewhere, which means that diagnosis and decisions around referrals are made without multiple disciplines influencing these significant moments in care planning.

The study seemed to look in a nuanced way at the communication that accompanied above processes and what is at play when collegiality and collaboration meet hierarchy and the tensions that lie in that.

Griffiths comments on the meaning of different conceptualisations of “team” and sees it typically used in contexts when it refers to a loose framework rather than a specific action plan. Whilst local societal culture and organisational culture may have some fundamental concepts about what teams should be like, there will always be a grey area where working arrangements must be discussed and agreed upon. He sees teamwork as a continuous practical achievement that results from the daily encounters and small-

scale conflicts of individuals tasked with making MDT- working a reality (Griffiths 1997). Griffith's study and his writing seems to emphasize the role making and role taking process as a moment where each individual team and their ways of being and coming together influences significantly how the structures are put into action. This highlights how the impact of optimising structures through policies and guidelines has limits in the way how it shapes relational processes from person to person within teams. This author applies great curiosity about the difference achieved within similar structures. Whilst acknowledging relationship and communication dilemmas that come with differences in power distribution, his writing also emphasises the local scope that teams and individuals hold. He considers teamwork needing continuous effort to negotiate daily encounters and highlights that societal and organisational structures cannot replace these.

2.5.3.7 Relational-emotional processes in MDTs

Arlene Vetere (2007) thinks about MDT communication across contextual levels and sees how on the one hand there seem to be macro-level initiatives that aim to aid mental health stabilisation across the population and acknowledge the vast impact neglected mental health needs can have on a human level, but also on an economic level. This includes an acknowledgement within services about no one field or way of thinking has all the answers and the need and benefit of cross-fertilisation of ideas across disciplines and services, MDT working being one part of this. On the other hand, she sees these initiatives as neglecting how these societal needs can be addressed on a micro level, which she refers to as relational/emotional processes.

"It could be said that in these days of biological reductionism, it is easy to forget that life is lived in relationships, and the quality of those relationships has much to do with how life turns out. Our lived relationships have both physiological and psychological implications. Confiding, supportive relationships and conflictual/hostile relationships can influence both vascular reactivity and cellular immune competence, for better or for worse" (Vetere cites Kielcolt-Glaser et al., 1993). Vetere highlights the negative impact of neglecting relational and emotional processes when considering mental health and interprofessional working and/ or working with families.

Hardwick (1999) also wrote about the meaning of emotions and relationships in a mental health work context. He sees the neglect of relationship and emotional processes as a risk. He thinks that this can lead to professionals not being in touch with their fears, possibly feeling paralysed, freezing or feeling overly responsible for ensuring a client's or colleague's safety or wellbeing; either can lead to avoiding working towards understanding and processing of difficult feelings or challenges in relationships. This can add to a blaming culture that divides individuals away from each other and possibly leads to scapegoating individuals or groups. Professionals may adopt overly protective behaviours if they believe that people feeling too challenged can end in disasters, for example when a professional interacts with one family member in a way that replicates distressing patterns inside the family without noticing and reflecting on it and this creates circumstances that make it unlikely that effective action will be taken. Hardwick suggests that the onus is on professionals to understand themselves and their relationships within their families so that they are aware of their strengths and

vulnerabilities and know what situations they may try to avoid, or which situations may activate individual professionals in a sense that they feel they need to protect themselves or rescue others.

Both Vetere (2007) and Hardwick (1999) refer to emotional processes. Although both seem to speak from a relativist paradigm, their construction of "emotions" is not elaborated on in their writings. Fredman (2003), who also seems situated in a relativist ideology, constructs emotions relationally and understands them as socially constructed. She acknowledges that there is no one universal story of emotion that is necessarily acceptable to all cultures. She believes we cannot assume a common language of emotion that accurately translates meanings and experiences between people. Instead, she suggests examining emotion as the story people weave of physical sensation, display, and judgments through multi-layered contexts of their relationships and cultures. When applying this to the argument Vetere and Hardwick make about including emotional processes in thinking about communication in MDTs, it highlights the significance of another contextual area at play when different disciplines meet and communicate.

2.6 Review of empirical literature material and relating it to communication theory

The dilemmas that are introduced from the empirical material from the literature above connect in at least one aspect, which is that they hold relevance for a dilemma which can be seen as being at the very heart of multi-disciplinary communication. It is the

integration of differences in a collaborative way, but under the influence of power differences. From the literature on MDTs, this is a part that seems under-theorised in that writings don't capture the dilemma and potential that both lie within this paradox explicitly. The described holds, on one hand, the aspect of "difference talking" and additionally the aspect of "unequally empowered difference talking".

Difference Talking + Unequally empowered difference talking seems relevant within leadership, communication, and making sense of clients' mental health struggles and the above empirical examples demonstrate how research initiatives have studied and experimented around those challenges.

They show and speak to the complexity of the task that is expected to be performed by health and mental health teams, whilst the thinking about communication that is drawn on, doesn't seem to address what could be understood as a paradoxical request. The literature presented here speaks about results though, about the results of processes and structures that are more or less successful when trying to integrate differing knowledge, skills, beliefs and values within MDT working with the aim to be most helpful to clients, whilst simultaneously to work against divergence that can come from unsuccessful attempts to synthesise difference in beliefs and power.

Bateson's concept of schismogenesis (Bateson, 2000) and related theorising could be helpful here, in that it accounts for and examines interactions between individuals or groups which can contribute to the progressive disintegration (Krause, 2007) or the creation of division. In his well-known book "Ecology of Mind", Bateson describes this and sees schismogenesis as potentially self-destructive to the individuals or groups involved and that therefore it was significant to develop insights into methods and ways

to help interrupt shismogenesis before reaching a destructive place. Bateson saw two categories of schismogenesis. The symmetrical one which is between categorical equals (rivals) and the complementary one which is between categorical unequals (submission and dominance). He saw certain cultural ritual behaviours as having the potential to either inhibit or stimulate schismogenesis in relationships.

If we conceptualise MDT work as cross-cultural work in a wider sense and consider "…. that cultural differences always have a high potential for opening up schisms and becoming vehicles for differ- ences in power and authority …" (Krause 2010, p. 393), then one can see both the symmetrical and complementary schismogenesis being a risk for teams and organisations. The risk of strengthening division appears if the aspect of difference is not given the consideration it requires to function as an asset to teamwork, as opposed to a nuisance or destruction in the worst-case scenario. For organisations and teams, the task is to organise difference, and this implies communication between difference in a helpful way.

The various examples given here show how within research programmes or innovation projects different ideas are being offered to organise this particular constellation of difference and its communication; the idea of dialogue in a variety of forms seems to appear as a pattern, in that it seems relevant to many of the ideas offered, for example applying a reflective team structure to MDT exchange, recognising integration of the psychiatrist in the case discussions as significant, giving opportunity for input from all disciplines within different steps of assessments, using a formulation process that includes multiple perspectives for making sense of clients' mental health struggles or giving value to multi-dimensional considerations when screening new referrals for

"severe mental health".

2.7 Summary of the literature review

Within the above-introduced literature review, I started by looking at writings that constitute NHS literature on MDTs. I argued that the NHS contributions that are introduced in 2.2 seem organisational told stories which, in my view, due to a lack of transparency in relation to the writers' onto-epistemological stance remain somewhat vague in the meanings of what they say. They don't' guide as to the "how?" of "effective or collaborative communication" and place thinking about MDT communication in the context of a taken-for-granted-knowledge around "effective/ collaborative communication" that provides little meaning because minimal contextual information is given about ideas on communication, policies around communication or evaluation around communication. I suggested that the context that seems to be missing most is the one about beliefs that would allow for the insights that are presented to be understood within the epistemology they were constructed in.

I then went on to introduce empirical material from several other studies which I understood to be rooted in organisations' and teams' lived stories, and they are the ones that are introduced in 2.5.3. I understood the authors' transparency of positioning themselves within certain research paradigms as strengths in their methodology.

The research landscape and thinking I introduced there spoke first about the challenges, barriers and dilemmas that are noticed, observed, or experienced within MDT communication. I introduced how the variety of differences (general differences between individuals, differences in education, status, pay, worldview, professional

identity and so on) that professionals come with hold the potential for creating conflict that leads to tribalism in its worst form and needs ways to be tolerated, negotiated, integrated, and synthesised into shared and coordinated responses to people's mental health struggles. I introduced what risks lay in unhelpful responses to conflict in teams and wrote about the meaning that cultural differences between disciplines can have, especially how professional training often encourages differentiated socialisation into a profession, which can form an additional barrier when trying to synthesise differences into a helpful response to people with mental health struggles.

I also introduced writing that referred to communication challenges which resulted from working under pressure in relation to limited time, resources or risk and how this can activate stressful feelings for professionals. I showed how a common response to professionals' anxiety can be to hold on to what is familiar and reject differences or innovation. I used literature contributions to explain that this has the potential to result in isolation and being less able to benefit each other as a team, for example, through social emotion regulation that can otherwise have a containment function. Further challenges to helpful MDT communication, which I introduced were related to limitations in understanding other professionals' conceptual backgrounds, which have sometimes led to disengagement and competition within a team.

I then went on to introduce writing that spoke about the different methods that had been experimented with to support or explore communication practices in MDTs and counteract the risks coming from the challenges, barriers, and dilemmas.

I first introduced a study that contrasted a diagnosis-based approach to case discussions in the context of a gatekeeping referral process as opposed to a process that includes

multiple perspectives. I highlighted findings that point out how the presence of multiple disciplines in a discussion alone does not ensure the influence of a variety of disciplines in case discussion and MDT decision-making. I showed how it needs a well-coordinated communication exchange between disciplines that allows for flexibly applying organisational structures to local conditions for a decision that is tailored to fit individual clients.

I then went on to introduce contributions that spoke to the variety of beliefs around mental health struggles which different disciplines identify with. I presented findings that say how different disciplines' beliefs tend to be referred to by other disciplines and integrated well for individual clients who are on more polarised ends of a continuum in terms of risk. For clients who are not considered high or low risk, but considered more somewhere in an in-between space, it seems more difficult to refer to and synthesise a range of perspectives into a shared view and the power that individual perspectives hold tends to be used to respond to conflict.

I then go on to show how client's views on their struggles can be seen as an additional perspective in terms of mental health struggle. I showed how integrating their view adds another significant perspective that speaks from a within perspective, could be conceptualised as an additional discipline and help to make use of different ways of knowing when planning and delivering care. In terms of communication, I introduced the idea of clients with lived experience holding the potential to build bridges between professional teams and client groups.

I introduced examples from the literature that show attempts to integrate different perspectives into a shared understanding of individuals' mental health struggles.
I showed how team formulations can help to invite a variety of perspectives proactively and explicitly, which can allow for better tailoring a service to individual clients' needs, as the person is considered more holistically.
Another example of an assessment process I introduced, showed how individual professional roles and their negotiations in team case discussions can depend on relational processes of role-making and role-taking. At the same time, these relational processes do not happen in a vacuum and are influenced by organisational structures and are embedded in an individual's professional socialisation. Professional socialisation happens in professional communities and is influenced by each discipline's educational institution. Within these, professionals have often not been taught to integrate with other professions but have been supported in becoming fully identified with their own discipline and the common cultures within this group. Some authors suggest that tentative role-making and innovation can be a way towards more integrated collaboration between professionals.

I introduced research contributions that show how innovation and tentative role-making can be applied through jointly planned and conducted assessments, where two professions talk to a client jointly and are part of the same conversation, how they use a jointly developed form to do this and how further perspectives are invited and welcomed by routinely presenting their joint assessment to their MDT. I introduce

another example of innovation where a Reflective Team Process approach is used to hold MDT case discussions. The emphasis is put on supporting a dialogically characterised type of communication. This is done by using a facilitator who invites the focus in communication to be exchanged, listening and understanding, noticing links, and avoiding “knowing too early”.

The examples I introduced here highlighted dilemmas around power and hierarchies encountered when attempting to integrate various perspectives.
I introduce literature that speaks about the impact of hierarchical structures that equip one discipline and one mental health narrative with more power than others.
The writing acknowledges dilemmas around such organisational hierarchical structures. At the same time it emphasises the limits of the influence of organisational structure . It highlights the potential that is there locally in team relations to making and taking of roles and the day to day negotiations within the encounters and exchanges between people in MDTs.

I then introduce authors that write about the meaning of emotions and relationships in a work and team context and show how these seem neglected phenomena when looking at research and writing around teams and organisations, but also when looking at NHS thinking about peoples’ mental health.
Within the then following section in the literature review, I discuss the above and shine a light on an acknowledgement within the literature that MDT communication is a complex phenomenon that holds potential and limits. I shed a light on a gap in

theorising the type of communication that seems to be happening within MDTs. I demonstrate how I see Bateson's schismogenesis-theory to be potentially helpful in filling in the gap, in that it speaks about communication between differences, equally empowered differences and unequally empowered difference and the risk of divergence that comes with unsuccessful communication for both cases. Bateson talked about cultural ritual behaviours that have the potential to either inhibit or stimulate divergence. I show how I see schismogenesis-theory applying to MDT communication in that I consider MDT work as cross-cultural work in terms of the different professional cultures. I introduce writing that points to the challenges that can come with cross-cultural communication *"...for opening up schisms and becoming vehicles for differ- ences in power and authority ..."* (Krause 2010, p. 393). One of Bateson's conclusions in relation to these risks was that there is a need to consider methods that may help to respond to these risks, and I showed in the literature review how I see the NHS and its MDT teams being faced with exactly this challenge in that the task for successful MDT communication is to find ways to organise cross-cultural communication in helpful ways. The writings I summarised above provide empirical insights from applying a variety of ways to organise communication and I explained what link I saw between the different suggestions. They all seem to suggest communication that is characterised by dialogical features, which I listed and summarised at the end of the literature review.

The above literature shows that there are many insights about the challenges that teams encounter when aiming for collaborative exchange and cross-fertilising communication between disciplines. I recognised insights relating to methods that support the aims of

MDT communication and I saw Bateson's schismogenesis theory filling the theoretical gap I saw within the writing I looked at. I saw how the meaning of relationships and emotions in an MDT context is addressed very little.

Another gap I saw was relating to an overview of MDT participants' experiences when they meet in MDT case discussions. The insights into different practitioners' perspectives on their experiences during MDT case discussions did not seem to capture a broad range of phenomena that get perceived and what individuals from their disciplinary perspectives and with the social differences they come with, notice about what is at play when they meet to discuss cases. In my view, the NHS literature that I reviewed represents "told stories", in that it remains vague in capturing experiences of participants in a nuanced way; whilst I saw the literature by other authors representing "lived stories" of MDT communication in that it relies on empirical data, I identified results being based on specific aspects of MDT communication (e.g. "challenges in MDT communication", "Role-making and role-taking:, "referral acceptance and rejection"). The studies within the reviewed literature did not invite participants to expand on their way of looking at MDT communication and the inviting of all phenomena that they may perceive in this.
This seems to leave out an area of practice-experience that could bring additional insight to MDT communication.

My study aims at filling some of this gap by addressing the following research questions:

-What are team members' experiences of communication practices in their MDT case discussions?

-What contexts do MDT participants experience as relevant in their case discussions?

In the next chapter I will show how I went about addressing these questions, what methods I applied to gather information about MDT members experiences. This will be embedded in explanations about my beliefs relating to knowledge and the way to gain insight and this is where the next chapter starts.

3 Methodology

3.1 Introduction

Science sets out to discover our world and the phenomena that are perceived within this world. Within the realm of research and science, people have been thinking about the nature of science, knowledge, and how we acquire it in many ways. Methodology can be understood as the study of research methods and the corresponding philosophical foundational presumptions (Denzin, 2008).

I believe that our approach to conducting research as researchers—from picking an area of interest to concluding the data we've collected and analysed—is shaped by our philosophical convictions.

Within the literature, research paradigms are introduced as belief set categories that allow for conceptualising the different possible ways of researching. When considering research paradigms, two areas of questions are often given significant weight. One group of questions relates to how we understand what there is to know and is referred to as “ontology”. The second set of queries focuses on how we believe we will learn more about the phenomena we regard as our field of interest. “Epistemology” is the term used to describe this (Guba and Lincoln 1994).

Since both involve beliefs, they cannot be refuted or supported by facts but can be made explicit and explained to be seen and understood. Defining one's own beliefs makes one's actions more transparent. As a researcher, I see this as an ethical activity in that it can contribute to a power-equalising process between researcher and reader in that it pays attention to power distributions that can come with knowledge distributions.

Gaventa and Cornwall (2008). Zhang et al. (2021) theorise about power dimensions when pointing out that research and knowledge "can be conceived as resources to be mobilised to influence public debates" , which highlights one way of how research and the way that it is practised can influence others. They also say that the knowledge-production process can hold a high risk of the mobilisation of bias and bring a few examples of how this may happen. They mention the setting of scientific rules that declare the knowledge of some groups more valid than others, for example, experts over lay people. Another example relates to how some groups are given more attention than others due to asymmetries and disparities in research funding and the lobbyism that can come with it; established "methods" or "rules of the game" can be utilised to favour some voices and undermine the authority of others. Even when previously excluded actors participate in the policy-making process, they might need to adopt the vocabulary and expertise of the powerful to start being taken seriously (Gaventa & Cornwall, 2008).

When thinking about this and the position I take concerning power, not just as a systemic practitioner and researcher but also as a person with specific ethical values, I prefer to engage with readers, clients and other people collaboratively and therefore see transparency relating to my philosophical orientation as essential. At the same time, I wish to acknowledge the limitations that can come with the operationalising process when aiming to minimise power imbalances between participants and researchers. Seeing limitations within attempts to work on a balanced power level with participants corresponds to some of Karen Rosse's writing (Ross, 2017).

Ross talks about *"…moments of empowerment when methodological choices disrupt*

traditional power imbalances in the research dynamic" (Ross, 2017). She examined researchers' possibilities to offer "empowering opportunities" to participants. From her work, she concludes that there are many opportunities for researchers to put this into practice. Still, she also speaks about the limits that come with unavoidable biases each researcher brings.

I will introduce my philosophical outlook in Section 3.2, as well as my ontology, epistemology, and the research paradigm I believe this best aligns with.

In 3.3. I'll describe how this translated into my decisions about the research design, participant recruitment, data collecting, and data analysis methods, as well as some of the difficulties that emerged during each step.

3.2 More on my philosophical orientation

3.2.1 Ontology

Ulivi (2019) defines "ontology" as a branch of philosophy that strives to answer the most general and universal question about the world: what there is. This means for example considering what counts as an entity, and she introduces two basic ontological attitudes toward human experience.

One is the descriptive one that recognises an ontological status to whatever comes into human experience. The other is the revisionary type that establishes criteria for inclusion or exclusion when qualifying phenomena as entities. She sees Descarte's perspective with the emphasis on rationale as belonging to the revisionary kinds of ontologies, whilst she sees the systemic way of thinking with its allowance to forming

multiple ways of comprehension as belonging to the descriptive ontologies and with its pluralism relating to Aristotelian thinking (Ulivi, 2019).

Whilst Ulivi's use of the term "systemic" seems undefined; I can identify with what she describes as "systemic ontology" in that I believe that experiences exist and that the experiences we have, have been influenced by everyone's experiences of themselves as well as their interactions with the people and phenomena that they perceive. When I say, "individuals' experiences of themselves", I am referring to all possible categories of experience, such as physical, cognitive, emotional, spiritual and the ones that are more difficult to categorise and nevertheless experienced. With "phenomena", I mean any occurrences, such as beings, relationships, interactions, memories, communication, cultures, and practices, but also more concrete phenomena like material objects. It means that I consider most phenomena as nothing fixed but depending on our experience at that time. Emphasising experience when thinking about what I believe exists in the social world I refer to, means that I see occurrences or phenomena as changing over time and therefore not holding an essence as such but being dependent on the experience of it at a particular time and place and by a specific being or person. This applies to occurrences on all levels of concreteness and abstraction. For example, I do not see a piece of wood holding any objective essence but as being experienced in various ways by different beings at different times and locations. For one person at a particular time, it could be experienced as a tree, whilst it could be experienced as a table at another time. It may be experienced as a place to live for a bird at a certain time or as dust by a being in future times. Example on a higher abstraction level could be the

occurrence of a certain type of education, knowledge, information, which, that I see as holding no essence but only the local experience of a being at a specific time.
In relation to research, it means not looking to find the essence of certain phenomena but looking for the experience of certain phenomena. When applying this to studying communication in MDTs, it makes it most meaningful to inquire about experiences of exchange.

3.2.2 Epistemology

In the Stanford Encyclopedia of Philosophy (Nodelman et al. 1995), epistemology is described as a part of philosophy interested in knowledge and acquiring knowledge. The different facets of epistemology are introduced in relation to different thinkers across the history of philosophy.
For example, Plato's epistemology attempted to understand what it was to know. Locke's epistemology was an attempt to understand the operations of human understanding, and Kant's epistemology was an attempt to understand the conditions of the possibility of human understanding. Much recent work in formal epistemology attempts to understand how our evidence rationally constrains our degrees of confidence, and much recent work in critical epistemology is an attempt to understand how interests affect our evidence. (Seup and Neta 2005).
Hamilton (1994) sees Descartes and Kant as the two most notable innovators and influencers when thinking about acquiring knowledge over time. In his time (17th century), Descartes found the quantitative research field argued for refocusing natural

philosophy around mathematics and emphasising reason, logic, and objectivity in research. In his time (18th century), Kant sowed the seeds for qualitative research by questioning Cartesian objectivism. He looked at perceivable observations as evidence or ways to understand phenomena and acknowledged the mental apparatus that organises perceptions.

When explaining my epistemology, I am referring mainly to how I believe we learn about phenomena and see my own beliefs most identified with a post-modern, relativist epistemology. Polkinghorne (1992) understands post-modern epistemology as understanding knowledge as relative and subjective.

I understand "knowledge" or "knowing" as a place where meaning is made from an experience or perception. The meaning is generated through mental and interactional processes at a time by a person. This sees knowledge as local, in context and generated by a person or a group of people within their contexts of mental and interactional processes. I see knowledge as a provisional, subjective insight, particular to time, place, person, or person-group. I consider it insight-generating to inquire about people's experiences and the meaning- making of a phenomenon. I designed my study in a way that seemed most promising in generating insight into MDT team members' experiences during an MDT case discussion and the meanings attached to those experiences. I was doing this with an acknowledgement of me as the researcher and the research design creating a particular context for the insight being produced and therefore considering the insight a co- creation. I acknowledge that someone with a different ontology and epistemology would have generated different insights, and am not claiming that the insights generated from this study are generalisable, but nevertheless, I hope the local

and contextual insights from this study can be related to other insights and therefore contribute to be applied for general planning and conducting MDT
case discussion communication in a way that uses different “knowledges” to inform our offer to people who experience mental health struggles.

3.2.3 Research paradigm

Research paradigms can be understood as belief systems which hold assumptions concerning ontology, epistemology, and methodology. The distinction between different belief sets constitutes different frameworks for undertaking research activities and has also resulted in the distinction between quantitative and qualitative research. Historically, the dominance of quantitative methods has increased the inquiry into alternative possibilities when searching for the most suitable and meaningful ways of inquiry. This resulted in different research paradigms within humanities and social sciences (Guba & Lincoln, 1994). Quantitative methods are often embedded in a positivist research paradigm rooted in Descartes’s thinking, which objectifies the natural world. This resulted in a dualistic perspective where one looks at the subject and object as separate. Applied to science, it meant seeing the “observer” and “the observed” as two entities functioning independently. This view has been the dominant story within Western Science for the last 300 years (Simon and Chard, 2014). Parallelly other stories about research are being told and are represented under different research paradigms. The next section introduces the research paradigm I see my ontology and epistemology corresponding best with.

Constructivist research paradigm

Resulting from the type of epistemology and ontology I most identify with, when considering the features of different research paradigms, it seems that the constructivist belief system in the way how Guba and Lincoln (1994) describe it is the overall research frame that corresponds best with my beliefs and my way of thinking about knowledge and research.

Guba and Lincoln (1994) describe the constructivist paradigm as a relativist one in its ontology; there are multiple realities which refer to different mental constructions based on context and experience; these are local and particular in their essence, although aspects of these realities are shared between other individuals, society or can also be across cultures; constructions are understood to be more or less sophisticated or informed, but not more right or wrong than others.

The epistemology is transactional and subjectivist. The researcher and participant are exchanging, and the discoveries are evolving as their exchange is happening. Emphasis is put on acknowledging the researcher's background and how it may influence the study.

My considerations regarding research methods are built on this philosophical understanding of research and will be introduced in the next section.

3.3 Methods

Guba and Lincoln (1994) describe the methods that are used within a constructivist paradigm as hermeneutic and dialectic; individual constructions are understood to be only comprehendible through an exchange with the participant; the exchange not only

elicits their construction but also refines it; so, the process which happens between researcher and participant is acknowledged as something that brings additional insight and influences what emerges as data. The data is then interpreted, linked, and compared through a further exchange. I selected the methods for this study based on these considerations. Additionally, I used research considerations that have evolved from systemic thinkers and are coherent with constructivist thinking. These are introduced in 3.3.2. Before that, I introduce ethical considerations that I applied when seeking ethical approval from relevant bodies. This is shown in 3.3.1.

3.3.1 Ethics

This study was approved by the Ethics committee of the Tavistock Institute and by the NHS trust that the team belongs to, which took part in this study.

Participants were given the same information prior to giving their agreement to participate orally and in writing. I added information about the confidentiality of contributions. I joined the team for a part of one of their team meetings to provide this information, given the opportunity to ask questions and let information in writing with the same content. I then left printed versions of a study information sheet and the agreement form with the team.

Participants had two weeks to consider the information and if still in agreement to sign the forms and send them back to me.

3.3.2 Systemic considerations

I have outlined in the introduction section 1.3 that the term “systemic” can refer to

various theories and practices, and whilst they all relate to contextual thinking (Goldenberg and Goldenberg, 1996; Lorås, Bertrando and Ness, 2017), they can differ significantly in their underlying beliefs relating to ontology and epistemology. This means that not all systemic thinking would correspond with constructivist research. At the same time, I see some systemic thinking holding potential for complementing well known and established constructivist research methods. When I refer to "systemic methods", I am referring to the systemic considerations that I describe in this chapter, as I don't believe that there is "the systemic research method", but I believe that there are considerations based on systemic thinking, which will now be described, leading to the methods I then go on to call "systemic methods".

The aspects of systemic thinking that I consider adding innovation refer to the emphasis on ethical considerations relating to power relations within research activities and links between research and clinical practice. I have introduced the aspect of ethical research practice in the introduction of the methodology section. In relation to the choice of methods for my study, it meant looking for methods that allow collaboration in research relations, that allow for emphasising self-reflection of the researcher and that support the utilisation of clinical practice insights and practices for research.

Simon and Chard (2014) introduce different systemic researchers and their thinking as "Systemic inquiry", and the thinking introduced there refers to systemic research perspectives that allow collaboration between researcher and participants and self-reflexivity as crucial tools in making results contextual and particular. Links are made between systemic clinical skills and researcher skills. Considering the researcher's active part in the research is comparable to seeing the therapist as an active part in

therapy (Simon and Chard 2014).

Russel and Kelly (2002) refer to “dialogue” when talking about the interaction between researcher and participants” and suggest including information coming from the relational process between researcher and participant (which happens because of dialogical exchange) as data.

I understand the researcher as an active part of the research process and influencing research processes and results with their beliefs, values, and ways of thinking. It highlights the importance of awareness and transparency around one’s background. This is a common view within a constructivist paradigm, and there are different ways to practice reflexivity within the inquiry process. It is sometimes referred to as self-examination, mainly led by the researcher’s thoughts and actions; this might include completing a self-reflective diary or records, the awareness of personal assumptions and motivations and the awareness of one's belief systems (Russell and Kelly 2002).

Some literature on systemic research refers to significant trends in “systemic research”. One of those trends is the attention that is paid to “the context of discovery” as opposed to “the context of verification” (Sprenkle and Piercely 2005), which points towards the significance of influences on the research process and results through the researcher, the research set up and relationships within the research process.

The questions my study aims to bring insight into (e.g., how do team members experience communication within MDT case discussions? What do they see influencing the exchange between team members during case discussions?) are inquiring about people's experiences of phenomena. The questions relate to a constructivist ontology in that they have inherent the assumption that there are multiple truths, depending on

individuals' mental constructions based on their experiences, which are embedded in context.

The way I designed the study, so how I am hoping to acquire insights, assumes that my relationship with each participant will play a role and that the answers will also depend on how I ask the questions, what kind of context I offer for conducting the interview, and how my background influences me.

In the following sections, I introduce the methods I selected and applied within this study, because I understand them reflecting my research beliefs, which I introduced above. and which can be called a constructivist systemic paradigm.

I see an inquiry from a constructivist paradigm with the above systemic consideration offering possibilities to pay attention to aspects of research (context, relationships between people who are involved in a research process, ethical considerations relating to the impact of power imbalances within research projects), which may find less attention in research projects that are based on positivist and realist research paradigms . This can allow for a more nuanced and multilayered analysis and discussion of collected data on one hand. (Creswell and Creswell, 2017). On the other hand, it may be questioned in terms of the generalisability of data and the resource-intensity (Creswell and Creswell, 2017). This will be further considered within the discussion chapter .

3.3.3 Data analysis method

3.3.3.1 Interpretational Phenomenological Analysis (IPA)

Trying to find analysis methods which correspond with my research paradigm and allow for addressing my research questions meant to search within qualitative methods. The method I chose to use for data analysis is Interpretational Phenomenological Analysis (IPA), which is rooted in phenomenology, hermeneutics, and ideography.

IPA has evolved as an analysis method that allows a thorough exploration of subjective experiences. It takes the researcher's epistemological place from where the engagement with the participants and the data happens as an interpretative element. It assumes that one can access insight into individuals' inner worlds.

The aim of IPA (Pietkiewicz and Smith 2014) is to explore how participants make sense of their social world, and the main currency is what meaning participants make of a particular experience, a particular event; the researcher is trying to get close to the participant's social world.

IPA researchers work with the recognition that the chain of connection is complicated – people may struggle to express what they are thinking and feeling. The researcher may have to interpret people's mental and emotional states through what they are saying, which makes the research person and their perspective an active ingredient in the research process.

Within IPA literature, it is emphasised that the practical guidelines for the analysis are aimed to provide orientation. At the same time, there is an acknowledgement that each study will need adjustment to the requirements for that particular inquiry (Biggerstaff

and Thompson, 2008).

I believed that IPA was the most appropriate methodology for my study since it matches the constructivist paradigm and proposes an analysis strategy that tries to gain an understanding of participants' interpretations of the phenomena of interest. Additionally, I found it useful since it allows for creative pairing of non-IPA components to best match a particular study. At the same time, when critiquing the analysis method, I felt that IPA had fallen short in providing adequate solutions to various research predicaments. These appeared to be problems with an IPA analysis, on the one hand but also presented an opportunity for developing ideas that could best meet the requirements of my study. In the following query, I'll introduce these conundrums and the strategies I developed to address them.

3.3.3.2 My research dilemmas at the stage of planning the analysis

In this section I introduce the dilemmas I faced when planning the analysis phase. I introduce each dilemma and I introduce the systemic methods, I developed to meet the dilemmas. I consider these methods “systemic methods”, because they go back to research aspects which I had introduced in 3.7.2 and that refer to the conceptualisation of “systemic research methods” as described under that section (for example researcher-participant relationship, research set-up being influential contexts in how and what data is collected, as well as the researcher being acknowledged as an active ingredient for data collection, analysis and findings).

One problem arose from acknowledging my belief that the participant-researcher relationship had an impact on the research's analysis and findings but not finding that the IPA provided an acceptable means of resolving this.

Burnham (2018) encourages curiosity and awareness of practitioners' relative positioning in relation to the aspects of difference for themselves, their clients, and colleagues, which can reveal connections and disconnections. I saw this practice framework as helpful in my research context as I thought that working with awareness and sensitivity to this difference could help to analyse material with more awareness of the bias that can come from neglecting issues of diversity. I applied it by considering social connections and disconnections between me and the participants in relation to discipline, gender, ethnicity, and race.

Griffith and Griffith (1994) introduce the concept of "emotional postures" as a therapeutic tool to increase connectivity in the therapeutic relationship through paying attention to a person as a whole and not just through what is said. Within the concept, they also introduce a way of looking at connections between people on a continuum between tranquillity and mobilisation, which could be translated into "feeling at ease with each other" on one end of the continuum and "feeling stressed in the presence of each other" on the other end of the continuum (Griffith and Griffith, 1994).

On the basis of my own thinking as well as above introduced concepts from other peoples' contributions I developed a tool in form of a process, which involves looking at different aspects of my relationships with each participant. It includes reading reflective

notes I made prior to and post each interview, looking at social connections and disconnections (Burnham 2018) between each participant and me, the levels of familiarity and the "emotional postures" (Griffith and Griffith, 1994) I perceived between them and me.

I then translated these considerations of social connections/ disconnections, level of familiarity and emotional postures into numeric values for analysis. My idea was that giving numeric values to these different relationship characteristics would allow me to provide an overview of my relationships with the participants.

I also established numeric values for my level of familiarity with each participant. Within this aspect, I thought of my level of involvement with them by considering if I had met them in a work context before and if I had also socialised with them outside of work.

The involved steps in this process are shown also in the overview of analysis steps and described in more detail in the descriptions of analysis steps taken.

Another research dilemma I saw was related to how to explore and articulate the additional influences on results, which I see coming from dialogue and relationships within the research process and the research-set up. I was aiming for a method that would acknowledge that what is collected and used as data is not only seen as a representation of one person's world but the result of a person being offered a specific context/ relating-to to represent themselves and their contexts. I addressed this by considering the effects of each of the various study steps that participants underwent, as well as by asking participants questions designed to elicit feedback on how they

perceived the effects of the research setup on the case discussion.

I saw another challenge coming from using the interpretation and meaning-making of participants' contributions as an analysis method. Couture and Sutherland (2004) point out that the risk of producing analysis, which states the obvious, can be an issue in constructivist research. This can be the case if the research design does not allow for the transactional and transformative element in the exchange in the researcher-participant relationship to be given enough attention. It can then be challenging to address this without involving a research team or peer group. The research activity within IPA generally includes interpretation and meaning-making of what participants bring. I see this as offering opportunity for richness and a new perspective on participant contributions; however, I agree with Coutoure and Sutherland that it also holds the risk that I, as the researcher, find "the obvious" in the data, that which I expect and hope for. I believe this can happen more subtly, for example, when choosing the material that I comment on and not comment on, in what way I comment on it and where I put the emphasis. It means directing a selection and intonation process, which also implies leaving out some parts or aspects of the collected data. The necessity for reflection and self-reflection is apparent, and I incorporated relevant reflections in several ways. I considered it important to be aware of the parts of my background that were particularly relevant for choosing the topic for my study and my views and experiences of the phenomenon of interest, the communication within MDT case discussion. For this purpose, I introduced my personal and professional background leading to my interest in this subject in the introduction section. I also introduced some of my experiences in MDTs and the resulting pre-existing ideas on MDTs.

To further strengthen the reflective activity, I attended two peer group meetings to consider my way of analysing data and I had regular meetings with my research supervisor to get feedback on how I approached the analysis.

It seemed that the level to which IPA focuses on aiming to develop insight into individuals' inner psychological processes was neglecting the meaning of contextual factors. I wanted to give more weight to context than what is suggested in IPA. I developed opportunities within the analysis process to refer to individual and team contexts for their case discussions. Christine Oliver (2018) describes the influence and meaning of context within communication as crucial to understanding certain sequences of communication better. They can be described as embedded in several contextual layers, which can be seen as organised in a hierarchy and influencing each other. In relation to making meaning of a communicational episode, other layers of context are helpful to reflect on. Since the data I gathered were stories and reflections on communication in MDTs, I regarded this as being applicable to them. It appeared promising to be curious about the different contexts that participants refer to when considering their communication.

For this purpose, I considered each data entity in relation to the contextual level I saw them referring to and this step is documented within the analysis section. I did not consciously set up certain contexts before analysing the data; however, I want to acknowledge that I was planning and conducting the analysis with my implicit knowledge of everything I ever read, heard and experienced about work contexts. It meant that I did not expect to invent or discover contexts that had not been referred to

before, but I was hoping to understand the participants' referencing of contexts through my analysis.

3.3.4 Language and Terminology

The language used within the research is aimed to present material in a systemic-constructivist fashion. At the same time, I aimed to allow for the languages of research participants and literature to also be shown, so that their contributions could present themselves as authentically as possible.

3.4 Participants

3.4.1 Sampling

Keeping in mind my research questions that inquire about individuals' experiences of an MDT case discussion and the contexts they saw as relevant, I was aware that the data I was interested in was about individuals' meaning making of their experiences. I would therefor need to prioritise quality-aspects, such as participants'thoughts, feelings, behaviors, rather than quantitative aspects (such as as looking for certain numbers of participants or certain number s of case discussions) when sampling.

Although it made have brought additional insight, more ground to contrast between more differences and similarities, which would have enriched the data, I also had to respect the scope of a doctoral thesis and staid with one team and the number of team members present at the recorded case discussion.

To capture individuals' experiences of a phenomenon, it is suggested within IPA literature to focus on a small sample size of between three and six participants (Osborn and Smith, 2008; Tindall et al., 2009). The idea is that these numbers would allow sufficient participants to gain meaningful insights from convergence and divergence between participants; in other words, this would allow for obtaining valid points of similarity and difference.

Additionally, to the above criteria, I had to consider that my study uses reflections on an element from fieldwork, which is MDT case discussions that are held in a team consisting of a certain number of team members and this was also determining the sample size, in this case, six participating team members.

I did consider that recruiting two or more teams could provide a better ground for comparisons (Willig, 2017) and may provide richer data, in that data sets of different team case discussions could have been compared; however, qualitative methods generally and IPA in particular is time-intense and working with more than one sample would have gone beyond the scope of this doctoral thesis.

3.4.2 Inclusion / exclusion criteria

Tindall et al. (2009) suggest that IPA studies purposively choose participants, as it needs to be possible for them to express insight into a particular phenomenon or experience, which for this study required to be professionals who are part of MDTs in mental health settings.

The authors further argue that for an in-depth search for variability within the group

(through looking at divergence and convergence), the group of participants needs to be as homogenous as possible. This holds true in terms of "belonging to one team" in the context of this study. Still, it did not make sense in terms of disciplines because MDT conversations, by their very nature, include a diversity of mental health views. For this purpose, I decided to recruit one team rather than individual clinicians from different teams. A further criterion was “presence at the filmed MDT case discussion” that was filmed and “in agreement with being filmed and interviewed”.

3.4.3 Recruitment

I asked around among the group of colleagues I have gotten to know over the years of working in various child and adolescent mental health settings to find a team that would be interested in participating. Colleagues volunteered to check with their teams to see if there was any interest. Most answers were negative, with teams reporting that they would find it difficult to devote time to anything other than their regular work. In other cases no feedback was provided as to why teams did not volunteer their involvement. The study's featured team was the only one that consented to participate.

I had worked as a family therapy student in this team about 10 years before starting this study. I was well familiar with one of the team members, both professionally and personally, and she had initiated contact and indicated an interest in having her team participate in the study. When I worked for that specific trust in the past and was completing a family therapy placement in this team, I had already met the majority of the other team members, who at that time were not all part of this team, but were

colleagues within the trust. Haahr et al. (2014) discuss in their ethical research considerations pertaining to the researcher-participant relationship how there is a risk that the relationship can be too close, and one assumes to know where the other is coming from. Or it can be too distant, making it harder for participants to engage meaningfully in the relational process between researcher and participant. I saw these risks applying in my study, because I had different levels of familiarity with each participant. This made me consider ways and methods that could be helpful in developing insight into the features of my relationships with each participant. I developed a tool that could capture closeness and distance between me and participants by looking at social connections and disconnections and levels of familiarity. McEvoy (McEvoy, 2001) addresses the relationship between researcher and participant by looking at the position that the researcher takes; if he or she is an “insider” or “outsider” in relation to the phenomenon that is being explored. He speaks about an emic perspective when looking from the inside and an etic perspective when looking from the outside. He considers both positions' possibilities and limits and some of his points seem relevant here. I would see my position as researcher in this study as emic and etic; emic, in that I used to work in this team as a student on placement and that I know most of the team members either as team colleagues from that time or colleagues who worked in the same NHS trust at the time of my placement; at the same I am taking an etic perspective, in that I have not worked with anybody in this team for many years, the constellation has changed and my role has changed from colleague to researcher. McEvoy differentiates from a traditional research perspective that privileges the etic position and argues for the pros and cons of each position. He emphasises the need for

either position to consider what opportunities/challenges can come with each perspective. When asking participants for consent to participate in the study, I was mindful that they had heard about the study first through a senior team member. This person was my contact person in the team. I saw a dilemma coming from the power imbalance between the person and other team members. I was aware that the power disbalance between her and some more junior team members or newer team members could be experienced as pressure to participate. As a response, I paid particular attention to the wording in the consent forms. My aim was to encourage participants to make an informed decision and to notice that different responses are possible and acceptable . At the same I was aware that this was no guarantee that the power dynamic described above would not be at play.

3.5 Research Design

The way I designed the study, so how I was hoping to acquire some understanding, assumed that my relationship with the participant would play a role and that the answers would also depend on how I would ask the questions, what kind of context I would offer for conducting the interview, and how my own background would influence me. This can be described as a transactional and subjectivist epistemology, which also refers to a constructivist paradigm.

3.5.1 Data Collection Process

Figure 1 shows an overview of the chronologically set steps within the data collection process. Prior to the shown process, a case for discussion had been selected through the

following method:

3.5.1.1 Case Selection

The team was informed about the set-up of the study and that they should decide on the case they would like to use for the taped case-discussion, which would be the basis for the semi-structured interviews. The instruction for the team was to choose one case from the list of cases that they were planning to discuss. I was informed that the discussions of cases usually take about 10-15 minutes when there is time, otherwise also less if there is not enough time. I have described in the introduction chapter how case discussions are conceptualised in NHS MDTs generally and also that structures and details are decided by the participants in each MDT. I therefor thought it was important to orientate this part of the research design (selection of case and length of case) towards the common practice within fieldwork, so how the team usually does them. This is the reason why I let the team make the selection and decide on the length of the discussion.

3.5.1.2 Video-Recording and Video-Watching

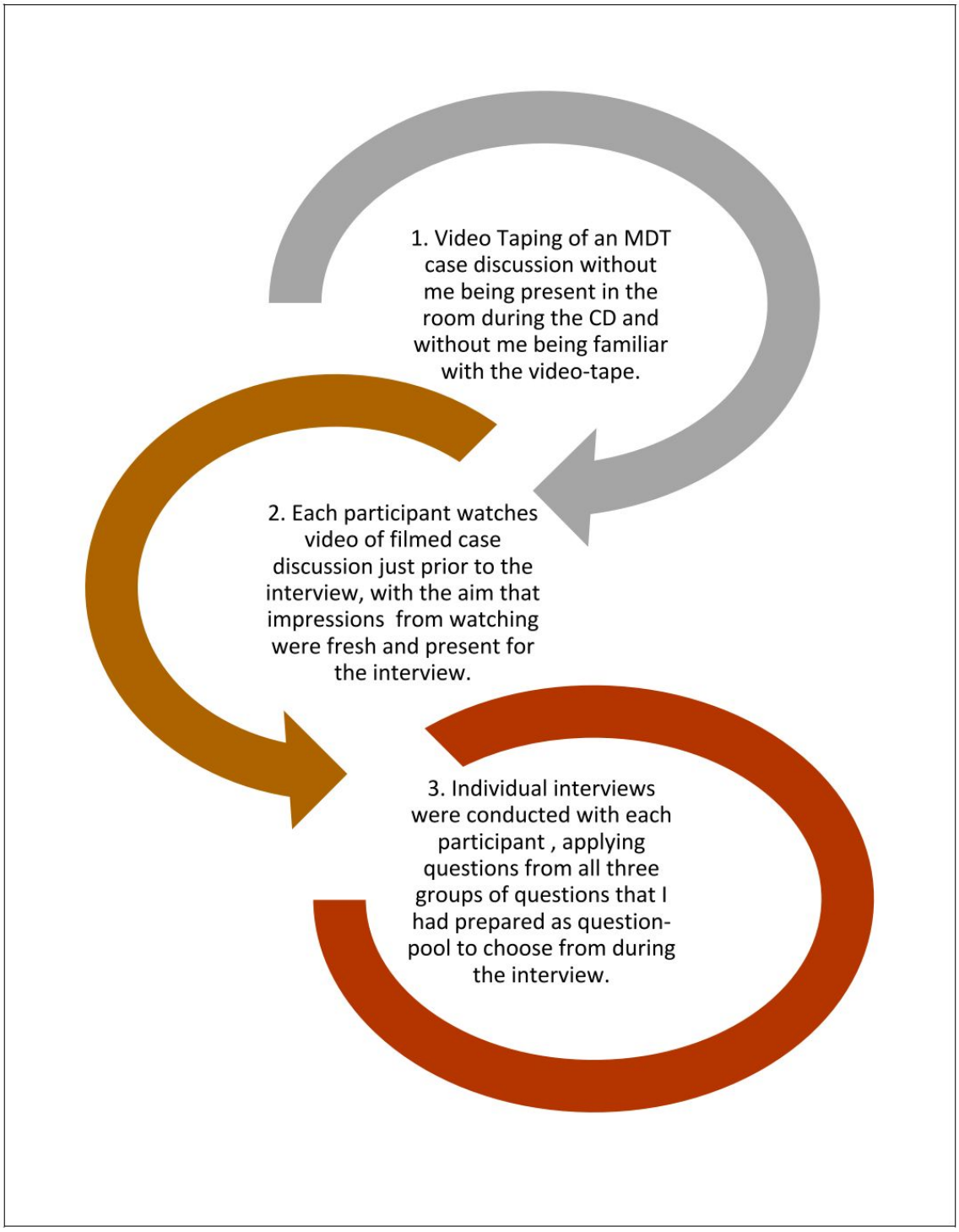
The selected case discussion within one Camhs team was videotaped. The video was shown to each interviewee prior to their interview. The interviews were conducted straight after each participant's slot for watching the video. The use of the video was meant as an auxiliary for participants to connect to the MDT and look at it from some distance, with the hope that this would add a reflective layer for the participants to the process of data collection.

3.5.1.3 Interviewing

The actual data collection happened through semi-structured interviews. The interviews were set up to facilitate dialogue that would allow for participants to consider and share their experiences during the MDT case discussion and the meanings which they assigned to what they noticed. The interviews were audio-taped and transcribed.

Additionally to the data collection process shown below, data was also produced through the literature review (see chapter 2) and the reflections on practice (see chapter 1). All data was used within the analysis and discussed in chapter 6.

Figure 1: Data Collection Process



3.5.2 Use of video material

There are many ways to use video material within a social research context. The applications vary between understanding the video as a representation of a social situation and the video being material used to explore people's interpretations of social situations (Erickson 2011).

There are also different ways to understand the impact of applying videotaping as a method within research. There is the view that being videotaped during a routine activity has a limited effect on the data and the tape material being understood as a representation of the unrecorded event (Vihman and Greenlee, 1987; Vuchinich, 1986). Others think the videoing activity distorts the research phenomenon (Gottdiener, 1979, Heider, 1976). Lomax and Casey (1998) point out that both marginalise the role of the research process and try to separate research data from the process. They see this as undermining the possibility of exploring how the process supports the interactional production of the data. "As we demonstrate, the data collection activity is constitutive of the very interaction which is then subsequently available for investigation. A reflexive analysis of this relationship is, therefore, essential. Video-generated data is an ideal resource as far as it can provide a faithful record of the process as an aspect of the naturally occurring interaction which comprises the research topics". (Lomax and Casey 1998, p.13)

For this study, the aim was to apply hermeneutically oriented video-use, in that participants will look at the content of the video but are also encouraged to comment on the process through an interview question which enquires about the participants' experience of having been video recorded in their MDT case discussion

The video material was used to be shown to the participants prior to their individual interview and to give them a chance to look and feel what went on during the case discussion with some distance in time; the idea was that this would add another layer to the experience from within through participants having the chance to look at it from some distance.

Additionally, it had an essential function in shaping the research process. I hoped it would bring more detailed awareness to a routine activity for participants.

I have not watched the case discussion videotape, meaning I had no representation of the case discussion other than how the participants referred to it in the interviews. I am not familiar with the case discussion tape. I hoped that designing the study in this way would increase participants' influence on directions in the interviews and would help me to stay curious about participants' experiences of the case discussion.

I asked participants about their perceptions of how the filmed case discussion compared to prior case discussions. The aim was to understand and how the research setup or videotaping may have affected the case discussion process.

3.5.3 Semi-structured interviews

3.5.3.1 Conceptual Considerations and Set-UP

My conceptual considerations regarding the interviews with participant are based on the constructivist research paradigm and the systemic considerations I outlined in 3.6.3 and 3.72. The principles from there guided me when thinking about the framework for the interviews. I aimed at developing an interview set up and questions, that could be

described as exploratory, open-ended, participant-centred, allowing and inviting of reflection, contextual thinking, and allowing for an iterative dynamic in the interview flow.

For the set up of the interviews I used the guidance that Pietkiewicz and Smith (2014) give in relation to data collection, which corresponds with an IPA framework. Additionally, I drew from some systemic thinking (Rober et al. 2008, Tomm 1988a and 1988b) for planning the interviews, with the aim to strengthen contextual, relational, reflective, and dialogical aspects within the interviewing process.

"The primary concern within IPA research is to elicit rich, detailed and first-person accounts of experiences and phenomena under investigation "(Pietkiewicz and Smith 2014, p.365). One way to do this is to set up semi-structured interviews, which allow the interviewer to take guidance in the content that is being brought in from the interviewee. This can help to get data, which is close to the participant's views, experiences and concerns relating to the phenomenon that is being researched.

I conducted the interviews in a semi-structured way in that I gave direction to the conversations with the participants through questions but also engage through selecting follow-up questions based on what comes from the participants. I did not set out which exact questions I would ask and in what chronology; instead, I had prepared a pool of suitable questions and the plan was to use them as orientation for the interview.

My understanding was that I can not assume how each of my questions would be heard and understood exactly, but that through responding to each of the participants individually and the flow of each individual interview, the open, circular, reflective questions as outlined in appendix 8.4 would contribute to gathering data that would talk

about the interplay of influences between team members and their different contextual levels through the communication applied.

Another aspect, that Pietkiewicz and Smith point out, is the significance of supporting engagement when aiming for participants to open up and share experiences, views and thoughts. I planned to use some warm-up questions to start that would help participants settle into the situation. Additionally, I was planning to pay attention to the structure and pace of the interview seems significant to notice impetuses, intonations, and the emotional quality of responses to get direction for pace and next steps when structuring the interview.

From a second-order systemic perspective, communication is understood to create reality, rather than only giving an account of it (Rober et al. 2008). This means that what happens between me as the interviewer and the participant who is interviewed is viewed as evolving at that moment as reciprocal interaction or dialogue. Questions and answers are part of the reality, which is being created.

I identify with this view and understand the questions that I ask as a researcher are not only leading to empirical results but also hold value for the ethical quality of the relationship between researcher and participant and the interactional processes that are being activated.

Frank (2005) refers to this when describing “dialogical research”. He talks about “the effect” on us when we talk and hear ourselves talking and how this calls out a response in us. This would suggest that once participants start talking about their experiences, they are also being faced with the impact their talk has on them and on others, which would mean something to them and to me as the researcher.

If captured well, this process can provide additional information regarding the phenomenon that we are trying to shed light on. Russel and Kelly (2002) refer to "dialogue" when talking about the interaction between researcher and participants and suggest including information coming from the relational process between researcher and participant (which happens as a result of dialogical exchange) as data. They highlight that this needs more experimenting to develop useful ways how to do this, so it can become a meaningful contribution to a research inquiry. I paid attention to the relationships between the participants and me and this is shown in the analysis chapter, where I introduce in detail each step in the analysis.

Burnham (2018) suggests using "relational reflexivity" when trying to invite dialogue in a relationship, which may not be experienced as equally powerful by both parties. Relational reflexivity can be invited through questions that express curiosity about what is going on for the other within the relationship, for example: "I wonder what it is like for you to be interviewed in this way?". It seemed to me that the concept seems transferrable between therapy and research in that it can help to work constructively with power differences between people who are part of one interaction, as it gives tools to create more dialogical sequences in the interaction and make relational dynamics more transparent.

3.5.3.2 Interview questions

When thinking more about the how and which questions would be helpful for the interviews, I took orientation from Karl Tomm's typology of lineal, circular, strategic, and reflexive questions and also the sub-typology of the reflexive questions (Tomm,

1988a, 1988b).

Although the questions are introduced in the articles as therapy-specific guidance, they appear to be also applicable to research interviews, in that similar to therapy the inquiry is about people's experiences and the meaning that they see in them. I hoped that reflexive questions would enable rich data to be elicited because these questions may activate and support engagement, exchange, and processing—all of which I thought could significantly contribute to developing a multi-layered picture of professionals' meaning-making within MDT Case discussions.

I selected interview questions that I thought would encourage and support participants in discussing their experiences with case discussion communication, as well as their views of what is happening, the meaning they are obtaining from it, and their comments on that meaning.

This meant that participants were asked to participate in a process that possibly generated new insight for them or caused them to view case discussions with more awareness, perhaps leading to a change in the meaning they would assign to some aspects of MDT case discussions and even how they might choose to behave in the case discussion that followed. (Please refer to the Appendix 9.4 for the pool of questions I had prepared on the basis of above described conceptualisation and considerations. The questions are divided into warm-up questions, main questions, concluding questions). Leaving the interview schedule flexible and using it as pool of questions to choose from on one hand gives opportunity to react to the flow of the interview depending on what and how each participant responds; at the same time it would make it difficult to repeat each interview in the exactly same way that I did them in this study. Choosing this level

of flexibility relating to interview questions seemed important to ensure I could stay close to what participants were bringing. This made me prioritise flexibility as opposed to exact repeatability.

I used a reflective diary to make notes of my impressions after each interview; these included thoughts, feelings, and self-reflective aspects, as well as what I noticed about the participants and our interactions. It aimed at capturing and bringing to awareness what the interview process activated in me and the atmospheres that were co-created in each interview. The notes were used within the analysis process;.

In the next chapter, I introduce the analysis process with an overview of the whole process and detailed descriptions of each step I took to analyse the data.

4 Data analysis

4.1 Introduction

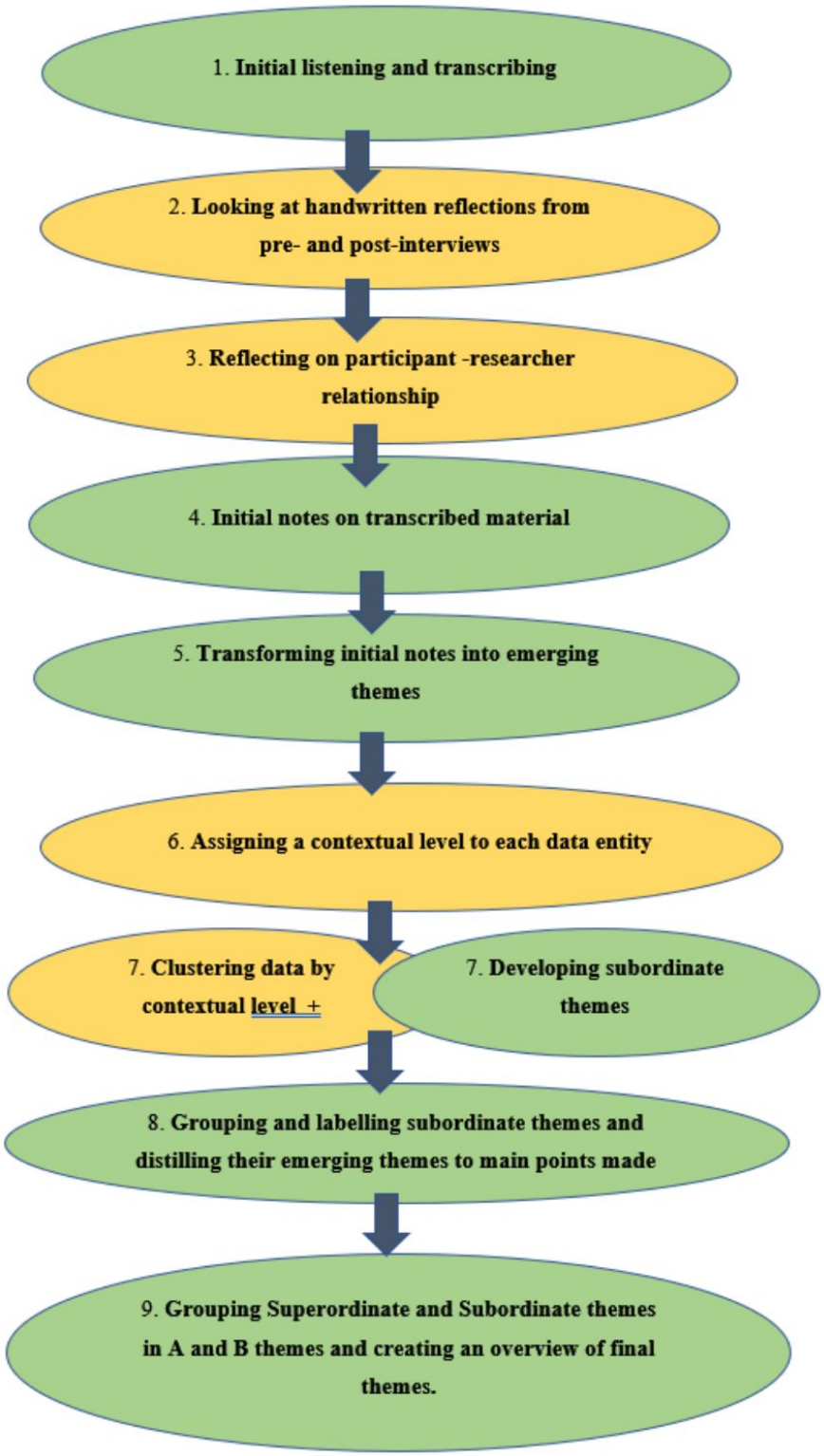
As introduced in Chapter 3, IPA and systemic research methods seem to be suitable for combining them, as both allow for flexibility in how they are applied, and both sit well within a constructivist research paradigm.

Even though I had a structure and strategy for the analytical process, it felt crucial to have some flexibility to allow for any unexpected discoveries that would help to further steer the process and allow for an iterative development when dealing with the data. The analysis process was significantly affected by the insights that came throughout, and I will outline the fundamentals of each phase, along with the reflections, and analysis-process-relevant discoveries that developed.

4.2 Overview of steps taken in the analysis process

The steps performed during the analytical process are summarised in Figure 5 as a flow. It shows each step taken and if I saw the method utilised in each phase rooted in IPA theory (green fields) or in systemic theory (yellow fields), or both.

Figure 2: Analysis Flow



4.3 Descriptions of individual steps within the analysis process

Analysis Step 1: Initial listening and transcribing

The first phase was planned as initial listening and transcribing of the data. The idea was to go through the data to get an overview of what is there.

I started the analysis process by listening to the tapes alongside transcribing them. Transcribing the data myself required me to listen to each word that was said, and it allowed me to focus on what each interviewee was sharing rather than being distracted by interviewing—transcribing brought closeness to the data in that each sentence needed to be given attention and it helped to recall the atmosphere.

At this stage, I noticed that each interview seemed to have its own rhythm in terms of content, process and relationship between the participant and myself as the researcher. From reflective notes before and after each interview as well as from demographics, it seemed relevant to look at each participant and my relationships with each of them to contextualise better the data that was emerging, and this led to the next step within the analysis.

Table 1: Text example for analysis step 1

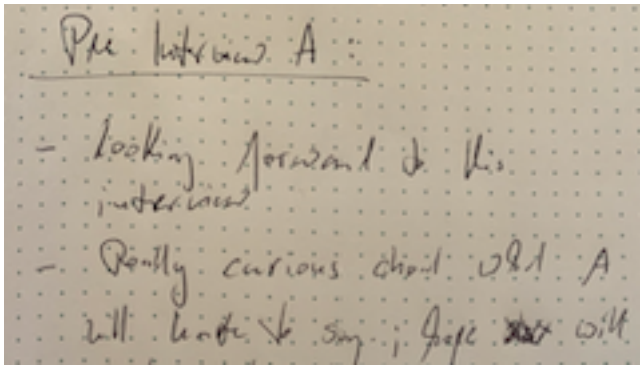
Me: I would just like to understand a bit better how this knowing each other, being attuned to each other, making assumptions, how does it influence the exchange?

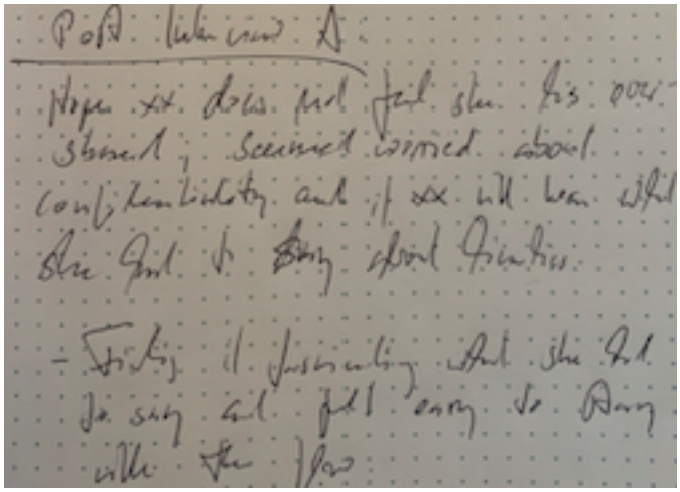
E: I think it , hm… it probably moderates the extend to which we do it. If the temperature is quite tense that day, we may do less curiosity. Maybe we bec a little bit more prescriptive in how we talk about things and I think it depen on the demands of that particular team meeting. I think if we got lot of cases talk about , then we get organized by time management and then the time management becomes the highest context; so then its kind of : well we need get thought things. Whereas , I guess, that's what I was trying to observe dur

Analysis Step 2: Looking at handwritten reflections from pre- and post-interviews

When looking through pre and post-handwritten reflections, I noticed differences between each interview and that part of the differences seemed to relate to the different kinds of relationships I had with each participant. Below is an example of the handwritten notes.

Table 2: Text example for analysis step 2





These reflections confirmed that it would be helpful to look at each relationship individually and look at the level of familiarity, connections, and disconnections and how these and other influences were impacting my interactions with the participants. Here I applied the process that is introduced in the method section and that is documented as a tool in analysis step 3.

Analysis Step 3: Reflecting on participant-researcher relationship

The process was intended to fill in the blank fields in Figure 3 by considering the notes from analysis Step 1. The notes provided information regarding my emotional postures toward each participant, my social connections and disconnections with each participant, and the degree of familiarity that I saw between me and each participant. I assigned colour codes to each participant which I referred to throughout the analysis and the findings.

Figure 3: Tool for capturing features of researcher-participant-relationships

Relationship with	**Level of familiarity (1-4, 4 being most familiar)**	**Number of connections/disconnections (relating to discipline, gender, age, ethnicity, race)**	**Emotional Posture between tranquillity (0) and mobilisation (10)**
Participant A			
Participant B			
Participant C			
Participant D			
Participant E			
Participant F			

Analysis Step 4: Initial notes on transcribed material

For this step, I applied IPA guidance on making exploratory comments (Pietkiewitcz and Smith 2014), looked for the content of what was said and the use of language, and made initial interpretational comments, reflections, and self-reflections. These comments are shown together with subsequent emerging, subordinate and superordinate themes within the transcription documents for every interview in Appendix 2. Still, in the text example below, I only show the initial comments, as I populated the fields for emerging, subordinate and superordinate themes only in later analysis steps.

Within the initial notes I made, I color-coded the different types of exploratory comments as follows: Interpretation, language, content, reflection

The interpretations I made are attempts to extract meaning from what is said that goes beyond the content and may include participants' social features to bring more context to the content.

The comments on language that I made refer to linguistic aspects of the contributions, for example, what kind of language is used, if metaphors are used, or if a specialised language is used.

Content refers to the aspects of the contributions expressed about the subject matter and may be the most prominent information in the data.

Reflections include my self-reflections, reflection on contributions or participants and relational reflections pertaining to the relationship between the participant and me. These reflective comments often also document insights from analysis step 3 where I analysed each of my relationships with the participants.

At this stage, I also started to mark my question-asking in yellow and started numbering

each contribution piece that was communicating and making a point.

Table 3: Text example for analysis step 4

Clinician E

Data Entity	Quotation	Initial Notes/Exploratory Comments
22	I would just like to understand a bit better how this knowing each other, being attuned to each other, making assumptions, how does it influence the exchange?	Level of familiarity and emotional posture with E allowing me to feel focused on being curious about the material that is presented; engagement feels easy.
23	I think it , hm... it probably moderates the extend to which we do it. If the temperature is quite tense that day, we may do less curiosity. Maybe we become a little bit more prescriptive in how we talk about things and I think it depends on the demands of that particular team meeting.	Think at people respond to high temperature with less curiosity and more prescriptive ways of talking about things and being less curious. Use of metaphor E sounds like preferring to not be prescriptive and valuing curiosity
24	I think if we got lot of cases to talk about, then we get organized by time management and then the time management becomes the highest context; so then its kind of : well we need to get through all cases on our list.	If lots of cases to discuss and there is time pressure then time management becomes the highest context and then team gets organized by the idea of going through all cases on the list. Wondering about impact of time pressure and aware that E was chairing the meeting. Maybe in

Analysis Step 5: Transforming initial notes into emerging themes

I took guidance from IPA (Pietkiewitcz and Smith 2014) and used this step in the analysis process mainly to develop concise statements to illustrate my understanding of what had been said. I tried looking at small steps from the initial notes to emergent themes, as it allowed me to stay closer to what had been commented on. As I was working with the idea of a hermeneutic cycle (the part is interpreted in relation to the whole and the whole is interpreted in relation to the part) as suggested within IPA, I noticed being influenced by having already annotated the transcript.

Table 4: Text example for analysis step 5

Clinician E

Data Entity	Quotation	Initial Notes/Exploratory Comments	Emerging Themes
22	I would just like to understand a bit better how this knowing each other, being attuned to each other, making assumptions, how does it influence the exchange?	Level of familiarity and emotional posture with E allowing me to feel focused on being curious about the material that is presented; engagement feels easy.	
23	I think it , hm... it probably moderates the extend to which we do it. If the temperature is quite tense that day, we may do less curiosity. Maybe we become a little bit more prescriptive in how we talk about things and I think it depends on the demands of that particular team meeting.	Thinks that people respond to high temperature with less curiosity and more prescriptive ways of talking about things and being less curious. Use of metaphor E sounds like preferring to not be prescriptive and valuing curiosity	Tension in individuals or team brings less curiosity and more prescriptive ways of talking.
24	I think if we got lot of cases to talk about, then we get organized by time management and then the time management becomes the highest context; so then its kind of : well we need to get through all cases on our list.	If lots of cases to discuss and there is time pressure then time management becomes the highest context and then team gets organized by the idea of going through all cases on the list. Wondering about impact of time pressure and aware that E was chairing the meeting. Maybe in	Limited time resources in MDT leads to time management being highest context.

Analysis Step 6: Assigning contexts to each identified data entity

In this step, I moved away from what IPA suggests in that I did not prepare for clustering the emerging themes and labelling the clusters with subordinate themes.

As outlined in 3.3.2.2 I wanted to give the contexts to which data was referring to, more weight than what was suggested in the IPA literature and as described in 3.3.2.2 I did this by identifying a context for each data entity and I consider this a systemic strategy in that it gives the thinking about context more weight than IPA does.

This resulted in the contexts grouping the data in four parts and in that way, they functioned as superordinate themes.

Within the documents at this stage, the contexts are referred to as “contextual levels”. I realised later that the term “contextual levels” seems suggestive of a clear boundary of each context, but that my view on these contexts was more fluid. I therefore changed “contextual levels” to “contexts” in the later stage of writing the thesis. I left the earlier documents (analysis steps 6-8) with the old term (“contextual level”) to show authentically my thinking at that time. In the final stage of the analysis, when presenting the superordinate and subordinate themes, I use “context” to show that I see these “surroundings” as fluid phenomena which don’t have concrete and linear boundaries but exist within movement.

Table 5: Text example for analysis step 6

Clinician E

Data Entity	Quotation	Initial Notes/Exploratory Comments	Emerging Themes	Contextual Level
22	I would just like to understand a bit better how this knowing each other, being attuned to each other, making assumptions, how does it influence the exchange?	Level of familiarity and emotional posture with E allowing me to feel focused on being curious about the material that is presented; engagement feels easy.		
23	I think it , hm... it probably moderates the extend to which we do it. If the temperature is quite tense that day, we may do less curiosity. Maybe we become a little bit more prescriptive in how we talk about things and I think it depends on the demands of that particular team meeting.	Thinks that people respond to high temperature with less curiosity and more prescriptive ways of talking about things and being less curious. Use of metaphor E sounds like preferring to not be prescriptive and valuing curiosity	Tension in individuals or team brings less curiosity and more prescriptive ways of talking.	Team
24	I think if we got lot of cases to talk about, then we get organized by time management and then the time management becomes the highest context; so then its kind of : well we need to get through all cases on our list.	If lots of cases to discuss and there is time pressure then time management becomes the highest context and then team gets organized by the idea of going through all cases on the list. Wondering about impact of time pressure and aware that E was chairing the meeting. Maybe in	Limited time resources in MDT leads to time management being highest context.	Team

Analysis Step 7: Clustering data by context and developing subordinate themes

Within this step in the analysis, I partly continued following through with the systemic strategy by clustering the data within the four contexts and colour-coding it by the individual participant. Having the data in these groups allowed me to look for conceptual similarities between the emerging themes that were under each context, which is an IPA-employed strategy (Pietkiewitcz and Smith 2014). It also allowed me to give descriptive labels to the groups of emerging themes, which formed the subordinate themes at this stage. The descriptive labels, which appear as subordinate themes in the documents at this stage were sketchy and not yet fully developed to their final stage, which means that I partly used them in the way they appear at this stage and partly changed them within the next step of the analysis.

Table 6: Text example for analysis step 7

Data relating to contextual level "Team"

Subordinate Theme	Emerging Theme	Data Entity	Quotation
Formulation Practice (Impact of pressure)	Tension in individuals or team brings less curiosity and more prescriptive ways of talking	23	I think it , hm... it probably moderates the extend to whic do it. If the temperature is quite tense that day, we may d curiosity. Maybe we become a little bit more prescriptive how we talk about things and I think it depends on the demands of that particular team meeting.
MDT practice (time pressure)	Limited time resources in MDT leads to taking less time for each individual case, but screening all selected cases.	24	I think if we got lot of cases to talk about , then we get organized by time management and then the time management becomes the highest context; so then its kin well we need to get through things.

Analysis Step 8:

Grouping and labelling subordinate themes and distilling their emerging themes to main points made

In this stage, I looked further for relationships between the different subordinate themes that were showing, clustered the similar subordinate themes and further developed the labels for them. I also distilled the emerging themes to the main points they were making within each subordinate theme. This is an IPA strategy to process data in a way that the variety of points made get bundled and given labels in the most concise form that is possible (Pietkiewitcz and Smith 2014).

Table 7: Text example for analysis step 8

Subordinate Themes	Distilled version of the main points made within the emerging themes
2. Nature of team's caseload	1. Caseload of high-risk cases 2. Holding high risk cases brings pressure 3. Co-working seen as helpful when working with high risk 4. High referral thresholds to protect space for high-risk cases 5. Risk and time pressure makes MDT communication favouring pragmatism 6. Relational safety between team members allows for discussing difficult cases in depth

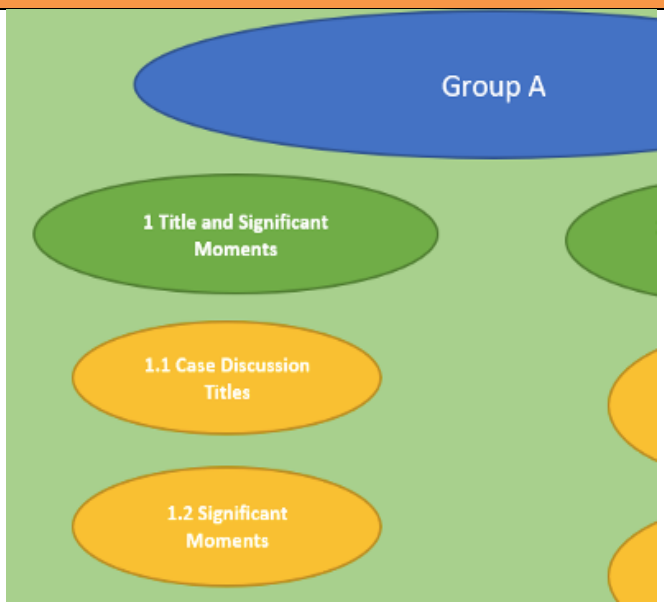
Analysis Step 9: Grouping Superordinate and Subordinate themes in A and B themes and creating an overview of final themes

I looked through the subordinate themes that had formed and realised that not all of them seemed part of the superordinate themes that had emerged. I noticed that the ones that did not fit, were all relating to four interview questions which asked for participants views on the research process and the overall process of the case discussion and the

information they were providing had a different quality, compared to the information that fitted the contextual levels that had formed. To capture the difference in information they were providing as distinctively as possible, I decided to group those in separate superordinate themes and summarize them as group A themes, whilst I summarized the other ones under group B themes.

The results from this stage form the overview and structure of the findings and will be introduced in the next chapter.

Table 8: Text example for analysis step 9



5 Findings

5.1 Introduction

Chapter 5 comprehensively presents the findings from my analysis process guided by an IPA structure and additional systemic research considerations. I applied both when aiming to capture participants' meanings of their contributions within the study interviews. As a constructivist researcher, I understand these findings to be particular and local to the study process that has been co-created between participants and me and the influences that come with each of our contexts. "Local" describing the context of this study, like for example this team with its constellation and demographics, it's caseload, how it is embedded within its organisational structure, and so on. At the same time, I consider insights coming from these results to hold the potential to inform general considerations relating to communication in MDT case discussions, because they could be used as starting point for further research. For example by taking the themes and insights from this team and exploring how they may compare to a team where the demographics look different (e.g. less experienced team, more heterogenous team in terms of ethnicity).

The communication processes during Camhs MDTs were my subject of interest when designing the study. Within this research, communication processes are conceptualised as phenomena co-constructed by the people who are part of them and the multiple and simultaneous contexts, they are moving in. Therefore, the focus was on how participants experienced the recorded multi-disciplinary case discussion in their team

and the contexts in which these experiences emerged.

The insight that this study aims to bring light to centres around the following questions: What do team members experience during interactions in a case discussion? What do they see influencing the exchange between team members during case discussions? The idea was that this would contribute to more understanding of the phenomena which play a role during MDT discussions.

In this chapter, I outline the results I believe came from the research process I created, the co-created interactions that occurred during the research interviews and the filmed case discussion, the individual reflections that took place between the shared processes, the influences that came from the various contexts that participants and I are situated in, and the influences from my selection and interpretation processes.

The findings presented include the area of findings that provide insight relating directly to the research questions and also to findings providing insight that came as "by-product" and provides insights into influences that came from the use of applied research methods and the design.

In terms of the format for presenting the findings, I'll start by introducing the findings in relation to the case that the team had selected for the taped case discussion. This is shown in 5.2

Then I go on to show findings relating to each participant with the social characteristics I found to be most pertinent. This is shown in Section 5.3.

I will then go on to show the findings from reflecting on my relationships with each

participant so that they may be understood within the relational contexts in which they were obtained. This is shown in 5.4.

In 5.5 the superordinate and subordinate themes that had emerged from the data will be introduced in a visual representation of the groupings and hierarchies of themes. This gives an overview of the themes that emerged.

In 5.6 and 5.7 I introduce the subordinate themes in some more detail and what I selected as the most relevant storylines and punctuations within each theme. I introduce quotations under each theme to evidence and illustrate the chosen storylines and punctuations, which were the basis for my interpretations. The quotations that are introduced aim at showing the participants' thoughts and feelings as authentically as possible, but I am aware that the selection (inclusion and exclusion of contributions to be presented) of certain contributions, as well as the context they are presented with, are inevitably shaping the meanings and therefor the results.

I show a written and visual summary of findings in 5.8

5.2 Case Discussion

The case discussed was concerning a 15-year-old female, W/B young person who had been seen in the team relating to self-harm. The local CAMHS pathways directed the young person to this team, as the team responds to the cases that are considered as at the higher end of risk on the risk continuum of received referrals in the local service.

The team's pathway offers response to crisis and high risk and is better resourced than other teams in the trust. This also means that the team can dedicate more time to MDT case discussions compared to other teams. The practitioner who brought the case for

discussion had systemic family-therapy-involvement with the young person in that she was covering the liaison with the hospital. She hoped for a "team think" and to "join up" between different practitioners and their involvement. This fits to how MDT work is generally conceptualised in terms of aiming to offer clients a holistic response within their mental health care.

There were several team members who had been involved with this case in the past through their particular roles (e.g. cognitive assessment, psychiatric input, care coordination).

The team agreed to give the case generous time and to give themselves 10-15 minutes, and then ended up discussing the case for 20minutes. This is above their usual time frame for each case (8-9 minutes) and was not corresponding with how I had planned the length of the discussion within my research design, where I had aimed for the team's typical length of case discussions.

Team member A had suggested to bring the case to discussion and hoped it would give her a "team think" and "join up the thinking" as there are several team members and services involved in the case.

5.3 Contextual Information for each participant

As part of the interviews with each participant, I inquired about their demographics related to their job, function in the team, length of time in the team, sex and ethnicity since I believed these to be the most pertinent for the study. The results of these inquiries are shown in Figure 4. Figures and quotes are part of this.

The below figure shows that in terms of disciplines, there was a representation of

psychology, nursing, family therapy, psychiatry, adult psychotherapy and CBT practice, equally represented through one professional each.

The roles of these professionals in the team vary in function and the level of organisational-hierarchical power they hold. There are two persons in leadership roles, one through holding the team lead role, the other through being a consultant and holding clinical leadership. Two members of the team have a “senior” in their title. This means that out of 6 team members, 4, the majority hold senior roles.

All team members have been in the team for between 1-14 years. One person has spent less than five years in the team, three people have been in the team between 5 and 10 years, and two people have more than ten years, which speaks of significant consistency. Four out of six team members are women, and two are men.

There is complete homogeneity in terms of race in that all team members are white and high homogeneity in terms of ethnicity, in that three of six team members identify as being British, one Irish, one Scottish and one mixed British/Greek.

Figure 4: Individual Participants

Clinician	Profession	ole in team	Time in team	Sex	Race/Ethnicity
A	Family Therapist	Senior Camhs Practitioner	10y. (with interruptions)	XX	XXX
B	Adult Psychotherapist	Team Lead	5y.	XX	XXX
C	Mental Health Nurse	Community Psychiatric Nurse in Early Intervention Psychosis	1	XX	XXX
D	CBT Practicioner	Camhs Practicioner	4	XX	XXX
E	Clinical Psychologist	Senior Psychologist	6	XX	XXX
F	Child and Adolescent Psychiatrist	CAMHS Consultant	14	XX	XXX

The below figure (Figure 5) documents findings from evaluating handwritten reflections pre and post each interview and applying the analysis tool introduced in chapter 4. It gives information about relational aspects between the participants and myself, which I understood to have influenced the research. I saw these relational aspects as having partly directed the postures and positions I asked my questions from and the postures and positions from which interviewees responded from. Showing these aims at showing the relational context for each interview and demonstrating how I see my relationship with each participant forming a variety of situations in which data was collected.

The tool helped to identify connections and disconnections in terms of social attributes as well as the level of familiarity between me and each participant. These then helped me to think about what I believed might have been each participant's attitude toward the interview and myself and the emotional postures this seemed to produce (Griffith and Griffith, 1994). The results that are shown in the table give an overview of the three relational aspects I explained above and I will introduce my analysis of these features and the meaning I saw them having when relating with each participant.

Feeling well familiar with someone seemed to allow me to ask more in-depth questions and include some more double-checking. Some other emotional postures seemed to have contributed to staying closer to the participants' first answer rather than asking follow-up questions. It may be that knowing me as a person a bit more from the past contributed to some participants presenting more nuances in their views, more contradictions, and more self-reflection, but there could have been other reasons for differences. Judging from the above considerations, it may be that the voices of people who were more familiar with me and more similar to me are featured in a more nuanced

and detailed way.

Figure 5: Features of relationships with each individual participant

Relationship with	**Level of familiarity (1-4, 4 being most familiar)**	**Number of connections/disconnections (relating to discipline, gen der, ethnicity, race)**	**Emotional Posture between tranquillity (0) and mobilisation (10)**
Participant A	4	3/1	2
Participant B	2	1/3	6
Participant C	1	2/2	5
Participant D	2	2/2	5
Participant E	3	2/2	3
Participant F	3	1/3	3

In terms of limits, what the above tables don't make explicit, is my own background relating to the social features that are addressed. It is implied in the number of connections and disconnections in the above tool, but to make this more transparent, I am adding here a selection of self reflections relating to my identity.

I reflected on this, based on my belief that every researcher brings their own set of biases,shaped by their personal experiences, ethnical and cultural backgrounds and their beliefs.

Me fitting into the race-homogenity in this team may have contributed to taken for granted practices, that are hard to be aware of due to not having representatives of other racial perspectives. For example: A researcher with a different racial background may have interpreted contributions with more awareness of the taken-for granted practices of white people.

Being the youngest in my family, I come with sensitivity and curiosity relating to power structures and this may have contributed to paying more attention to participant-contributions relating to hierarchies, but also to contributions of the youngest team member.

Coming from a family with migration experiences, makes me notice themes that connect to “giving voice” in light of “difference” and with a need to “belong”. I think that this part of my identity drew my attention to noticing the difference in how confident team members felt to challenge each other and dominant narratives.

5.4 Overview of Superordinate and Subordinate Themes

5.4.1 Introduction

The themes presented in this section in an overview format are superordinate and subordinate themes which resulted from the analysis process described in chapter 5. Once I had taken all steps in the analysis, I saw these themes as having crystalised. Looking at the themes highlighted that the questions I had asked in the interviews had generated two different groups of themes.

One group of themes came more from a within perspective. These themes brought across what participants experienced within the interactions during the recorded case discussion and what they saw these experiences connected and related to.

The other group of themes that emerged seemed to come from a perspective that looked at the participation in the research-process and that looked at the recorded communication from a meta-perspective.

The contributions within these themes seemed to have been generated from four specific questions that I asked in almost all interviews (What title would you give to the recorded case discussion? Which moment in the recorded case discussion do you consider most significant? How do the case discussions that you have routinely in your team compare to the recorded case discussions? What was it like for you to participate in this study?). These were quite directive moments within each interview, in that the questions were more narrowly formulated and allowed for less influence from participants in terms of the interview flow. In combination with the more flow- embedded questions, they seemed to have invited participants into a hermeneutic cycle. It activated a movement between looking from within and being focussed on parts of the whole and then moving to look at the whole and overall processes of the case discussion and participation in this study.

I introduce the group of themes that emerged from the overall-perspective first as they provide context to the other themes in that they speak about participants' main storylines in the case discussion and what they understood to be the impact of the research process on them individually and on their group process.

These contributions also added recursiveness to the study process and they are

summarised in Group A Themes.

The other themes which relate more directly to my research questions and are looking from within make the majority of the contributions and are convened in Group B.

5.4.2 Visual representation of superordinate and subordinate themes

Figure 6: Overview of group A superordinate and subordinate themes

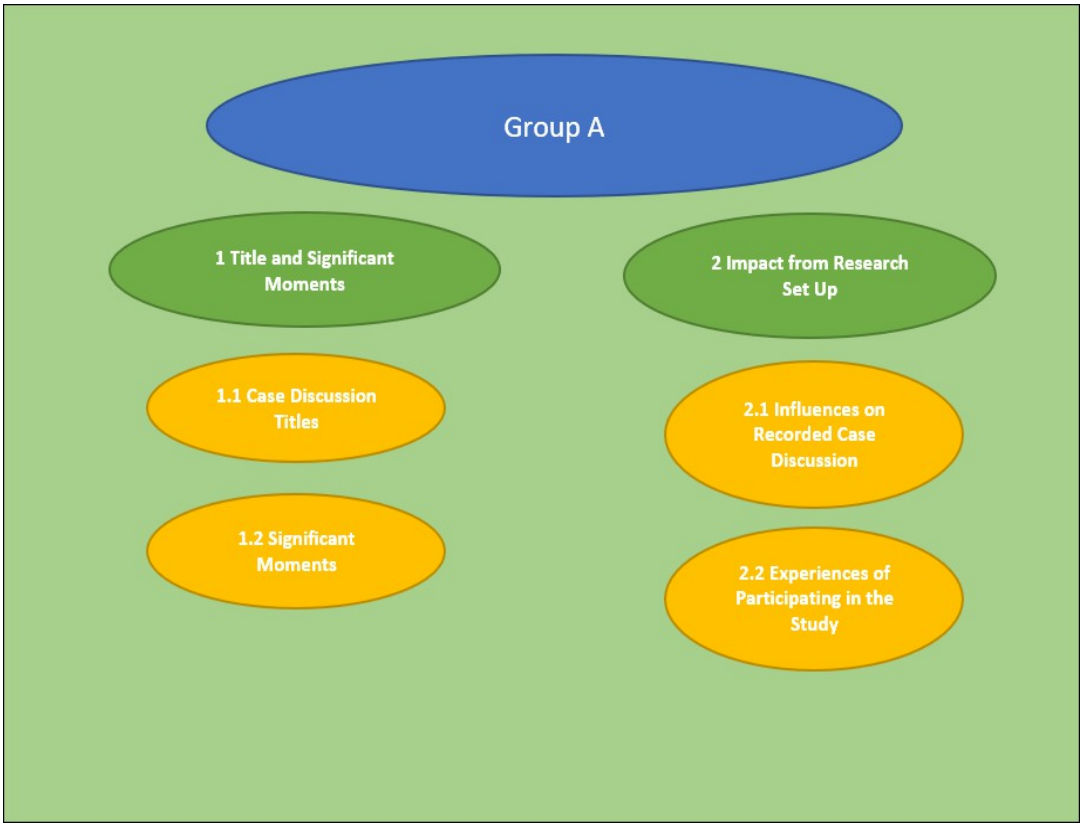
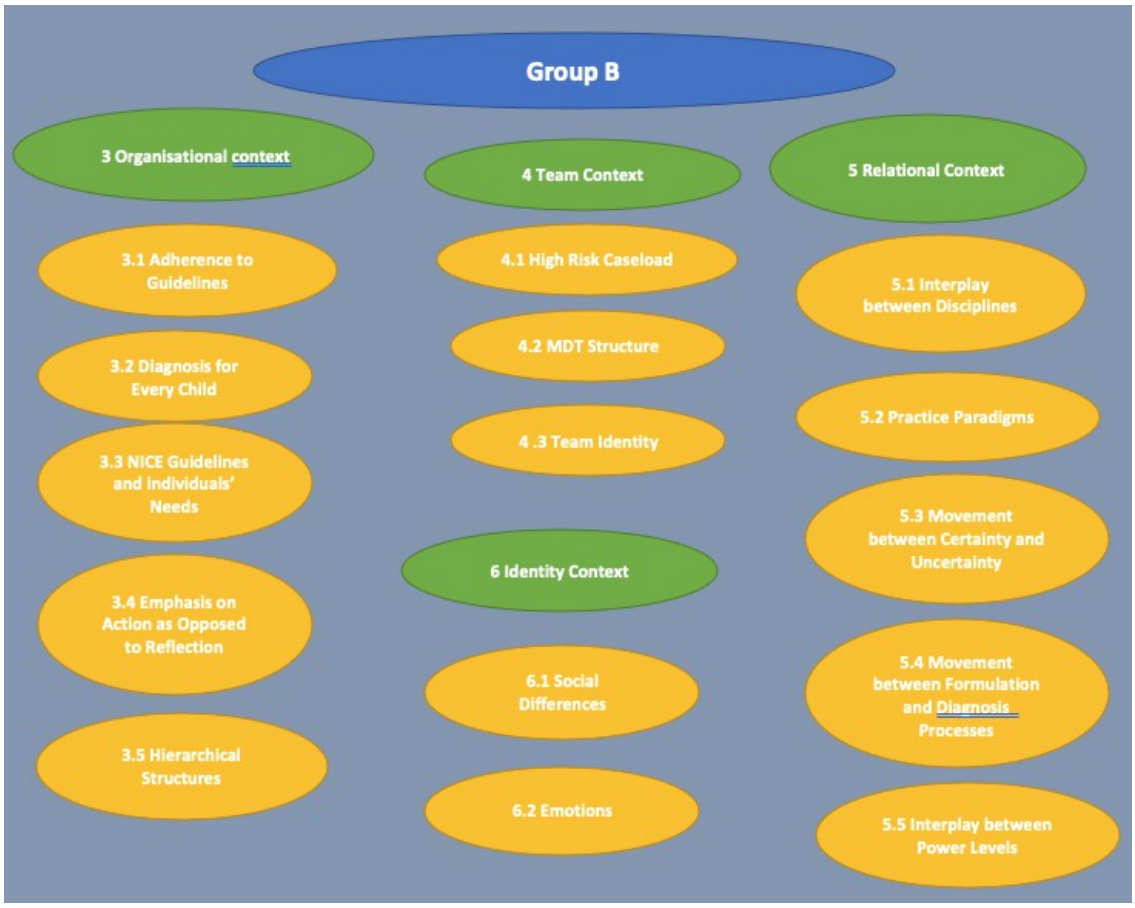


Figure 7: Overview of group B superordinate and subordinate themes



5.5 Group A superordinate and subordinate themes with quotations

Since I believe they represent the various points of view on each of the issues, I begin by introducing Group A themes with all participant quotations that were made under these themes. These contributions are succinct while still conveying their points and show homogeneity and heterogeneity to these specific few points relating to overall views on case discussion and the research process.

5.5.1 Superordinate Theme 1: Title and significant moments

5.5.1.1 Case discussion titles

This subordinate theme introduces what participants answered when I asked: "What title would you give to the filmed case discussion?" I understand them as speaking to some of the main stories participants made from the recorded case discussion. It may be that there were other main stories that were not mentioned, because they may be less permissible/ acceptable/ safe and so on. For example, stories that would include processes that are less visible or less noticed.

"…. sort of holistic thinking about this girl and her family. Forward planning…. risk and diagnosis …. query about diagnosis.." A30

"… it was rich thinking we're thinking neuro-developmentally, we are thinking diagnosis, we are thinking socially, we're thinking systemically…" A47

"…. Multiple Lenses. That was the analogy, looking at this through multiple lenses,.." F46

"… … it was a multi-disciplinary discussion. … … I think it was a provisional discussion. That would be the title that I am giving." B32

"…Trying to sort out difficult case…." G113

"Something like certainty versus uncertainty; do we really know?" E120

5.5.1.2 Significant moments

The contributions presented here were answers to my question "what do you consider the most significant moment or moments in the filmed case discussion?". I understood these responses to speak about some of the most notable/ important/ remarkable moments for participants in the case discussion. Similar to my remark in 5.5.1.1, it may be that the moments that were mentioned by participants here, only partly represent their experiences and that more personally or individually perceived important moments, maybe more emotionally or relationally relevant may have seemed not safe/appropriate/ acceptable enough to bring forward here.

"….. I think C's intervention was really good …where is the young person's view in this and how she'd feel about it?" A106

"… I thought…. that somebody brought in about her perspective about the patient's perspective. I thought that changed the gear…." B35

"…. having somebody say: What does she want? How does she feel in this?" G28

"..., I think, when it was brought up about boundaries how the team managed to talk about overall practice, rather, then talking specifically about the case, kind of more saying about: how we manage when someone might be over familiar but not: how you

Clinician A, B, C manage when…“ C15-16

“Ehm but I think one of the significant points was when F said very clearly: this is a case of emerging bipolar.” G20

5.5.2 Superordinate theme 2: Impact from research set up

This theme reflects what individual participants said in relation to how the research set-up and research process impacted the recorded MDT case discussion and how it may have shaped the subsequent reflections and insights the individual team members developed.

5.5.2.1 Influences on recorded case discussion

The following contributions were made in relation to my question: “How do you think the recorded case discussion compares to your “usual” case discussions”?

“…I was surprised that this one lasted 20 minutes, normally we do 8 or 9 minutes..“ C129

“…. very in-depth about our process with the discussion of this case, ……My feeling in the room is that we were allowing each other more time, in terms of just being able to explore more the different perspectives.” E2

"……, we were already kind of in an agreement that we have 10-15minutes …….so it was kind of like more a luxurious kind of exploratory discussion. " E25

"…. we were probably more organized in our thinking ..,,,and more comprehensive in our thinking than we may necessarily be, as it is a luxury, which we don't often have, because of the pressure of cases.." F53

"…slowed down a bit, …. then there was more time to think and for more, …. for people to be able to contribute from different perspectives …" A18

"….. questions about genetics came up … a really helpful question but … I am not sure if we would have had the time normally or if we would have …" A20

„…. there was a lot of input from a lot of different people for this case discussion, which sometimes in other cases discussions we don't do.." C8

"No, I think it was pretty standard … maybe slightly better behaved ehm maybe trying not to speak over each other and stuff like that. …". B70

"I think it all went a bit slower, maybe we did not talk so much over each other, because of the camera, but the actual discussion is similar to usually. "E116

5.5.2.2 Experiences of participating in the study

The following contributions were made in relation to the interview question: What was it like for you to participate in this study?

"It's quite nice for me, because …. I think a lot about what my role is …. to watch something back." C150

"… something like this as a team- intervention could be really helpful,.." E120

"I think often we come out from MDT…. often all feel sturd up and then …., bring it to the next meeting, a reflection would interrupt this …. regulate us and make us think clearer afterwards." E121

"… wouldn't it be nice to have time to do that in other cases …., I mean I felt like, I mean I felt like privileged to have that time for my case …." A134

"…because there is a lot of stuff that subconsciously I was doing that I was not aware of, so in summary, a very helpful experience; makes me think we should do this again and ah, I am really glad you chose us to do it. I learned a lot about myself today, by looking at myself today, that otherwise, I would have never necessarily believed; it's a powerful thing. I think it served a very helpful meta-function for me." F109

"…… reinforced ……. because I was in kind of more observing stance and having seen

it talking about it you know ... it …. reinforces that. “ B86

“…in my head ..it was much more fluid, but when, I watched it back…this is a bit more fragmented and things pop up all the time, come along….it all gets jumbled....“ C2-C4

“When you are in the team meeting, you feel that process happening, but not in a conscious way. you see each other’s disciplinary lenses really sharply when you are watching it in the video….” E5-E6

“…. process around the child being discussed, …as I remember, but … how I was in that session, that was not how I perceived myself …. quite different, seeing myself on camera.“ F76

5.6 Group B themes and quotations

5.6.1 Introduction

As outlined in the analysis chapter 4.1.2, where I describe the steps in the analysis process, there was one step in the process, where I read overarching themes in the data as contextual levels and labelled each data entity with a contextual level.

The four contexts that I read from the data were organisation, team, relationships, and identity. To make transparent what I mean with these four context-labels, I am giving

here a brief description of what kind of information I saw in each data entity oriented me to label each contextual level.

Organisational context: I read data that was concerning NHS structures or this team's NHS-trust's structures and guidelines as forming the organisational context for the participants in my study.

Team context: I saw the team-context as featuring in contributions that referred to this team as a unit. So, concerning this group of people and their work, like their specialism, team structures, and team practices (for example communication and clinical work).

Relational context: When participants talked about how individual's similarities and differences relate with each other I saw this as speaking about the relational context. This context was referred to by participants speaking about how individuals relate to certain aspects of each other.

Identity-Context: Participants commented on their social similarities and differences and on the feelings that are experienced. I understood these contributions speaking about aspects of the identity contexts of individual team members.

5.6.2 Superordinate theme 3: Organisational context

When considering what goes on between team members in MDT case discussions, participants brought in aspects that related to the organisational context. They saw this context showing itself in form of the NHS guidelines and structures as well as the culture.

The aspects commented on were the team's adherence to the guidelines, that the guidelines require each child and young person on caseloads to hold a diagnosis, the

dilemma that can be experienced from guidelines not catering for individuals' needs, how this translates into a culture that emphasises on action and neglects reflection as well as discussing values, and a hierarchical organisational structure that creates dominance for certain roles and dominance of a medical narrative around mental health.

5.6.2.1 Subordinate theme 3.1: Adherence to guidelines

One thread that appeared was relating to the team's adherence to guidelines relating to NICE recommendations and how they represent a framework to work within. There was a view that the team is committed to these, and it seemed that the guidelines are in individuals' minds when considering cases and are also verbalised within discussions.

"… we're working within our guidelines; we're working within our NHS structures. …." G58

"…conscious of the evidence base …. trying to provide appropriate …. interventions that's linking to the evidence base. …. … very much on our minds as a team." B28

It could be that the second comment, which was made by B who is in a leadership role within the team also expresses the leadership aspects and how there may be a sense of responsibility to refer to organisational guidelines in this role, even more than for others.

5.6.2.2 Subordinate theme 3.2: Diagnosis for every child

One of the guidelines that participants commented on was around the organisational diagnosis practice and that, within this NHS Trust every child or young person that is accepted onto a CAMHS caseload must have a diagnosis. This is the prerequisite to following further guidelines, pertaining to "evidence-based" treatment. It brought forward that with every case the team must think of diagnosis, which indicates a strong presence of medical model thinking when considering individual clients' mental health struggles.

".. as a trust, all the children have to have a diagnosis…., it's an expectation …. critical in terms of being able to provide an evidence-based treatment. " A73

"……with every case we think of diagnosis ……." B26

5.6.2.3 Subordinate theme 3.3: NICE guidelines and individuals' needs

Several participants pointed out how organisational pathways don't cater for tailoring mental health services to individuals and rather fitting individuals into standardised categories.

"…. all very well having care pathways … …. a set package …. needs to be ehm … tailored to the individual. You know we need to be able to account you know for difference. " G35

"…. within health … tendency to treat people a bit as a package…. certain category and that is how we are going to treat you," E107.

5.6.2.4 Subordinate theme 3.4: Emphasis on action as opposed to reflection

Some participants commented further on the impact they see coming from the above-mentioned organisational practices, in that pacing and discussing the process of diagnosing does not seem to feature within the guidelines; the focus is on diagnosing and the intervention that is recommended, and this results in an emphasis on planning action, rather than communication-processes which allow for considering values and reflection.

"… not enough time to challenge each other and then we become a bit automatic, we do not talk about our values, and this is probably about the NHS in general and the culture here. I think if we got lots of cases to talk about, then we get organised by time managment" E97

I understood this comment also in context of time and it being a temporal reference that highlights how less time means that time management becomes the organising principle, as opposed to emphasizing on reflective elements that would allow for more attention to individual needs and fostering multiple perspectives.

5.6.2.5 Subordinate theme 3.5: Hierarchical structures

Another aspect of NHS organisational practice got commented on in relation to challenging each other. This was the meaning of hierarchy and how this can be a significant feature within communication noticed in MDT discussions and on an organisational level.

"… well, I was thinking of – it's hierarchy of course ehm so you know it's a, for example I think it's at one point there was a query …… wondering whether or not the diagnosis was correct and the psychiatrist says the diagnosis is correct. There is no doubt about that. You know, quite assertive and clear. Ehm, which ehm, so that bit just demonstrates a sort of hierarchy, I suppose. This happens here and elsewhere in this organisation." B67 and B68

5.6.3 Superordinate theme 4: Team context

Another context that participants referred to as influencing MDT case discussion communication was the team context.

The aspects commented upon here were the high-risk caseload that the team holds, the team's MDT structure with roles and positions as well as the team identity as a "role model team" and as a "stable team".

5.6.3.1 Subordinate theme 4.1 High risk caseload

This theme refers to the aspects of the case discussion that were commented on in relation to the nature and characteristics of the team's casework.

Throughout the interviews, participants pointed out that their team holds a caseload of children and young people who present with significant risk. They shared how they see this being worked with and how this is showing in communication during case discussions.

"….and sometimes our view on what is high risk is different to how cases may be seen in other teams; this is because we are dealing with the highest levels of needs for young people who are sectioned or in-patient" E59

"…. it's recognised we work with most high-risk people in the borough, so you know we couldn't possibly, you know, there is crisis happening just about every day on somebody's case and …ehm, there is a lot of risk and I mean we need the time to be able to contain and manage that risk. And give families more intensive support.

Families, our families often would have three members of the team involved, the doctor, an individual worker, family therapist. Sometimes a care coordinator as well, not usually, usually only the other. But you know they have quite intense support. " A127

A and C felt that co-working is one way to work with significant risk and that they find this helpful. A particularly commented on the co-working with doctors.

“You don’t feel like you know holding everything on you on your case. Some do, some do have all that, involved. Usually always got a doctor and a clinician. So, you’re never entirely on your own. And I think that’s incredibly containing to know that people have doctors, there are, you know, they all work with us, and you know, co-work the cases and help us think.” A128

„…manage tricky cases by co-working quite well.“ C87

In relation to how risk is worked with, C additionally commented on experiencing the team meetings as organised and producing clear plans.

„So, we are quite organised…..difficult cases and we do that because we do have really good team meetings … come up with clear plans.“ C87

Several participants commented on risk management practice in relation to time pressures and the effect these two pressures may have within team discussions and how the risk-related communication process is organised by pragmatism rather than reflection, and that this changes depending on risk levels within a case.

“… becomes much more about: what have they got and what have we got to do? More pragmatic than reflective or process driven.” E28

„…not thinking too much and do more what we are saying.“ C86

„….if …risky we are more tight in our planning.Whereas if it‘s …. young person who’s …a safe place ….. it needed joint up thinking, rather than because of the really high risk. That made the plan a bit softer…“ C99-C100

“And in fact, the knock-on effect of discussing this case in detail, somebody was not discussed at the end, because we do have a rigid cut-off time. Eh, so there is always a price to be paid. It's great for that kid, so she has a careful community team discussion today, but it is at the expense of someone else., so that’s a real tension.” F54

There was a view that the team- structure, in that the team has smaller caseloads and more MDT discussion time for each case compared to other teams in the trust, does joint-working and has medical involvement with every case and allows them to work more intensely within individual families; contributes to a sense of safety around risk cases.

“…we’ve got a smaller caseload. So, I don’t have as many cases as my colleagues at x-team (other team in the trust) have. And we’ve got because it’s recognised, we work with most high-risk people in the borough, so you know we couldn’t possibly, you know, there is crisis happening just about every day on somebody’s case and …ehm ,there is a lot of risk and I mean we need the time to be able to contain and manage that risk. And give families more intensive support. Families our families often would have three members of the team involved, the doctor, an individual worker, family therapist. …. you know they have quite intense support.” A127

"So you're never entirely on your own. And I think that's incredibly containing to know that people have doctors, there are, you know, they all work with us, and you know, co-work the cases and help us think. " A128

(Contrasting other teams in the trust with this team) "I…think, ehm …. that people just don't have, they are … they don't have the team structure to be able to do that. Because to do that sort of discussion you need to do it in a very as I said safe and secure team with a good grounding." G108

G comments on in-depth discussions about complex cases and alongside connecting it to some of the team structure, she also brings in that perceiving the team as "safe and secure and with a good grounding" is a prerequisite for having these sorts of discussions. This touches on the MDT structure that this team practices and the next section summarises further points made about this.

5.6.3.2 Subordinate theme 4.2: MDT structure

Participants shared thoughts on how their MDT is set up and how different aspects of their structure impact the flow and punctuation in case discussions.

Some participants attached some of what is happening in MDTs to formal or informal roles and positions. They commented on how these roles and positions can shape the flow and structure of the discussion and shared their observations of what adds to an individual's power in participating and influencing the flow of discussion, like having a

senior position, holding the role of meeting chair or case presenter.

Regarding the decision which cases get discussed, it seems that individuals decide when and if they present a case. One person commented that it is usually about wanting a "team- think" on something that feels particularly complex.

"….a query that I have that I need several brains to …for sort of tricky issues, ….to make sure that I am not going off track that I am missing things. " G15

This could be speaking to team members' autonomy in decision-making around bringing cases and may be linked to a possibly collaborative leadership style.
There were views shared about the leadership styles practised in this team, and it seemed that there was value and recognition for both a collaborative leadership style and one that is more directive.

(As the manager) "And I don't mean to interfere unless they need me to interfere. " B11

"…. I try to bring in … ehm my thoughts in a way that's ehm is not dominating." B15/16

"….I am not delving into their work all the time…. they come to me when they need support." B57

“I don’t often, ehm, …. since my time here, since 2005, …. call things wrong, but sometimes I …. regret I haven’t made things clear enough…or being more dogmatic about something needing to happen. “ F93

“….just actually that.. we don’t question him and I think, that’s helpful, cause otherwise we would’ve case discussions lasting like hours.” C127-128

Regarding the influence on the flow and pace of case discussions, E had chaired the meeting, and shared some observations from that role’s perspective. Her view was that frustration and challenge in relation to the case may give some team members an impetus to want to move on, while others may feel differently. At the same time, with time pressure in the background, team members seem less attuned to each other. It then may come down to roles and hierarchies to decide to move on.

“…some people who will say: ‘let’s move on. And then take that role.” E36

“……. usually more senior people do that. “ E38

“…. that is frustrating or challenging or maybe the temperature how people are feeling and that makes us move on. And my impression is that if we are all under pressure, we are less attuned to each other…. it is ok for 2-3 of us to move on, for others it is different.” E41

E thinks that in this team, “the team” feels safe enough to come back and challenge this if it happens a few times, and they believe it was not a helpful experience.
It may be that E, being in a senior position in the team, having worked in the team for numerous years and belonging to a discipline that is well established and respected, it may be that “feeling safe to challenge” is partly connected to these social features.

“……..I do feel that the team feel safe enough to say: Look, I am feeling this …… It feels safe enough to do that in the team. “ E45

This again touches on power distributions within what numerous individuals described as different forms of a polyphonic exchange (e.g. “rich exchange”, “MTD discussion, see chapter 3.2.11 on “Individuals’ Titles for the Recorded Case Discussion “ for more details). More senior people, possibly through the power attached to their roles or their experience and resulting confidence, may feel more equipped to own authority to take the initiative in orchestrating the exchanges in case discussions. A contribution from a more junior team member seems to confirm and contradict this at the same time. It illustrates how power and hierarchies, although present, may be more fluid in this team whilst at the same time contrasting this with experiences from within a different team.

“…that..other team a lot by like from a top-down perspective, Here it‘s like…. I think there is a really nice.. balance of power and people sit more equally within each other…” C89

„…we can disagree but one person isn't gonna take a standard get a final saying anything." C92

F's feeling that one "needs to fight to make your position heard" contradicts a stereotypical idea about psychiatrists' role. The role is equipped with formal power through for example holding overall clinical responsibility for decisions and clinical leadership and pay scale. This can invite assumptions about psychiatrists feeling powerful or empowered, whilst F's experience challenges this assumption.

"Again, because we are a quite flat hierarchy, you kind of need to fight to make your position heard." F23

Several participants commented on taking a position of "remaining silent" during case discussions, and all seemed to value when individuals in the team choose to be silent and placed meaning on this position that mainly seemed helpful to them, in that silence can contain others emotionally, being able to "jump in" when things feel stuck, somebody linked it to a psychoanalytic perspective or that the listening is focussed on and that this can be a protective thing against all the "awfulness" which is referred to when some cases get discussed.

"…sometimes we get stuck….he'll do it at the end. Which I think that's quite nice.…" A93

"……maybe he is curious about the team process, maybe he was looking for meta position." E112

"…. the two most psychoanalytic members of the team." F30

"…. how important it is to have team members to remain silent… and people who just listen … because it acts as a container for the team." F33

(About "everybody retrieving sometimes") "And I think that's healthy, it maintains a little bit of distance, so we don't get consumed by the awfulness…. " F42

Participants commented on the balance between reflective practice and concrete planning during their MDTs. This referred to reflections on a particular case and the process. One impression was that there are MDTs where space for thinking and reflecting is given priority as opposed to action planning. There seem to be several influences that permit more or less time for reflection, and there were different views on a helpful balance between reflecting and planning.

"….gave everyone space … to talk and … develop a plan ..in other discussions we don't …. we don't come up with a clear plan … no one's ……saying this is what should be done…" C96-97

"…. not consciously reflecting on the process of the process in the team meeting…" E10.

"…. something like this as a team- intervention could be really helpful, just something like: what do we feel, reflect on the process, wondering what that was like for everyone, we don't do that." E121

"…. go on to the next thing, and you can see this in the clip "right, now who do we have next" a bit like a machine, ……". B122

5.6.3.3 Subordinate theme 4.3: Team identity

This theme includes contributions that individuals made about how they see their team being seen from the outside. I understood these contributions to be speaking about aspects of team identity. The two main points seemed: to see themselves as a "role model team" for working with complex cases and as a "stable team". Participants spoke about the meanings these team identity aspects have for their case discussions.

Being *"the team"* to work with high risk/ high complexity can create pressure to demonstrate "gold standard" practice and organise the team to come up with clear plans.

"….I think we hold ..such a risk-case- load and we had been doing lots of case consultations for other people and the Psychosis pathway in particular is meant to be this, like gold standard: this is how everyone else should be doing things, so that's..the

sort of thing that brings a lot of like pressure on and organizes us quite quickly to have really clear plans.“ C85

There was a view that the quality of management and co-working contributes to a supportive and containing environment and that presence of senior leadership and the level of experience and expertise contributes to a sense of containment within the team.

“…good management … don’t feel like, you know, holding everything on you on your case. …. always got a doctor and a clinician.” A128

“…there is real support for each other in the team;” E48

“…. something about the senior leadership that’s been stable and … level of experience and knowledge in the team …. that’s very containing for all of us, I think.” A129

Other participants seem to share the view of “working well together” and shared thoughts regarding the relationships within the team and how they see their team being perceived from the outside in this respect. They characterised their team as stable, nurturing, able to constructively express differences, supportive, and close.

“…so nurturing, …. such closeness? How do you …how is that created?”. So, there is,…it is acknowledged;” E57

"… there is a lot of experience in the team, and people have the ability to sit with … something and not get defensive about what we are bringing." E51

"They are a pretty seasoned group of people, they can express difference without it becoming emotionally loaded." F28

"…. because we're a very stable team unlike other parts of the service. …" A123

"We protect each other as well…" B65

Relationships in the team seem to be experienced as overall positive and functional, and the team appears to experience themselves as capable and able to manage challenges together.

"„..that we can manage the difficult cases and we do that, because we do have really good team meetings and we do ....manage tricky cases by co-working quite well." C86

"We got on well, not a lot of undercurrents or, you know, we're trying, there is no major… team dysfunctional dynamic." A130

"…. there is a real knowledge that we want to get the best out of each other…" E49

"We're pretty good, really, on the whole, I think we can, you know, when things are

getting tricky, we try and sort them out." A130

"….and I think there is quite a lot of ability." E51

Some clinicians contrasted this overall very positive view of the team with experiences they have in other teams.

"…I see the difference cause I'm in two teams, and there is difference to my other team." C89.

"…. within our team we had these comments (if less containment) …how these cases would play out in other teams?" E55

In terms of team identity there may have been an untold story when looking at homogeneity of race and ethnicity within the team. All team members identified culturally with White/British . And although the below comment was made about the different accents that team members speak, there may be an untold story. The untold story may say something about a cultural level that everyone in the team is very familiar with without being aware of it, because it may be a "taken for granted" part of being with each other.

"…that room today, you've got a A, (ethnical background), she is so entirely XXX

(ethnical background); the lack of compromise in her accent, that's just great, D, you know is, so XXX (etnical background) as well…then me…" F96

5.6.4 Superordinate theme 5: Relational context

I saw the context in which communication within case discussion is most directly embedded, being the relational context, where communication seems to take on the most concrete form, because it refers to the processes between team members in case discussions.

Concerning this context, participants made contributions referring to the interplay between different disciplines, the different practice paradigms that are meeting, the movement between different levels of certainty and uncertainty, as well as a movement between formulation and diagnosis practice and the interplay between different levels of power that come with different social features.

5.6.4.1 Subordinate theme 5.1 Interplay between disciplines

Within this theme, participants' contributions refer to how the different disciplines are represented within case discussions and how the effects of differences in disciplines are experienced in case discussions. As introduced at the beginning of the findings chapter, within the case discussion, there is one nurse in the team, one systemic psychotherapist , one adult psychotherapist who is also the team manager, one consultant psychiatrist, one psychologist and one CBT practitioner.

Comments relating to the representation of the different disciplines in the case

discussion, participants talked about a mixture of individuals making contributions that would typically be seen as being part of their discipline's school of thought, but partly also bringing other discipline's perspectives or bringing in more holistic thinking.

"…doctors …. nurses in the team …. they come from a very medical perspective. …. there is also other thoughts that get brought up from clinicians with different backgrounds and from those …. with the medical model" G40-42

"I can often find myself bringing…just my own, like: views and opinions and feelings to case discussion rather my discipline hat.." C74.

"…but I do notice that often F and E have really strongly, like their professional hat." C76

"B had a very psychotherapeutic lens on today. I was more in my medication role; although today, I was in an unusual role, I was very much advocating for safeguarding… " F49

Participants spoke about the impact they perceive resulting from representations of various disciplines. They mentioned reassurance through looking from several perspectives, broadening views, and that it adds complexity, learning, and a deeper understanding of specific clients, whilst it can also feel tricky to have difference of views being shared.

"…. different …. more opportunities for solutions, and you know I have got a team head, it's not just my head… " A152-153

"…is aimed at broadening the boundaries of the perspectives so that other people can see more than their own bit. And that is helpful ……, in seeing more of the patient and more of the problem and more of the solution. " B80

"…feeling tricky but sort of positive …. I learned something about, you know, the complex assessment, diagnosis." G75

"… painted a deeper richer picture of her to me……come upon duty, …I've appreciated what people's understanding and assessment of her is." G89

Participants seem to speak less distinct about each of the disciplines, but distinguished more between the types of beliefs around mental health and grouped resulting frameworks of thinking and practising in "medical model thinking/ working" on one side and "alternative frameworks" or "holistic thinking" on the other side. These contributions are introduced in the next section as the "practice paradigms" that were commented on.

5.6.4.2 Subordinate theme 5.2 Practice paradigms

A medical model interpretation of mental health struggles was referred to throughout the interviews and seemed central in how participants organised their thinking around

practice paradigms. They referred to how they positioned themselves in relation to medical model thinking, as in being close to it or less close, finding it useful or not.

There were fewer deliberations that referred to other distinct models of thinking and practising. As part of that, they expressed different ways of relating to diagnosis.

Some team members saw a medical perspective as a helpful way to respond to complexity and risk and that diagnosis makes "what is" said.

"…it was a very medical model interpretation thing … this is bipolar … … it might be in form of medication and it might in form of the treatment plan." G31

"……. understandably because you know the complex needs of the young people." G38

"……it might help us to think you know: Is this borderline personality, is this depression or whatever." G39

"… don't think … we are a medical model team is a dominant strength of the way we think … we have a team that works with …severe mental illness ……." B25-B28

"We've got to say what it is." B28

B distinguishes between "being a medical model team" and "using medical model

thinking", which implies that he sees other constructs of mental health struggles are also applied.

G, who expressed that XXX voicing the diagnosis of Bipolar Disorder as the most significant moment in the case discussion (See contributions in Group A, theme Significant Moments) expressed her confidence about the diagnosis XXX made and from her contribution it seems related to XXX's experience or working with Bipolar Disorder, but it may also be linked to XXX's discipline as psychiatrist and the authority or ownership of diagnosis being placed with this discipline.

"…he used to work in a specialist team for bipolar. … If…. his assessment is that …, I feel confident that recognition, that's where we are. " G21

In contrast to the above voices, which correspond well with the understanding of mental health within the NICE guidelines, some individuals expressed struggle with a traditional view on mental health and highlighted alternative views from research, which they felt more identified with.

"…. I … I do struggle a bit with the diagnostic aspects…. Cause when I heard that she had the diagnosis of bipolar, I was, I was shocked. And I'm thinking, is this helpful?" A56

"...it's a bit not talked about so much.… you know there is benefits and risks of early

diagnosis. …" A66-67

"…. new body of evidence ……. Open Dialogue, which is actually talking about the importance of, rather than rushing to diagnosis and medication. " A79 – 80

"……I have been quite influenced by ……reading…. we often ask *'what have you got?* rather than 'what happened to you?" E16

"…. well, the ward (mental health ward in local hospital, where young person had been admitted to recently, before returning to community mental health) are actually bringing …the question if bipolar is the most appropriate diagnosis for this girl…" A61

The aforementioned contributions introduce what I took to be the two extremes of the team's continuum of beliefs. These could be understood as moving between the medical model thinking and practising and alternative ways of thinking about mental health while remaining more frequently or vehemently on the side of medical model thinking. How this movement was seen to be expressed within communication was considered in a number of ways. These will be introduced in the next three sections, referring to "movement between certainty and uncertainty", "movement between formulation and diagnosis practices" and the "interplay between different levels of power" that were commented on.

5.6.4.3 Subordinate theme 5.3 Movement between certainty and uncertainty

Participants commented on how different views are held within the team communication and referred to "certainty and uncertainty" as a way to categorise the different positions.

"…. her doctors are very…certain…that that's the diagnosis, it's the right thing to diagnose, and that's the thing we need to treat. " A57

While identifying with an alternative view of mental health, A felt that holding a position of uncertainty allowed her to work in a mainstream mental health service. The ambiguity that uncertainty can cater for allows for tolerating difference. It also allows for working with more flexibly within an organisation that is based on guidelines, that facilitate a dominant epistemological discourse.

"…. I wouldn't …. completely disagree ….in an unknowing position …if I was very certain …. I couldn't work here t would be too contradictory. " A86

E sees positions of certainty being more activated when the overall atmosphere in the case discussion is tense.

"If the temperature is quite tense that day, we may do less curiosity, we become a…. bit more prescriptive ……it depends on the demands …" E23

E uses a mixed metaphor of temperature and tension to describe an emotional quality that sets the context for team members applying less curiosity and flexibility.
To "sit with uncertainty" is experienced differently by different people and varies between experiencing "loose ends" and experiencing it as giving flexibility and allowing the team to adapt responses more to individuals, rather than treating clients as "…a package…"

"…. sometimes we end up with loads of ideas that are not – come together in some way." B21-22

"… function of the team … to bring the pieces together, " E71

"We formulate each other's edges, as in some disciplines are quite good with uncertainty, …so the flexibility is punctuated through voicing the uncertainty; this makes it all more fluid, really important for a young person, that there is flexibility, fluidity, adaptability." E106

"I think within health … tendency to treat people … as a package, looking at them in a certain category and that is how we are going to treat you, but I think people are fluid, dynamic, not so fragmented." E107-108

"There is value in us in an MDT discussion being able to tolerate that, rather than

falling into the trap of thinking we need to come to a concrete outcome, category …" E109

5.6.4.4 Subordinate theme 5.4 Movement between formulation and diagnosis processes

Another way that the differences in beliefs and disciplines showed up in communication was seen in the movement between formulation - and diagnosis practices. Participants commented on how different epistemologies meet in their case discussion exchanges and how communication in the team looks when these differences show up. One way of showing was through a "taken for granted" way to do diagnose. Diagnosis is used as framework to consider the client, but it is not discussed if diagnosis as such is helpful or if pacing the process of diagnosing could make sense. The formulation process that is applied seems to build around the diagnosis and confirms a diagnostic perspective as central to all others.

"…I don't think there was an awful lot of discussion about … more about how she met the criteria rather than if it is helpful or not. " A75

"….. people wouldn't often say: can we just hold off with diagnosis. " A75

"…. which is a common systemic … I think to be, isn't it? Which I think we're working with constantly…" A76

C, similar to A does not see the team discussing diagnosis, once it is made, but somewhat contrasting A in that she finds this helpful, as it otherwise may go beyond the time resources that the team has otherwise and "lasting forever".

.

"….just actually that.. we don't question him (the psychiatrist)..and I think, that's helpful, cause otherwise we would've case discussions lasting like hours." C127-128

A felt that besides different perspectives being expressed, it is clear what the dominant narrative is, which corresponds to some of what F said about his responses when the diagnosis is challenged.

"…. don't get into battles. …… because we know what the dominant discourse is …… medical might be the dominant one but it's not exclusive…." A70a

". … I will stamp my foot and I am quite clear about the diagnosis, ……" F101 - F103

Whilst A points out her discomfort with diagnosis and seeing the medical framework as the dominant one, she seems also to be referring to a "both-and" in the discussion and what could be understood as formulation. G comments on a balance between diagnosis and formulation.

"But there was also enough discussion about the other things that were going on in her life……. it was a reasonable balance" G33

5.6.4.5 Subordinate theme 5.5 Interplay between power levels

Participants commented on different kinds of power which they see shaping interactions and communication in their MDT case discussions.

I introduced hierarchical organisational structures within the organisation context chapter, but I am introducing in this chapter how they influence MDT discussion in more detail. Hierarchical organisational structures were commented on throughout the interviews as one structure that creates power differences. It was referred to as consisting of NICE guidelines creating dominance of the medical model thinking, policies requesting diagnosis for each child on a CAMHS caseload and the role of the psychiatrist who represents this way of thinking, is the authority in the central clinical practice, which is diagnosis and holds a clinical leadership role in the team.

Participants shared a variation of experiences in this context.

Regarding hierarchical structure through the NICE guidelines, A. talked about alternative approaches to psychosis and how it can feel risky to bring them in and question diagnosis. NICE guidelines see early diagnosis for psychosis as imperative and A explained how this implies negligence if the diagnosis is questioned or paced (NICE 2014).

"… new body of evidence …. Open Dialog … talking about the importance of, rather than rushing to diagnosis and medication." A79 – 83

"…., … guideline …. the duration of the untreated psychosis makes the prognosis worse. I mean Jesus, that's hard to.. go there, I don't wanna do that." A85

Other participants also commented on the ways they perceive how hierarchical structures are showing up within the team's interactions.

On one hand there were perceptions of the hierarchies being flat within team interactions and a sense of equality. On the other hand, the expression of hierarchical power is noticed and perceived as allowing certain voices more space and influence than others. This was attached to the role of the psychiatrist and how the making and taking of this role is experienced in this team. The making of the role is linked to formal structures that influence power distributions, such as a high up hierarchical position, NICE guidelines which support a medical model and to informal factors, such as assertiveness in communication style, the psychiatrist's strong presence through level of involvement in cases and being full time in the team.

"Again, because we are a quite flat hierarchy, you kind of need to fight to make your position heard." F23

"…everyone has.. is listening to everyone's opinions, one opinion is as important as everyone else's...and that's ok. .. and we can disagree but one person isn't gonna take ….a final saying anything." C102

"…. - the psychiatrist has a strong presence in the team, almost full time in the team and is very involved in all those patients." B30

"… … the in-patient Psychiatrist …wondering …. diagnosis was correct and the

psychiatrist says the diagnosis is correct. …. quite assertive …. demonstrates …. hierarchy….happens here and elsewhere in this organisation." B67

„For me, I see the difference, cause Im in two teams …… is a really nice.. balance of power and people sit more equally within each other „…..anyone will not be looking on everyone else's as a higher banding than me" C89

"Yes, people are able to assert themselves, more a sense of….Different to a classical mental health team where the Psychiatrist says what it is and everybody kind of agrees and gets on with it. Whereas we kind of never was like that….in this team. " F26

"…. about power and positions and who challenges and if the person has to adhere to what a particular person is saying. It's a about status and who would challenge them if they don't adhere to it…it depends on how. … open that person is to feedback." E79 - E81

F referred to a challenge to the hierarchical structures (NICE guidelines and the role of the psychiatrist) that appeared within the recorded case discussion and described how he reacted to a challenge in relation to the diagnosis he made. Although he sees hierarchies as flat from his earlier comment, he acknowledges how he asserts himself through the body language he uses. He realised from watching the video, that although he responds politely on a verbal level, his body language communicates authority, and he perceived others in the room as accepting.

"….. and asks if it is Bipolar, then wondering about it and then I go (stamps foot), before I answer. And I answer politely…then I stamp my foot, as if to say 'listen, this is it.' …it seems to have been accepted as in 'ok, he has now authoritatively pronounced on this.'" F11-F14

F refers to the exchange in the recording and describes A as being comfortable challenging him and that she may know that he will assert himself anyway in relation to diagnosis. This comment and A's comments on this sequence of interactions speak about the sense of safety or lack of safety that can come within exchanges where hierarchical structures are challenged.
A also comments on this exchange and brings in a contrasting view, of how the body language is read and also that it can be stressful and anxiety-provoking when it communicates impatience or when not knowing what it means.

"…. A …. challenges me… feels comfortable to do that…, she knows …how I am going to react to this. … I will stamp my foot and I am quite clear about the diagnosis, ……" F101 - F103

"... these are all very helpful things to bring out in each other; I would hate to work in a team where we would be sanitised…" F105

"…. looking at body language …. communicate sort of impatience …. A…. of sense of ehm: hurry up and get to the point…. I don't know that's what ……it raises anxiety for

me…" A99

The way how A sees the safety aspect within conversations seems to contrast some of what F and G said, in that when talking about this in the interview, it was said through whispering and A double-checking how confidential it was what she was saying here.

"… hmmm … what is shared? I hope all is … back ……. I mean just in terms of all the transcripts or the book analysis and people don't really want to …" A97

E comments on the different factors that she sees possibly being at play that determine how individuals may experience an exchange that includes challenging each other.

"Sometimes … valued …… rich ……but sometimes …. stressful, ….., I think, depending on… where people are at professionally, …workload or how they are personally, depending on how they have come in that day;" E19

Other contributions in relation to challenges and conflicts suggested that the team addresses these in form of debates and questioning each other.
This links to Chapter 5.3.1 on NHS pathways, which requires evidence-based practice and that every client holds a diagnosis and highlights the dilemma of different epistemologies coming together and one holding more authority.

" there will be debates … we may question certain ways in which people

describe others … …. it feels safe enough. …., …it allows that …. a holistic view to be developed. “ G44-45

“…there are that many points of view, you know, there’s a lot of – there’s no shortage of assertiveness in expressing clinical opinion. “ B27

F seems to echo this view and connects safety to “knowing each other well”.

“…. we are a team …. hold diametrically opposed views of what should happen …. seen as a healthy discourse.” F20

(About communication in relation to disagreements) “And sometimes we just probably dance together in this way, because we know each other so well. …” F58

Along hierarchical structures, there were also comments that referred to other aspects of team meetings which may express and create power difference.
B commented on individuals' communication style that can equip individuals with more or less power. He sees it as a factor that influences what is dominant in a case discussion exchange.

“…..the level of insistence on the particular clinician… talk in a very persistent way from their perspective. …. I think that we you know that can dominate …”B74

"….people who structure that more …, people with a slightly more dominant voice." E3

5.6.5 Superordinate theme 6: Identity context

Another context referred to related to the contexts that influenced the case discussion from a more individual place. I considered these as referring to different aspects of individuals' identities. I included contributions that were made relating to individuals' social features (presented in 5.6.4.1) and contributions that were made in relation to emotions and feelings (presented in 5.6.4.2).

I construct emotions generally as both, individual and relational phenomena, but had to make a choice where to introduce them and decided to include contributions made relating to them in the identity section.

5.6.5.1 Subordinate theme 6.1 Social differences

This section introduces some of the social differences between team members, which were commented on. They provide examples of how team members perceive their social differences to show up in MDT case discussions. The social differences mentioned were one team member's lived experience of mental health, the difference in levels of professional experience in mental health, length of team membership, gender, age, and ethnicity.

B valued a contribution from a team member with lived experience of mental health struggles and thought that it brought in a "patient's perspective".

"…the person who brought it up has the same diagnosis…. … it, yeah it's important, it's really important for a patient's perspective. …" …B41-42

The team member who has lived experience spoke from her perspective and whilst she had been open about this, she sees her lived experience as well as her way of practising with this as being communicated indirectly rather than in a straight forward way; C understood this way of team communication as aiming to protect her but also as an expression of the team wanting to practice in a professional manner.

"…I am …open about my own lived experience,. ….so I do think, although I am not sure the team will acknowledge that, they've got a bit protective over me …..It's something I thought about before, is how sitting in a room, knowing your colleague has lived experience.. With this case is very, very familiar to my, to my own experience... „...but it never comes up in case discussion and I then take that to supervision. …Nobody says are you finding this case difficult because it is close to you. „„…I would really like the opportunity…. after the meeting, …And here (in this team) we planned bringing it to discussion, but we don't do that, I noticed that we are trying to be very professional, not just because of the camera, this is something we are doing always; „XXX

"..to have someone with lived experience so open about it in the room… who can manage that?" C121

XXX's observations about her colleagues and her mentalisation of what goes on for them in relation to her lived experience seemed to correspond with some contributions from other team members. This is documented through B's comment earlier in this section (B41-42), in that B felt he could bring in this aspect in the interview in an explicit way, whilst E may have felt more uncomfortable or protective and spoke about it in a more indirect way also in the research interview. E referred to an „unresolved process" in this context but did not comment on what this was about or what she thought organised the team to no further plan/ think about this.

"..dilemma ….was not unpacked …. refer to how our own team processes … how we think about families …. for example, "over-familiarity"
I just don't think we have this discussion at a meta-level and think together: what is it that we want to offer? E88 -E91

C saw the team generally speaking about „over-familiarity", rather than referring it specifically to her and thought this was connected to it being too difficult to talk about, not wanting to trigger stressful feelings or making her feel criticized and putting it aside..
„..it was quite interesting to see how the team managed talking about overall practice, rather, then talking specifically about the case, kind of more saying about:

"how we manage when someone might be over familiar" or: "how you Clinician A, B, C manage when… "C16

"....ehm, but that didn't get said in the room, ….there was some holding back, I think that was being protective, of just saying why that might be. " C116

XXX brought in her observations and interpretations in relation to other team members' responses to her lived experience. She talked about protectiveness and professionalism being behind the "indirect", maybe "removed" communication style. I understood this as speaking to the moments in case discussions where team members respond to the perceived vulnerability of each other. On the one hand, wanting to be respectful and helpful ("protective"), at the same time, with ideas and dilemmas around what kind of communication relating to this suits a working environment ("professional"). It would have added relevant data to have contributions from others in the team about how they understand the "not talking directly about it in the group".

In terms of other social differences, XXX shared self-reflections which seemed to refer to some of his told and lived stories around gender and ethnicity.

"…I think my behaviour in the meeting speaks to ehm, the kind of dinosaur part of me you know the kind of XXX, man, white, feels his kind of primitive need to kind of chop his hands, point with his fingers, stamp his feet, to kind of put the ideas kind of forcefully, kind of the alpha, (chuckles) I think I am not a particularly finesse person, you know, I am, I am an XXX farmer, that's what I really am inside biologically and historically, that the person that people hear talking, but an XXX farmer that has lots of experience with children…" XXX.

The difference in age, professional experience and membership in the team got commented on only by the team member who represents a minority regarding these three social features. XXX spoke about how she sees this showing up in team interactions and seeing that the team response to this, similar to her lived experience of mental health seems to be protectiveness.

„.. me in particular, … off work …element of being protective over me but also cause I'm the newest team member…the youngest.." XXX

„Yeah, I suppose for the viewing of the others I often think about being in the team and what my role is in the team and even now, I've been there nearly a year, I am still the newest person and the youngest person..and the least clinical experience." XXX

C spoke about what it feels like to be so well protected, which spoke to a gender story of „ women in the team being mothering" that she sees in relation to the team.

"….Mhmmm.. it's nice sometimes but other times, it feels like you've been mothered and..(laughs) it's overwhelming and.. but I'd much rather have people be overprotective then a bit ignorant…" C123

"…like particularly the women in the team are quite mothering and I've wondered if they noticed what they are doing." C141-142

5.6.5.2 Subordinate theme 6.2 Emotions and feelings

Under this overarching theme, there are contributions that participants made about their experiences with the emotions that may play a role for themselves and others in case discussions, how the feelings may influence interactions and what is used to regulate feelings.

From what participants reported, it seems that a broad range of emotions is experienced in case discussions. Emotions may be commonly associated with both ends of a spectrum between feelings being experienced as stressful and negative or as pleasant and positive. On one end of this continuum feelings like anxiety, pressure, sadness, overwhelm, feeling attacked, shame and feeling put on the spot. On the other side, feelings like empathy, affection, safety, pride, enthusiasm and interest, compassion, attachment, and care.

As below citations show, participants brought examples of how feelings show up during MDT case discussions through the way how people talk (for example raising voices), they referred to body language that speaks to emotion (for example finger pointing to strengthen once position when feeling under attack), through behaviours that are meant to help regulate emotions (for example distracting oneself on the phone when feeling anxious, eating, being quiet, talking a lot and so on).

Feeling under pressure was mentioned in relation to having to be fast with capturing a case with all its complexities, and concern about how time is shared between all team members.

"…. feeling that I was taking too much time…" A14

"…impetus to move on and get straight to the point. ….cases are quite complicated " A14-A15

Or pressure from needing to talk about a case but being unsure if there will be time.

"That the meeting is highly pressures, there is not enough time, ehm people feel, they worry that they are not gonna get their cases talked about." B93

Anxiety was mentioned in relation to the risks that are held within cases.

"….It makes us anxious…" C103

"….I think, when we all are in that room, it just gets pushed, you can feel the anxiety anyway, wether the people want you to know.. or not…" C110

"…..we had not have anybody killed themselves for a long time …ehm … but ehm that's the bottom-line fear… " B96-B102

"…But you know there is that life and death fear, anxiety that's in the team…." B96-B102

“Anxiety…..They don’t know what to do…but young people don’t fit into pathways …..then that can create an anxiety of it….” B96-B102

Sadness seemed triggered in context of what clients are going through, their life and family conditions and circumstances.

“…and there is something terribly sad about that, …., but it’s also tragic, cause its some kind of transitory space for them..” F87b

“… a shared kind of sadness ….. something, that was quite nice shared moment of people being moved and feeling something….“ C133-134

“… …..trans generational transmission of mental disorder. parents, but just don’t have the resources. …… very ill lot of the time. ….sense of sadness.” F79

Participants commented on a sense of safety in a variety of contexts.

“I do feel that the team feel safe enough to say: Look, I am feeling this or have seen this in the process, does everyone else feel like that?” E45

“…. so there is something around the safety, …it allows that that sort of more dynamic, holistic view to be developed. “ G45

"…think it's about having the maturity; …as a team and that that gives you a solid feeling." G66

Respect between individuals and disciplines was mentioned in relation to creating safety.

"….as well it's having a group of professionals from different disciplines who also respect each other." G65

G talked about the confidence that she feels in colleagues who are more senior in the team.

"…. team members are quite senior. And that they also have that sort of confidence." G69

Compassion was mentioned in relation to others in the team.

"….you may feel compassionate for what is going on for the other person that day. " E47

Overwhelm was talked about in relation to a number of aspects of team discussion.

"MDTs can be an overwhelming place ad I think our team is like that. I am comfortable with that, but maybe not everybody is." B114

“„„manage what could be sort of overwhelming. Because these – some of the young people … ehm have so many needs.” G47

“.. it’s nice sometimes but other times, it feels like you’ve been mothered and ..(laught) it’s overwhelming …“ C123

“….the camera is focused on the group … in the middle of the group is this table …overflowing with food. … an indication of … the emotional state of the team…” B91

F referred to a feeling of pride in relation to achievements that clients or team members may accomplish.

“…..a young person has come back and she has turned things around, she has cracked it, and we feel so so proud of her.” F84

(looking overall at the discussion) “I think, looking at it overall, I felt proud of us as a team. That we are able to give such advanced thought to a case.” F56

Appreciation was felt towards other Clinicians’ work.

“….appreciation of the input of other team members and the hard work people like C, D and F have all done.” G73

Empathy was mentioned as a feeling towards the client that was discussed.

"… it evoked just a lot of empathy towards this girl (*emotional*) and you know her family and her situation." G72

XXX talked about feeling ashamed about some body language he sees himself performing in the video of the case discussion.

"…when I am saying that this child needs an advocate, I am ashamed to see that my index finger is pointing and it is a kind of telling off to assert dominance over the team.." XXX

G commented on "feeling being put on the spot" in relation to being Care Coordinator of a case that is being discussed.

"…as the care coordinator, felt … on the spot with the way … …of people asking … has that been done, has this been done." G79

Clinicians' attachment to clients was commented on.

"…a lot of people wanted to be part of the discussion. A lot of people know the patient and…. Well it's like ehm the attachment is not just from client. But the team is attached to the patient as well. " B49-B51

“This girl…lots of us feel, ….have a positive counter transference to her.” F80

Feeling criticised in context of own practice was brought up.

“„..you can feel very criticized, particularly within our team because it meant to be this like flag ship. Wonderful, best, the best team in geographical area..“ C123

“And I, it was really interesting watching him and his body language you know. And I think he did, not by us. I think he felt attacked by ehm the querying his diagnosis.” G77

Reactive responses to feelings

From how Clinicians talked about the responses or dealing with emotions, it seemed that there are on one hand responses that seem more reactive and immediate and where there seems to be less awareness of the feelings. On the other hand, there are responses that seem to be directed towards regulating and containing emotions.

In terms of the first category, individuals commented on how emotions can impact on the overall atmosphere and ways of interacting and understood some of what is displayed by individuals and the group as a result of stressful feelings.

“…..it can become quite chaotic … dancing around the food table …… people coming in and out..” B94

"… got a bit frantic in the team meetings.." A136

"…..people talk over to each other, interrupt each other, ehm … get a bit cranky." A136

" … ehm impatient, ehm … rushing on like move on'' A136

"…… acted out, translated into chaos….. could be showing what went into people….there is no space to deal with it, it compresses and then expresses as collective chaos." E117

A's experience is that this kind of atmosphere can lead to a lack of containment or frustration when individuals don't get to talk about a case.

"…we haven't got enough containment when that happens. ''A136 "Oh, I didn't get to what I wanted to talk about." A136

B thought that strong feelings can compromise clear thinking.

" ..the capacity to think clearly is slightly to be compromised…" B53

A thought that there can be an impact on the ability to hold a therapeutically minded position when there is pressure.

"…when we're not stressed ……we are all therapeutically minded... when we're all stressed then … certain topic becomes more of a …. retraction I think for all of us…" A146

Containment responses

The following contributions could be understood to belong more to the second category of responses, which seem to be more consciously chosen strategies for containment and emotion regulation.

G talked about how when vulnerability appears within the team or with clients, she sees the team being supportive and taking care of this vulnerability.

"…… if somebody is vulnerable … we support them. .. we bring them in and we make sure that they are looked after. …. happens in the team…. happens in joint sessions ….." G70

G observes that when upset or distress is caused within communication and interaction, she sees that this is recognised, acknowledged and reflected on and taken into account for further planning.

"…..are said or there are difficulties …..they have got very upset or very distressed that is recognised, acknowledged. …, we've thought together of how we can manage that…." G66

"….if somebody does do something that doesn't feel safe, it will be questioned and people will say things in a way that is appropriate…. and we'll try and respond differently." G67

A number of experiences in socially regulating feelings in team meetings were shared.

"….even if we are extremely busy; it helps to commit to the team meetings and to attend in time" A138

"….and anxiety means we all need to have a tight.. yeah, plan..." C104

"…. young people who bring up a lot of anxiety in the room, to the point where we do mindfulness and breaks and.. (laugh) ..or QiGOng…" C104

"…..it was quite nice.. we just can hold it …and acknowledge that." C137

"I like naming emotions so..I would rather be like ..named in the room but ..that just a personal thing, more then a team thing." C138

"… we often all feel steered up and then we take that away with us, bring it to the next meeting, a reflection would interrupt this I think and regulate us and make us think clearer afterwards…." E121

Several participants commented on eating during MDT as a way to regulate or manage emotions.

“At least you’re feeding … that we need something nice. “ B90

“…as some sort of a talisman against the stuff we are discussing. We kind of eat …. to kind of smooth us, take us through this awfulness….” F44

“… and you know some people said it is distracting. .. other people have said: …a way of giving us, ourselves some treats while we are discussing particularly painful things.” G89

F thought about that he disengaged in the case discussion to deal with overwhelm.

“…I had been absolutely tuned out, on my phone you cant maintain focus in that meeting continuously. “ F64

The team is seen as a place where emotions can be expressed, and this is seen as a way to processing emotions.

“… the emotional impact in some and it can come up and you’ll go: ‘oh my goodness…that was really hard, that was really difficult..I’ve learned this..I think that’s one of the strengths.” G59

6 Discussion

6.1 Introduction

This is the final chapter of my thesis. It speaks to how I see insights from literature, practice insights, insights from analysing the collected data and applying the introduced methods relating to each other, how I reflected on their interplay and finally, how I see this informing future practice and research.

As outlined in my introduction to this thesis, context holds a central place within systemic thinking and my thinking. I identify with Bateson's postulation that context gives meaning, and questions of context and surroundings have organised my thinking throughout all research elements. This is no different in this last chapter. I talked about my philosophical orientation right at the beginning of the thesis. Although my philosophical orientation has not changed and continues to constitute a part of my current perspective, my view on methods has changed over the time of this study. I therefore think it is essential to first explain to the reader these changes in my view on methods and talk about how they came about. I hope this once again defines some of my contexts and articulates the surrounding I am standing in when reflecting on the different insights from this study.

I will begin in 6.2 by reflecting on my journey as a researcher and discussing what meaning my research journey had on my view on research methods and my systemic practice.

I also discuss what I thought influenced the findings and how I may have done things

differently to show how results are local and particular to researcher choices, participant contributions and researcher-participant- relationships.

In 6.3, I speak about limitations, learning points and what I could have done differently. I then go on to show how I see the findings relating to my research questions, to insights from literature and to my practice experiences. C3: The overall process showed that although I had aimed at findings that bring insight to my research questions, “additional insights” showed themselves. These results seem meaningful to introduce because they can help think about future research and practice and are interwoven within each section. From section 6.4 to section 6.7, I discuss findings according to the chronology they had in Chapter 5. To help the reader connect the findings with the discussion, I start each section with a summary of the findings being discussed. Where relevant, I introduce how I see results informing future research and practice.

6.2 Research journey and its influences on my view on methods and my practice

A feature that accompanied my research journey and that may be common for research processes in general, was the high levels of uncertainty in terms of what challenges and dilemmas may show themselves in the process and what solutions I would find. If I think back at the beginning of the journey, I saw a linear and structured path in front of me with several tasks and processes that I conceptualised and planned in a straightforward chronology. Not un-similar to a moment in an MDT-case discussion, when everyone comes together with a structure for the meeting, a list of cases to discuss and ideas to create plans.

Then, as my-research- journey continued, unpredicted junctions and cross-roads

appeared which at times looked foggy or showed obstacles on the paths. Obstacles, junctions, crossroads, and fogs came in the form of research dilemmas, administrative delays, and life events. Alongside that came a discovery of levels, dimensions, and facets of the processes and contents I was interacting with that formed a level of complexity which for me at times invited doubts and an uncomfortable, sometimes painful sense of not knowing and being uncertain.

My relationship to this kind of uncertainty has changed in that it has increasingly felt more tolerable to experience "not knowing" and moving within an open process. Initially I was seeking certainty through guidance from other people and literature as well as methods that give concrete structure and orientation. Through going through this process many times within this research project, I increasingly recognised that the "not knowing" is a "not knowing yet" or "not knowing some things" or "not knowing exactly". I saw that solutions showed themselves when I stayed immersed in the content and process at each given time, when I gave attention to the material and when I acknowledged that this needed as much time as it needs.

This experience and insight seemed familiar from my practice as an MDT member in different teams. Communication and thinking in MDTs bring comparable dilemmas in that, as practitioners, we often try to understand clients and the challenges they are experiencing with their complexities and their multiple dimensions.

We don't have answers to these challenges and may have different views amongst our teams. Some of the requirements in these situations then become about settling for a level of uncertainty that is helpful to the client and doable for the team.

The described process I experienced as a researcher and systemic practitioner also featured in the data. It showed, for example, when participants talked about how they work with the differences between them (for example, the difference in discipline or role), how they work with the contradictions that come within some of the tasks that MDTs are supposed to deliver (e.g. to work collaboratively within hierarchical structures), or when participants talked about the movement between positions of certainty and uncertainty in their communication.

Participants described how this can come with intra- and interpersonal tensions and touches on dilemmas that I see at the heart of MDT communication. The tension can be described as located between two aims that are there at the same time.
On one side, the aim is to understand and acknowledge as many differences, nuances, layers, and dimensions of a phenomenon as possible. On the other side, there is the wish to translate the insight that comes with looking from different perspectives into coherent and concise narratives, nameable entities, plans and actions that allow for a helpful response.

For me, within this research process, it felt like a never-ending search for a helpful balance between these two polarities for each chapter and maybe featured the strongest in writing this chapter, as it felt like an authoring crescendo that must bring all complexities together into a concise and coherent picture that would ideally allow for some level of concreteness in its conclusions.
Experiences throughout the time that I have been working on this study contributed to

the movement in the perspectives I took on methods.

Observing the movement regarding my views, priorities and preferences showed that I became increasingly interested in autonomy and flexibility within research methods. The shift showed in how I experienced IPA as an analysis method. From finding it helpful in the beginning to perceiving it as full of dilemmas later in the process. IPA asks researchers to distil data into very few themes, and I wanted to capture the broad range of contributions. The idea of distilling data into fewer and more concise themes is an IPA strategy to communicate the main points found in the data (Pietkiewitcz and Smith 2014). I noticed that I could only do this to a certain extent because my research question was asking for the data to show itself in its broadness, and the further narrowing into fewer themes did not seem meaningful when aiming for showing a broad range of experiences.

6.3 Limitations, learning points and what I could have done differently

In this section, I will discuss some moments and choices from my research project where I have identified limitations or learning points related to my choices. It shows a selection of points that I saw as most relevant.

Recruitment

More towards the beginning of this research project and during the phase of recruitment, I was focused on finding a team to participate. I was thankful that this team agreed to become part of the study. From the results, I realise that this team sees themselves as generally working well together and they seem confident in their capability to fulfil

their role and to work together in this; there were also numerous comments on relationships in the team feeling supportive and a sense of safety often being experienced. I realise that from this place, it may feel easier to agree to let an outsider come in and look at one's MDT practice; compared to a team where there may be more relational struggles or teams that are experiencing significant challenges in providing the service, for example when holding a "never-ending" waiting list.

A study like this may have brought about very different results in a team that experiences significant challenges in their working together, for example feeling unsafe or disempowered, or facing unfulfillable tasks; results in teams with significant working-together-challenges may have questioned the idea of MDT working fundamentally. This could have highlighted experiences that I see very much being part of some teams, which did not show in this study. Whilst I have highlighted throughout my study, that results are local and particular, I think it would have been helpful to have available data from other teams, not just to show a wider range of experiences but also to explore and address general doubts about an MDT set up within the NHS. This debate is often held in a somewhat reductionist manner and mainly under the question of cost-effectiveness, which is also a relevant question, alongside the question of outcomes for teams and, most importantly, clients.

Recursiveness

My research design included opportunities for recursiveness within the research process in that I asked participants about their experiences of the research process and also how it compares to their experiences of routinely held MDT case discussions. These results

were introduced and discussed in chapters 5 and 6. I also contacted the team once I had identified the main themes and subthemes to introduce them and invite the participants to comment on them. This happened three years after running the study. This length of time in progressing to that stage was to do with personal circumstances that had required me to ask for intermissions.I had no response to this correspondence, which may have to do with the overall changes in the trust and team, also the team constellation, this is not clear. It may also have to do with the length of time it took for me to get back to the team, in that it may have contributed to the team feeling less invested in contributing to the process.

It could have added very valuable information to have put more thought into planning this element of "inviting recursiveness" better. I could have perhaps allowed more time for a response, or I could have attempted correspondence more than just once. I realised that practical and life pressures created a context that led to my choices, but it would have added another opportunity for recursiveness, which, holds potential to add validity and depth to results within qualitative research.

Confidentiality

Although I had considered how best to protect the team's and individuals' confidentiality, and this is described in Chapter 3, I realised at some point, when I was writing up results that the measures I had taken to anonymise data, may not seem to address confidentiality dilemmas sufficiently.

For a meaningful account of the data, analysis and result accounts required to link individuals' contributions to their discipline or to mention certain specific team features.

It linked contributions to a specific person, because there is only one psychologist, one family therapist and so on in this team. It also linked contributions to this specific team, due to some of the team's specific features that needed to be discussed within the context of this study. These are confidentiality issues related to the team internally, but also to audiences from outside the team, for example other teams in the trust or senior managers in the NHS trust.

Whilst I would have liked to make my full study available on the Tavistock repository, individuals' confidentiality was more important and I decided to apply for thesis-embargo, which aims at ensuring that only parts of the thesis are accessible and participants' confidentiality is protected sufficiently.

Analysis

-I am aware that the analysis could have paid attention to aspects that I have not mentioned, such as spatial aspects or the tone of communication, but due to the limit in word count I had to set priorities and make selections on what to expand on and what to leave out.

-With a larger word count I could have included a section dedicated to body language, how it showed up in the data. One option would have been to map out in what way body language had been referred to. Methodologically, something like an "embodied inquiry" (Johnson, 2013) could have provided a helpful framework for capturing embodiment and felt feelings. This approach corresponds with a phenomenological method like IPA in that it acknowledges the inseparability of mind, body and environment in human experience. It stresses the significance of bodily sensations, movements and gestures in

understanding phenomena.

Case Discussion

As any case, the case that was selected by the team for the recorded case discussion had particular features, as outlined in the findings. These features also form part of the context for the team discussion. The discussion of a different case with for example less involvement of different team members or maybe a client that would have been newer to the team, or one that had less safeguarding aspects involved is likely to have organised the team differently and it would have been helpful to ask more questions about this, for example to ask how the discussion for this case was similar or different to discussions relating to other cases. It could have also make sense to organise contributions relating to the features of the case and the particular young person that was discussed as one distinct contextual level. This may have brought about clearer results pertaining to the impact of the selected case and it's features on the case discussion communication, for example summarising what this young person or this case meant to individual team members and how this impacted their contributions and responses in the discussion.

6.4 Discussion of findings presented in 5.2 (Contextual information for each participant)

Ethnicities: Whilst the literature I introduced in chapter 2 (Health and Social Care Information Centre 2013) does suggest the underrepresentation of BAME, a completely ethnically homogenous team seems unusual. To better understand this, it may have been relevant to know more about this homogeneity's time frame and include interview questions referring to this. Me fitting into this homogeneity in terms of race may have contributed to me not noticing this at the time of the interviews.

Gender: The ratio in this team is 4 female and 2 male team members, which seems to correspond with feminisation tendencies in the healthcare field (Geordan et al., 2019) and also has been my experience in the various MDTs I practised. It seemed striking to me that the only two male professionals hold the highest leadership positions, which fits with Lantz's findings (Lantz, 2008) that I introduced in the literature section. It suggested that although the number of women in leadership roles is increasing, women remain underrepresented in healthcare leadership.

Time in the team: This level of staff retention seems extraordinary when comparing it to the overall retention crisis in the mental health field (Yifeng et al., 2018). I have not enquired directly about this in the interview, but some of the results relating to team identity, team structure and relational features would explain that team members appreciate working in this team. Some of the appreciative team-descriptions were a

sense of capability, helpful leadership, feeling respected with their contributions, a sense that it is a supportive environment. These perceptions could partly explain the unusual retention level in this team.

Disciplines: As outlined in the literature, numerous authors (Colombo *et al.*, 2003; Peck and Norman, 1999; King, 2001; Nic a Bháird *et al.*, 2016) mention different discipline constellations as common. What seems to stand out is how the role of systemic psychotherapists, also called family therapists has not been featuring much in the literature. This may be related to ongoing changes in how systemic therapists are being employed within NHS mental health teams. From my practice experience over the last 13 years, it seems that there has been an increase of systemic therapists in mental health teams, but this seems to also vary between NHS trusts and may further vary when comparing mental health teams in London and other big cities, compared to mental health teams in more rural areas of the UK.

On reflection, incorporating social class may have brought additional insight. Coming from cultures (Serbian, Croatian, German) where social class is referred to differently than in British culture made me consider social class less.

The team holding the features described above demonstrates that additionally to the difference that is assumed in MDTs concerning disciplines, MDTs hold many more differences and vary by the level of these differences. I see these variations in differences highlighting the local and particular character of results in this study and this forming one context for communication. For example, suppose there had been more heterogeneity in ethnicity or a different gender constellation. In that case, participants

may talk about experiences and perceptions of their MDT communication that were not mentioned by this team, or they would have experienced them differently.

HOW I SEE THIS INFORMING FUTURE RESEARCH AND/OR PRACTICE:

-In terms of future research, these results highlight the need for MDT research paying attention to the local characteristics of the participating teams, how they impact results and how results may look different in other teams. The results show how small scale studies like this one can give weight to local characteristics of a team and complement bigger scale research that often have to work in a somewhat reductionist fashion to make date generalisable.

6.5 Discussion of findings presented in 5.3 (Results relating to my relationships with participants)

The **level of familiarity, connections and disconnections and emotional postures** between each participant and me varied, and these were some of the factors that impacted how I offered interview questions. Where higher levels of familiarity and connections were featured in the relationship, I had a more tranquil emotional posture. Coming from a more tranquil emotional posture made me ask more in-depth questions and included more double-checking; some other emotional postures seemed to have contributed to staying closer to the participants' first answer rather than asking follow-up questions. Knowing me as a person a bit more from the past may have contributed to some participants presenting more nuances in their views, more contradictions, and more self-reflection.

This would correspond with McEvoy's view (2001) on pros and cons of both emic and etic researcher positions. In introduced McEvoy (2001) in the methodology chapter. I agree with his view that both research-positions need awareness of the opportunities and challenges that come with each position. To pay attention to this, I incorporated reflections and developed the tool for analysing my relationships with each participant. Whilst these elements in the research design brought some awareness of the relationship aspects above, they did not clarify or reassess in what way the level of familiarity influenced interviewees' positions in the interviews. This part of the process would have benefitted from more recursiveness through inquiry of participants' perceptions of the researcher-participant relationship.

Judging from the above considerations, it may be that the voices of people who were more familiar with me and more similar to me feature in a more nuanced and detailed way.

HOW I SEE THIS INFORMING FUTURE RESEARCH AND/OR PRACTICE:

-I think that the research aspect of "relationship between the researcher and participants" could benefit from continued inquiry. Although my method of inquiry was helpful, it also showed its limitations in the format I applied it. As outlined above, it would have benefitted from adding a recursive element in it or other elements that would allow recognising better and more of how relationships between researcher and participants influence results. Future research can build on these results and could use insights from practice to do this, for example, inquiring about this through relational reflexivity questions (Burnham 2018).

6.6 Discussion of findings presented in 5.5 (Influences on recorded case discussion; Experiences of Participating in the study)

Influences on Recorded Case Discussion:

As outlined in the literature that I introduced in the methods section and relating to the use of video recordings in research (3.4.2), there is some controversy in writers' views on the impact that videotaping of a routine activity has on its authenticity. Some think the video material represents routine activity (Vihman and Greenlee, 1987; Vuchinich, 1986). Others think the videoing activity distorts the research phenomenon (Gottdiener, 1979: p. 61; Heider, 1). Participants' comments in this study seem to correspond with both. My impressions from family therapy practice, where one-way mirrors are used to include a team of therapists in an intervention. Surprisingly for me and my colleagues, clients often commented that they forgot about the set-up once the process and interaction in the room started. On the one hand, one could say from the contributions that spoke about "business as usual" when comparing the taped case discussion with the ones that the team usually has, in that the technical recording of the case discussion did not seem to organize team members significantly and corresponds to one part of the literature commented above and my practice experiences. On the other hand, team members did comment on "being on best behavior" as in "interrupting less" in terms of their communication style, due to being aware of the camera. Listening to each other, as opposed to "interrupting" can contribute to a more relationally and emotional aware exchange (Kielcolt-Glaser et al., 1993). Whilst team members did not connect the

presence of the camera with achieving more debth and a more holistic exchange in the recorded discussion, I am understanding “less interruption” as participants managing to regulate impulses and emotions better. As outlined in the literature review, this can contribute to a more attuned exchange (Hardwick, 1999) and may have felt encouraging of contributions.

There was a difference in the time frame for the taped case discussion compared to usual case discussions. This was as a response to being given autonomy over the case selection and time frame. The team gave themselves 10-15 minutes and ended up discussing the case for 20 minutes as opposed to 8-9 minutes which they usually do and they felt that more time brought more depth to the discussion. These experiences correspond with the introduced literature that highlights the impact of time pressure on the nature of - and outcome on communication during MDT case discussions (Donnison, Thompson and Turpin, 2009). Donnison and colleagues found that stress through time pressure results in case discussions that encompass less depth. The results in this study showed how the team noticed the difference of having had more time than usual, in that more time generated more holism.

Both the above aspects, the impact from the camera and the impact from less time pressure sheds light on emotional-relational aspects of MDT communication that in my view often get overlooked or not so much talked about and yet, as shown here significantly impact how much individuals decide to contribute.

It seems important to note that the team changed the design of the study in that more time was invested in the case discussion than usually, which took out stress that usually comes with time pressure; the presence of the camera added an emotion or impulse

control element, which seems to have reduced relational or emotional stress that can come with interrupting and being interrupted. The notion of both is significant when trying to understand the reliability of the results found, in that that the results need to be seen with the above described context, rather than the context that I had planned for in my study design.

Experiences of Participating in the Study:

The comments communicate that watching the video of their case discussion and being interviewed about it was experienced as interventive. In that, the research design and the researcher-participant relationship not only facilitated data collection but were experienced as reflective processes for participants and the team, in that they contributed to generating and capturing new insights about team members' inner and relational processes. Reflection processes in MDTs are commented in the literature I reviewed and Garven (2011) sees reflective practice as a method to effectively assist teams in coordinating their many talents, concepts, and duties in a multidisciplinary setting.

Considering participants' comments on their experiences with reflections from a meta-perspective in this study confirm Garven's insights about the effectiveness of reflective practices in MDT contexts and demonstrate how powerful self-observation through video-material combined with the opportunity to reflect can impact on thinking about MDT communication.

HOW I SEE THIS INFORMING FUTURE RESEARCH AND/OR PRACTICE:

-Using the filming of an MDT case discussion and the subsequent watching and reflecting on it as a reflective tool for teams could support teams in developing more clarity and awareness of their individual and relational processes in their MDTs. Sharing their observations from watching the video could allow teams develop more understanding of each other's positions in communication. If this tool was applied routinely regularly, it could help teams to include changes of their team- constellations in ongoing reflections and adjust MDT setups and features for the team at a certain time.

6.7 Discussion of findings presented in 5.6 (Organisational-, Team-, Relational- and Identity Contexts)

6.7.1 Introduction

As outlined in the introduction to this chapter (6.1), there were findings that relate directly to the research questions asked. They are summarised and discussed in this section (6.6) and form the heart of the results.

The research questions I worked with when setting up and conducting the study and analysing the collected data were:

What do team members experience during communication in a case discussion? What do they see influencing the exchange between team members during case discussions?

Results suggest that participants experience their case discussion communication influenced by various contexts that I understood as referring to organisational, team, relational and identity contexts. Although I used these compartmentalisations when capturing and structuring the influences on case discussion communication, I want to be clear that I do not consider these contexts distinct fields but, in part, overlapping and fluid. I will discuss each context in the now following sections.

In this chapter (6.6), I summarise results from each contextual level and the according subordinate themes. In the discussion for each context, the chronologies of the subthemes at times vary compared to the chronology of the subthemes in the findings in chapter 5 and finding-summary sections in this chapter. The reason for it is that they connect and interrelate between each other. To articulate links between subthemes and show how they are intertwined, I changed the chronology of how they appear within the discussions. To help the reader's orientation I have used a bold font for the subordinate themes in each of the summary of findings sections.

6.7.2 Organisational Context

Hierarchical Structures and Adherence to guidelines:

Results show that the team adheres to NHS and their NHS-trust's guidelines. The NHS guidelines which are part of a hierarchical organisational structure in the NHS that goes alongside guidelines that request the team to collaboratively consider and plan care in MDT communication. This highlights an oxymoron that is implied in the NHS guidelines. The guidelines request an influence of various disciplines and views on the

one hand, whilst equipping one narrative, which is the medical model thinking and one discipline, psychiatry, with more power.

The guidelines referring to MDT practice define MDT working as:

"A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations." (DOH 2015, p.12). Although the definition indicates communication between differences, the referred document does not comment on how differences can communicate and misses to acknowledge the complexity that is implied in this task. I argued in my literature review that NHS publications and guidance lack substance on a content level, in that often meanings that seem implied in terms like "drawing appropriately", "effective collaboration", and "cost-effective" remain undefined and therefore their meaning stays unclear. Not contextualising those terms leaves meanings un-articulated and shows how the strategic leadership of policymaking gives little attention to the existence of the variety of epistemologies whilst at the same time claiming to be integrating and inviting them on an operational level.

I referred to Galvin and McCarthy (1995) and their point about the challenges that come with the medical perspective being given power above other perspectives. They found that this can undermine the multi-disciplinary nature of teamwork, in that the disciplines may be present but don't get to influence views and decisions.

Whilst the team's experiences in this study seem more nuanced and show the

interdependency to other factors, for example time pressure or emotional safety, participants also spoke about the tendency to centre case discussions around medical model thinking. Galvin and McCarthy's points bring awareness to the contradictions and dilemmas which lay in the idea of MDT-meetings; contradiction and dilemmas that are not acknowledged within NHS guidelines (DOH 2005) for MDT communication and leave each team to deal with this in their own way. From literature (Bhaird, 2016) and my own practice experience, the result is a huge variety in how MDT case discussion communication is organised and leaves a vacuum in the organisational guidance for teams. This also corresponds with my experience when working in different MDTs. Depending on how equipped leadership in a team or service feels around facilitation of communication between difference, this can result in rich exchanges that contribute to holistic and individualised perspectives on clients on one end of the continuum. If individuals in leadership positions feel less equipped in facilitating communication between difference, the vacuum in guidance may be occupied in random, less planned and intentional ways, which means that a costly resource, namely MDT meetings are not used as well as they could be.

Diagnosis for each child:

In this NHS trust, the above described is further strengthened through each child requiring a diagnosis, and participants spoke about how a diagnosis is thought about for each case. The reductionism that can come with this can undermine multi-dimensional exchange. King's findings (King 2001) suggest that when multi-dimensional exchange gets challenged through hierarchical structures, it can lead to clinicians not feeling

valued in their profession or expertise. This was not voiced directly in this team; however, one participant described that an alternative approach (to NICE guidelines) when responding to psychosis is being spoken about more on a one-to-one basis, but not as part of a team's case discussion. It may indicate a culture that sees "alternative views to psychosis" as private views that don't fit or are not welcome within the NHS organisational structure, which can be seen as a form of weakening or undermining multi-dimensional exchange.

It highlights how communication between difference in an organisational context that holds hierarchical structures is likely to need explicit invitation of difference to create a welcome culture for different disciplines to feel safe contributing from their perspective. The NHS literature I reviewed and also my practice experience suggests that organizational structures within NHS teams currently don't offer this guidance and would benefit from adjustments that take this into account.

<u>NICE Guidelines and individual needs and Action and planning vs reflection:</u>

Tailoring guidelines to meet individual needs is experienced as a challenge due to the organisational structure. Guidelines were experienced as treating individuals as standard "packages" instead of catering to their unique requirements and diagnosis is a practice that strengthens this. In the recorded case discussion, this dilemma seemed to have been addressed by one team member by bringing in the question about the client's wishes. Other team members, including people in leadership roles, welcomed this direction in the discussion and gave it space. At the same time, some comments acknowledged that the team may not have considered the client in such a multi-

dimensional way as in this discussion, if they had not agreed beforehand to give this discussion more time than usual for the purpose of the research participation.
The structures described above asks for labels, for action plans, they do not ask for the team to reflect on their process or consider the different values; this plays out in team communication in that reflection and consideration of values is not prioritised or routinely embedded in the structure. In terms of the MDT concept benefititing clients, for example by ensuring a holistic perspective on individuals as part of their mental health care (as outlined in chapter 1 on page 10) , it highlights that achieving a holistic view on clients and planning for holisitic care seems not to be automatically achieved by including a number of professions into a team. It depends for example on how much time is available for discussing each client and also how this then impacts which professional voices get heard and which may be not expressed in light of time pressures and in light of hierarchical team structures.

From my practice experiences in several different Camhs teams, the somewhat paradoxical task of collaboration within hierarchical structures is not impossible to translate into a type of MDT exchange that caters for a communication where people can influence each other whilst respecting guidelines and structure. At the same time, in my experience it depends on each team's team members' (including management) awareness and willingness to actively invite difference and explicitly welcome alternative perspectives as well as reflective practice.
Structures that are given through NHS guidelines don't seem to currently support or guide in this direction. As shown in my literature review, there seems to be a "told

story” in NHS publications of actions to implement helpful communication in MDTs (DOH 2015). When looking through the literature, I introduced and the results in this study, the “lived stories” do not confirm NHS guidelines providing orientation for MDTs to organise their case discussion communication in a way that can respond helpfully to the dilemmas described above.

Instead, teams are left with responding to this task individually, which may partly explain why there is such a variety in how communication in MDTs looks in different teams and how this dilemma is responded to. When encountering the different ways to do MDT case discussion communication within my practice as a therapist in CAMHS teams, I never considered what guidelines offer in terms of orientation for communication in MDTs. As outlined in the literature review, the NHS guidelines relating to MDT communication seemed vague and don't acknowledge the paradox in the requests to MDT teams. It seems like a missed opportunity.

HOW I SEE THIS INFORMING FUTURE RESEARCH AND/OR PRACTICE:

-If the paradox within NHS guidelines and related challenges were acknowledged by policy makers and articulated within guidelines, it could help organisations develop helpful guidelines that better support teams when finding ways to implement the guidelines that come with contradictions.

For example, guidelines that suggest a structure that includes a regular forum for teams to consider with each other the meaning of the power imbalances within their communication and how they see it impacting their exchange and outcomes from MDT case discussion.

-It would be essential that policy-makers consider and articulate the philosophical stance they come from when creating guidelines.

-Additionally, it would be essential to develop processes that consider how "helpful or effective MDT communication looks like" and consider how a "multi-dimensional formulation" as a result of an MDT case discussion could look like. This could give teams orientation that go beyond "following NICE guidelines" and "diagnosing each child" whilst "working collaboratively" and applying "effective communication".

6.7.3 Team Context

Working with risk:

Working with risk is a significant team context for this team. Participants talked about how risk in cases that are discussed organises communication. The experiences are that high risk brings pressure, which can result in stress and anxiety, making it harder to consider different ways of thinking but prioritising clear and fast plans. This was also referred in literature. Foster (1997) found that the impact of stress and anxiety on communication in a multi-professional team can result in an attempt to hold on to the most familiar, which can make listening and negotiations between differences difficult, but also challenge the ability to tolerate and hold ambiguity and uncertainty about insights and understandings as well as care planning. Further pressure was mentioned in relation to an aspect of team identity.

Team Identity:

This team sees themselves as functioning as role model to other teams due to their specialism for severe mental health and risk. The experience is that this can translate into the idea of needing to function at "golden standard" in relation to risk management and can feel stressful, which then may be another factor that invites pragmatism.

Participants also spoke about their experiences when working with high risk in combination with working under time pressure. They see this adding further pressure to being fast in making clear plans rather than inviting multiple dimensions. In cases or time periods where risk is lower or there is more time, case discussions are perceived as allowing more holistic thinking about individuals.

As I showed in the literature review, the aspect of time constraints inviting less multi-dimensional thinking is also referred to by Johnstone (2018) and Fay et al (2006) and my practice experience in different teams confirms the correlation between stress and pressure challenging the aim to hear, discuss and expand different perspectives, but often directs conversations into planning.

In this NHS trust, there seems to be an acknowledgment that higher risk needs more time and the team is set up to have smaller caseloads than other teams in the trust, which was described as allowing the team to have more in-depth discussions.

From my practice experience, this is not the case for all teams who work with high-risk and a team context of high risk combined with time pressure can lead to decision-making that is mainly led by hierarchies and medical model thinking and leading to influences from other perspectives not being utilised as much as they could.

MDT Structure:

Regarding the MDT structure, there were contributions that commented on what influences the flow and punctuation in case discussions. Results showed that formal structures only form one force that influences case discussion flow, such as the meeting chair or a leadership role suggesting it. At the same time, informal factors influenced punctuation and pacing in the discussion. One point that was made related to how complications in casework may trigger frustration for some people. Whilst this may not be the case for everyone, through their body language or voice, they may communicate impatience, and this could become an impetus to move on. What may be considered a subtle feature becomes significant depending on how this does or does not get negotiated.

The aspect of negotiating daily encounters and the meaning this may have for MDT case discussions is also discussed by Griffith (1997), who highlights that societal and organisational structures cannot replace these. As outlined in my literature review, he sees teamwork as a continuous practical achievement that results from the daily encounters and small-scale conflicts of individuals tasked with making MDT- working a reality (Griffiths 1997). My experience as MTD practitioner has been that a feature like "impatience as response to complications in casework" may not necessarily be noticed with awareness by everyone, but nevertheless trigger an impulse in some people to move on in the discussion or conclude with a plan. The pace in which then the next thing is discussed does not invite negotiations; rather, at times impulses to move on are so strong that this type of dynamic could be understood as a "taken for granted" course

of action. The taken-for-granted course of action is then “when there are strong impulses to move on, we move on “.

In this team, there are negotiations from person to person as Griffith (1997) speaks about. They challenge how the flow of the discussion goes if they feel what is happening is not helpful. At the same time, participants commented that this is not the case in all MDTs and depends on team members’ sense of safety with each other and touches on team identity. Participants spoke about feeling they are a “stable team” with a sense of capability and confidence to manage difficulties together. They characterised their team as stable, nurturing, able to constructively express differences, supportive, and close.

Alongside experiencing themselves overall as able to constructively express difference and some voices that commented on feeling safe to challenge each other, there were also experiences of feeling anxious when challenging each other.

The sense of safety is experienced differently by different people in different moments in the discussion and additionally touches on how power differences are being negotiated. This is just one of numerous micro-examples that participants talked about, which speak about the complex and at times complicated relational processes that go on in MDTs. It corresponds with and illustrates contributions that Shaw et al. (2007) made when they argue that the rhetoric often applied in relation to multi-disciplinary working does not address the complexity of the relational processes that are part of it.

Addressing the complexity includes paying attention to these different dimensions and the next chapter, which discusses the relational level, presents more details of these dimensions.

HOW I SEE THIS INFORMING FUTURE RESEARCH AND/OR PRACTICE:

-It would be helpful if teams would have a regular forum to consider their process of MDT communication and reflect on how they experience the different perspectives being invited/ received/ expressed/ integrated. Depending on team dynamics and resources, this could be facilitated by team members or facilitators. Resulting awareness could shape communication in future meetings in helpful directions that could support a multidimensional exchange. If this is not suggested within guidelines, this could be initiated within teams.

6.7.4 Relational Context

Interplay between different disciplines:

The literature I introduced referred to the ambiguity in relation to working with different disciplines which were experienced in this team. Participants referred to this ambivalence when talking about appreciating various views and the richness and multiple possibilities of this. At the same time, they referred to the challenges that the difference in disciplines can bring for communication and interaction when aiming to agree on a plan forward.

Colombo et al. (Colombo *et al.*, 2003) looked at beliefs around mental health held by different disciplines. They found that the beliefs tend to correspond with what may be assumed for each discipline, but each discipline acknowledges and recognises influences from factors commonly associated with other disciplines. This could be understood as the experience of appreciating differences in perspectives. This process seems to include looking from one own's perspective, whilst hearing and

acknowledging others' perspectives and Colombo and his colleagues found that "*Few disagreements arise when working with patients described by all disciplines as 'clear-cut'", for example non-medical staff supporting the need for medication or care in hospital for people who pose risk." "... with patients somewhere on the road between distress and illness, things can become difficult"* (Colombo, 2003, p. 1566).

There were experiences in the team of this study which contradict that, in that the team was discussing a case that included high risk and hospitalisation, but the controversy between disciplines seemed to evolve around the way how diagnosis is applied; one professional insisting on a certain diagnosis whilst another asks questions about the symptoms and the different views that could be held on these, whilst also wondering about the pacing of diagnosis, which is eventually met with an authority stance by the professional who occupies a role that holds more power.

In my experience, it does not happen often that the psychiatrist's diagnosis is responded to with questions and alternative ideas. Diagnosis and high risk are often considered needing medical input and being lead through the psychiatrist and he or she would not often get challenged in their assessment, as they are considered to hold most expertise on this aspect of care. In this team, it may be that the high level of experience with psychosis by both clinicians and both holding senior roles allowed more debate. This contradicts Colombo's (Colombo *et al.*, 2003) view that a "clear-cut-case" does not lend itself to contrary views.

What happened in this recorded case discussion shows how the discussion can expand when the "taken for granted" narrative is questioned;. However, it also showed how the hierarchical structure was invited to decide. This seems to touch on what Shaw et al.

(Shaw *et al.*, 2007) addressed when they consider the different disciplines' socialisations in their professional identity and the impact of hierarchical structures on collaboration between different disciplines. They found that professional socialisation through educational institutions does not teach much about collaboration and synthesising with other perspectives but more about professional boundaries and the discipline's expertise. I would argue that educational institutions that teach second-order systemic theory and practice cannot and do not avoid teaching about collaboration between professionals and colleagues from a multi-dimensional perspective. This is because the inclusion of difference and collaboration are essential parts of systemic second-order thinking. From my practice experience, systemic practitioners, through their training seem one of the best-equipped disciplines to work in an MDT context. In the above-described communicational exchange, it may not be a coincidence that the systemic practitioner challenges a taken-for-granted practice. Parts of the systemic training could be be utilised to help teams make use of their differences in views and Garven (2011) spoke about her work with MDTs, where she employed a reflective team approach to help teams achieve exchange, dialogue and synthesising of the different views. I will talk about my resulting ideas in terms of guidance for teams and the NHS as an organisation in the conclusion section.

An additional aspect that played a role in the above communication section was the use of power. How power differences show up in communication in this team was commented on from several angles.

Interplay between power levels:

Medical discipline, the role of psychiatrists, the medical model narrative of mental health, and the diagnosis practice were all mentioned as holding superior power levels to other disciplines, roles, narratives, and practices. These power imbalances were experienced differently by different individuals in the team. They can not all be discussed here due to word count, but I will discuss a few examples to illustrate the impact power distributions can have within MDT communication.

Regarding hierarchical structure through the NICE guidelines, A. talked about alternative approaches to psychosis and how it can feel risky to bring them in and question diagnosis. NICE guidelines see early diagnosis for psychosis as imperative (NICE 2014), and A explained how this implies negligence if the diagnosis is questioned or paced. It highlights how the imperative in the guidelines may stop someone from expressing alternative views while being invited to bring them.

Some participants commented on a flat hierarchy in this team and that „there is no shortage of assertiveness“ in case discussions; the psychiatrist commented how he feels he has to work hard to assert himself, which implies him experiencing others‘ assertiveness as powerful. At the same time, he saw himself insisting on „being right“ through body language that conveyed dominance („I stamp my foot“). The person who challenged the diagnosis experienced XXX as powerful and reacted with „feeling anxious “and withdrawing.

This interaction is experienced differently by the different individuals involved. It shows how the formal hierarchical structures can lead to results in debates that adhere to

whatever is given formal power.

One is the medical model narrative and one being the role of the psychiatrist, both eventually leading to the alternative views not being expanded beyond a certain point in the exchange.

This is just one example how power imbalances played out in the recorded case discussion, and represent one of the most polarised exchanges that was referred to. The power differences at play may be the ones that are embedded in the difference of disciplines and show how medical thinking and systemic thinking can bring significant difference to the table.

Others in the team spoke to how their thinking corresponds with medical model thinking (From B: „diagnosis is important, we got to say what it is“) or how they value directiveness in leadership (From C: „Somebody has to make a decision at some point, otherwise we would be sitting here forever“). Both voices appreciating the helpful aspects in practices that bring power imbalances.

The complex picture that forms through a number of differences meeting within a hierarchical structure corresponds to what is mentioned in some of the literature I introduced. Ovretveit (1995) for example sees differences in world views holding potential for divergence or conflict and needing ways to be tolerated, communicated, integrated, negotiated, and synergised into shared and coordinated responses to people's mental health struggles. The above-mentioned results from this study show in detail what the teams can be faced with and how the risk is to eventually fail at "synthesising of difference" and to favour pragmatism. Griffiths (1997) emphasises on the aspects that teams and individuals in their relationships will have to negotiate and that structures

cannot replace this. Whilst I agree with this, I can also see how power dynamics coming from hierarchical structures constitute a constant temptation (especially in light of highly pressurised work environments that NHS mental health teams work in) to settle with the fastest, most straightforward resolution of difference. This also applies to the different practice paradigms that professionals apply as well the movement between formulation and diagnosis practice.

Practice Paradigms and Movement between formulation and diagnosis practices:
Participants in this study described their ways of practising as mental health professionals in ways that hold the medical model central; whilst it is not exclusive, it is dominant. Alternative practice paradigms were often referred to as "holistic" or "multidimensional", rather than being specific in terms of their school of thought. This may have to do with guidelines in this trust and the imperative for each child to be given diagnosis.

It may also, similar to the "Interplay between different disciplines" relate to different disciplines' professional socialisation (Shaw *et al.*, 2007) and is closely linked to the movement between formulation and diagnosis. From what participants described, formulation seems to be built around diagnosis, confirming the diagnostic label as central.

Team members experience the richness that comes with the multiple disciplines. At the same time, their contributions document the challenges that can come with MDT practice.

It shows that the hierarchical structures ultimately decide on the overall framework or

practice paradigm, whilst other influences seem to function as “add-ons”. This is also referred to in literature. Shaw et al. (2007) showed in their contribution how the rhetoric often applied in relation to multi-disciplinary working does not address the complexity of the relational processes that are part of it and that hierarchical structures become central in how differences in disciplines and epistemologies get organised within MDT communication.

I drew on Bateson’s schismogenesis model (Baeson 2000) to conceptualise communicational and interactional dilemmas that can come with difference. It accounts for and examines interactions between individuals or groups which can contribute to the progressive disintegration (Krause, 2007) or the creation of division. To avoid divergence or “self-destruction” as Bateson called it, methods and ways are needed to interrupt schismogenesis processes in a group. Bateson saw certain “cultural ritual behaviours” as having the potential to either inhibit or stimulate schismogenesis in relationships.

I understand cultural ritual behaviours in an MDT context as the practices that specific disciplines perform based on their cultures or the NHS culture around different disciplines. Bateson’s schismogenesis concept gives a basis for identifying “cultural ritual behaviours” in MDT as inhibiting or stimulating schismogenesis dynamics; schismogenesis in relation to dividing people and dividing disciplines/ practice paradigms/ formulation-diagnosis practices.

Within literature and the results from this study, there are ideas and experiences that give direction. “Cultural rituals” or practices that have been experienced to inhibit schismogenesis or divergence tendencies and promote engagement amongst difference

and in context of hierarchical structures. A position of “uncertainty” was talked about by numerous participants.

Movement between certainty and uncertainty:

Some results in this study showed how a position of uncertainty can interrupt divergence. The systemic therapist spoke about how taking a position of uncertainty allowed her to work in a mainstream mental health service whilst having open questions about the meaning of diagnosis. The ambiguity that uncertainty can cater for allows her to tolerate difference. It also allows her to work more flexibly within an organisation which applies guidelines that facilitate a dominant epistemological discourse.

Other results spoke about how a position of certainty is occupied more when there is more pressure or a tense atmosphere in the room, how positions of uncertainty can feel like “lose ends” or that the different positions typically get occupied by certain disciplines and form a discipline’s “cultural ritual” (Bateson 2000). The findings in this study document moments in this team’s MDT communication when the cultural ritual of certainty around diagnosis invites a power dynamic to resolve differences. This can be understood as divergence and shows one of the challenges when aiming to synthesise differences.

Garven (2011), whom I introduced in my literature review, referred to challenges to successfully combine a variety of competencies, roles, and philosophical paradigms. She spoke about a position of certainty in the form of “the tendency to offer one's model as a solution to a colleague's problem”. Garven speaks about the risks that she finds in this way of practising MDT communication and points out that it can lead to confusion

as a *"….flurry of different maps and frames are offered…."* (p.284). The other risk is that it results in competition between the different models *"…as clinicians lobby for their model to become the preferred on."* (p.284).

Some results in this study point toward the helpfulness of a position of uncertainty in MDT working, and Garven's writing (2011) supports this. She sees the postmodern and dialogical context, which includes positions of uncertainty, as offering opportunities to work towards bringing together differences and developing new ideas and solutions. This can be understood as inhibiting complementary schismogenesis and assisting a team to work with differences in light of power imbalance.

She suggests that exchanges between the different epistemologies, usually aligned to different disciplines, can be influential to each other when the way how they are practised is dialogical, which she defines through contributions from Bertrando (2007), Seikkula (2003)

Within dialogical communication "…..reality is open to multiple versions and to negotiation…that is, a polyphonic cohabitation of different discourses and different visions from which a new vision — a new language — may possibly emerge, but where the difference of discourses is accepted in any case'. "(Garven 2011, p. 286).

HOW I SEE THIS INFORMING RESEARCH AND/OR PRACTICE

-The dialogical communication that is practised within the Reflective Team approach to multi-disciplinary communication that Garven facilitates in teams, could give orientation and ideas to teams to work towards a better integration and synthesising of the different disciplines. The emphasis on dialogical communication, including the

practising a position of uncertainty could be instrumental in achieving this. Depending on resources, constellations and dynamics in teams, this could be facilitated by team members who are familiar and experienced with a Reflective Team approach.

-It could be helpful to test a model like the Reflective Team for MDT communication within a research study. Garven spoke about her practice-based insights and a study could complement or contrast her findings and resulting insights could be helpful to policy makers and teams when planning and conducting MDT communication.
-I applied Bateson's Schismogenesis concept to MDT working and this may be another tool to work with when aiming to explore and adjust MDT communication. Introducing the concept to teams could invite discussions about the idea of MDT work being "multi-cultural work" ; furthermore it could invite team members to exchange experiences about "cultural rituals" which inhibit or promote Schismogenesis.

6.7.5 Identity Context

Social Differences:

One of the team members spoke about her lived experience of mental health struggles and of her diagnosis of Bipolar Disorder. Although she has been transparent with the team, she sees the team only talking "indirectly" about her diagnosis and the meaning of it in the context of casework.
C would prefer a direct conversation, which she felt the team seemed less comfortable with, possibly feeling concerned about feeding into a vulnerability. C feels this is common also in other case discussions and also concerns her being the youngest and

least experienced member of the team. This seemed to be speaking about moments in team communication when on the one hand, team colleagues want to be respectful and helpful ("protective"), at the same time, unsure what kind of communication relating to this suits a working environment ("professional").

What C describes here in relation to individuals' social features that are interpreted as vulnerabilities in a team and the "protective" and "professional" response that translates into not talking directly about this, is familiar to me, as a practice dilemma. Both, my own experiences and practice accounts from colleagues document how, as practising mental health professionals, we often struggle to find ways to address this with each other in the group. Then it translates into "not talking directly" or maybe addressing it in individuals' supervision, as also described by C.

Whilst I did not find this dilemma specifically featuring in the literature I reviewed, I did see it addressed more broadly.

Hardwick (1991) looked at practices in professional networks and how they support or hinder the growth for clients. He sees the onus being on professionals to understand themselves and their relationships within their families so that they are aware of their strengths and vulnerabilities and know what situations they may try to avoid or which situations may activate individual professionals in a sense that they feel they need to protect themselves or rescue others. Whilst Hardwick focuses on the impact professionals' awareness and owning of emotions and tendencies can have on clients, I see his writing as transferrable to professionals working together. I think it would be beneficial if it was possible to expand awareness and owning of emotions to also include communication about this awareness in a form that suits local relationships in

each team.

Another result in this context was a team member's experience of having a team member with lived experience in the team contributing to aspects of clients' perspectives. Further strengthening this view were several other contributions that talked about seeing XXX's question about the client's perspective as a significant moment in the case discussion.

I introduced Oborn (Oborn et al 2020) in the literature review. They conducted a study where they integrated peer workers into MDTs, who were individuals with experience of mental illness and accessing mental health services in the past. What they found corresponds with experiences in this team. Although XXX is not employed as "peer worker", she brings an "ontology of knowing" that includes what Oborn called "knowledge within". He sees this type of knowledge complimenting a "knowing about". When professional knowledge meets the knowledge of experience, be it within a person or a team, it can represent a combination of insights that allows alignment between embodied and local insight with care pathways.

Emotions and Feelings:

How team members experience emotions and feelings and how they are responded to, was commented on throughout all interviews. In terms of responses to stressful feelings, there are responses that seem more reactive and immediate and where there seems to be less awareness of the feelings. These emotions can impact on the overall atmosphere and ways of interacting. Emotions were described as significantly influencing MDT discussions, in that for example, stressful feelings can lead to people becoming

impatient and trying to move the discussion on, or not being able to think very well, or becoming impatient with each other and interrupting or expressing impatience through body language.

On the other hand, there are responses that seem to be directed towards regulating and containing emotions, either individually, for example through “taking a breath” or “taking a break from the awfulness of what is being discussed” by checking their phone or pouring a drink. Emotion regulation also happens socially or relationally, for example through acknowledging and naming emotions, checking in with each other, responding with compassion to others’ distress, aiming to create a nurturing environment through bringing food, practising mindfulness or qigong as ways to achieve grounding in MDTs which are experienced as particularly stressful.

I introduced Veter’s (2011) and Hardwick’s (1999) writing about emotions in MDTs. Both emphasise the importance of professionals knowing their emotions as part of understanding themselves and taking them into account when working with clients or with colleagues. Developing and holding awareness of one’s own emotions allows for regulating them and/ or using them constructively in relational processes.

Whilst the team in this study seemed to have moments where feelings influence the situation in more covert ways and speak of less awareness, they also seemed to practice what Vetere and Hardwick talk about. There were numerous examples of emotions being noticed, named and considered in terms of regulation. I did not always experience this in the teams I worked. Often there is little conversation or attention paid to how professionals feel or which emotions are present in an MDT discussion. There may be a variety of factors that enable this team to speak about and take care of feelings in

MDTs. For example, “knowing each other well” and experiencing safety with each other may be significant, whilst not always the case in teams.

HOW I SEE THIS INFORMING RESEARCH AND/OR PRACTICE

-Future research that explores MDT members’ experiences and reactions to what they perceive as vulnerabilities in colleagues could help to understand more about an aspect of MDT working that possibly organises dynamics within MDTs quite significantly.

-Systemic research focusing on professionals’ emotions and feelings in MDTs could contribute valuably. It would add systemic thinking to an area that is traditionally more associated with and researched through other thinking traditions’ perspectives.

7 Conclusions

Within this study I investigated team members' experiences of their NHS - MDT case discussion communication with the aim to contribute to empirical research in the field of MDT case discussion communicaiton. According to NHS guidelines MDT case discussions are supposed to synthesise multiple disciplines' contributions into a "….new understanding of complex situations." (DOH 2015, p.12). The purpose is to deliver care that aids recovery in an "effective and patient-centred" way (Onyett, 2003). It is assumed that this would benefit clients in that professional responses are more holistic and meet clients' mental health needs in a more individually tailored fashion (DOH 2015).

I thought it would be a relevant contribution to understand more about MDT team members' broad range of experiences of their case discussion communication and the contexts they understand as influential in shaping the communication processes. I believed that this could contribute to thinking about optimising MDT communication in a sense that contributes to achieving more synthesis of different disciplines' perspectives.

I was guided by my research questions:

1. What are team members' experiences of their communication during MDT case discussion?
2. What contexts do team members see influencing their case discussions.

Identifying with constructivist research paradigm and within that, giving weight to systemic research considerations, I conceptualised communication as context-

dependent, dynamic and relational processes that are co created by the interplay between the people involved and the contexts they sit in and come from. From that perspective, I developed a qualitative methodology and applied a combination of IPA and systemic methods when collecting, anlysing and interpreting data. The data I processed came from the literature review, the data collected through the semi-structured interviews and through the reflective elements within the analysis.

I identified the NHS guidelines relating to MDT case discussion communication as holding some paradox, in that a request for collaboration is implied, whilst organisatinally operating MDTs with hierarchical decision making structures and equipping the medical metnal health narrative with more power than other perspectives.

The complexity which lies in this somewhat paradoxical task was also referred to by team members. Participants perceived their communication as influenced by factors related to organisational, team, relational, and identity contexts. Communication between team disciplines allowed for various influences, including different disciplines' perspectives; whilst the medical model thinking and diagnosis practices were experienced as central, they were not considered exclusive.
The findings also showed that the team exchanges during case discussions are influenced by pressures through limited time resources and levels of risk, as well as individuals responses to these. It can not be anticipated that a holistic view on clients is developed, soley on the basis of a variety of disciplines being present for a case discussion.

Communication under less time pressure and relating to less risk, permitted more diverse perspectives, more reflective elements, and holding uncertainty in the views. With higher risk and more time constraints, the discussions tend to focus more on diagnosis and action planning; differences in perspectives were then less negotiated and decisions were made more through referring to hierarchies.

Conceptualising multidisciplinary team (MDT) communication as multicultural exchange, Bateson's schismogenesis concept was relevant, highlighting the importance of understanding helpful and less helpful cultural rituals for synthesizing different perspectives.

The implications on future research and practice I see from these results are the importance to work with awareness of the complexity that lies in the communicational task that MDTs hold and to acknowledge the need to support teams in organizing the task to exchange from different perspectives within hierarchical structures, to not assume that the presence of different disciplines ensures a holistic view on clients and to look for opportunities, methods and ways how to organize the exchange between different perspectives within hierarchical structures in the most promising way when aiming to produce synthesized responses to clients.

The awareness of the need for considerations like the above needs to be held and operationalized on all four context levels.

Participants' responses to parts of the research design, for example the watching of their case discussion on video I pointed towards an example of how this could happen.

Whilst the results provide grounds for further exploration, in that they identify numerous contexts and themes that participants in this study found relevant when thinking about MDT case discussion communication, it seems also significant to note that the results emerged in a team that showed perhaps unusual homogeneity in terms team members' ethnical background and level of experience. A comparison between results in teams with different features could add more differentiated data.

A continuation of exploring the meaning of emotions and feelings in MDT caese discussion in future research is another aspects from results in this study that could add value to the understanding of what appeared as a significant and much referred to influence on the case discussion here.

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9 Appendices

9.1 NHS IRAS approval form

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement Directorate of Education & Training

Tavistock Centre 120 Belsize Lane

London NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Vanja Stipetic

By Email

12 October 2018 Dear Ms Stipetic,

Re: Trust Research Ethics Application

Title: CAMHMS MDT Team Members' Experience Interactions within MDT cases discussions

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me. I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research. Yours sincerely,

Best regards,

Paru Jeram

Secretary to the Trust Research Degrees Subcommittee T: 020 938 2699

E: pjeram@tavi-Port.nhs.uk

cc. Course Lead, Research Tutors/Supervisor

9.2 Info Sheet for Research Participants

Research Title

"Camhs MDT Team Members' Experience of communication within an MDT case discussion"

Research Team

Principal Researcher: Vanja Rossberg 1st Supervisor: Dr Sarah Helps 2nd Supervisor: Dr Britt Krause

Dear Camhs Teams,

Thank you for considering participation in above study.

This document aims at providing you with written information about the study details, so you can make an informed decision about your participation.

Aim and nature of study

- - The study is part of a self funded Doctorate in Systemic Psychotherapy at the Tavistock and Portman NHS Foundation Trust and it is relating to Camhs Clinicians' experiences of communication during an MDT case discussion within their team.
- - The study is exploratory in nature and uses qualitative research methods to generate new understanding about communication in MDT case discussions.
- - The aim is to generate data, which will allow developing insight into the impact of MDT case discussion communication on individual Clinicians, the

team, the organization. Following this, to conclude from there how MDT case discussion can be approached to make them as meaningful for the clinical work as possible and /or what further knowledge/ understanding would be needed to achieve this.

How will the study be conducted?

- - One of your MDT Case discussions would be video-taped on an agreed day/time.
- - Following this, individual interviews would be undertaken with all

Clinicians who were part of the case discussion and gave consent to be interviewed.

- - The interviews would take place at your clinic in a confidential space and would last approximately 60-90minutes.
- - The interviews would be happening on days and weeks following the case discussion. These interviews would be audio-taped.
- - The interviews would then be transcribed verbatim and analysed with an analysis method called “Interpretational Phenomenological Analysis”.

This method is used when the aim is to capture individuals’ experience and meaning-making of a particular phenomenon. The hope is, that this method will help to capture your experience of communication during the MDT case discussion and to understand what meaning you are making of this communication.

- I, as the main researcher would not be viewing the video-tape of your case discussion and would also not be present during the case discussion, except to set

up the technical equipment. The videotape would be only used to allow you to watch your case discussion with some distance, to be reminded of the interactions and to help you consider which elements in the interactions you found most significant and what meaning you make of those moments.

Risks to participants, which would go beyond the day-to-day-risk, which we all encounter in our usual daily lives?

- Taking part in the interviews is likely to engage participants in reflective processes. These processes could potentially activate or bring to awareness aspects of life, which may be perceived as distressing by a participant. As interviewer, I will work with awareness of this, I will check in with each individual participant as we go along and support individuals in ensuring some level of containment through the option to talk about what is going on for them. Should this be needed, I can also provide information for support that goes beyond a one-off-conversation, for example counseling services.

Confidentiality

- - The video tape of the case discussion will only be viewed by the participants themselves. The audio-tapes of the interviews will only be listened to by the research team and will be kept safely in a locked cabinet.

- - Access to the written material will be only possible for the research team.
- - Names of people and services will be anonymised.
- - Since the sample size for this study is quite small (est.5-10 participants),

particular attention will be paid to how certain personal information, which may be relevant for the research analysis (e.g. professional group), but could also give someone's identity away is being presented;

- - Although I aim to fully protect your confidentiality, I would like to make you aware that due to the small sample size of the study, there is some remaining level of risk that some information may be identifiable when reading the final study report.
- - There would be some limitation to confidentiality if information relating to imminent risk to safety of participants or others would be shared.

Consent and withdrawal of consent

- If you agree to participate in the study, you will be given two consent forms to sign. One will be in relation to your agreement to be video taped in your team's case discussion and one for being interviewed individually after the case discussion.

- Both consents can be withdrawn up until 2 weeks after completion of interviews. How you can get more information about the study should you need it?
- I could attend an additional team meeting to provide more detailed information and be available to respond to any questions or concerns. - I can be contacted directly via email or telephone to answer to any questions or concerns (please find contact details below)

Other relevant Information

- - The study has been approved by the Tavistock and Portman NHS Foundation Trust Research Ethics Committee (TREC).
- - If participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they can contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk) or the Researcher's supervisor Dr Sarah Helps (SHelps@tavi-port.nhs.uk)

- - The data generated in the course of this research will be retained in accordance with the University's Data Protection Policy.

Many thanks for taking the time to read through this. Yours sincerely, Vanja Rossberg Email: vanjastipetic@gmail.com Tel.: 07910017994

9.3 Participant consent forms

9.3.1 Consent form re video - taping the case discussion

Consent Part I :

Consent to being video-taped as a Camhs team member during an MDT Case Discussion

Research Title

"Camhs MDT Team Members' Experience of communication within an MDT case discussion"

Research Team

Principal Researcher: Vanja Rossberg

(tel: 07910017994; email: vanjastipetic@gmail.com) 1st Supervisor: Dr Sarah Helps

2nd Supervisor: Dr Britt Krause

- I would like to speak to the researcher confidentially as part of my considerations to participate. Please tick here and provide your email address or telephone number here and the researcher will get in touch.

- I.voluntarily agree to participate in this research
  study.
- I understand that participation involves being video taped as part of a Camhs MDT case discussion in my team.
- I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
- I understand that this research is being conducted with ethical approval from the Tavistock and Portman NHS Foundation Trust Research Ethical Committee.
- I understand that there may be some parts or results of this study being published in journals or in other contexts of research publications.
- I understand that even if I agree to participate now, I can withdraw my consent re my contributions in the video-material being used for the research up to 2 weeks after interviews having been conducted.
- I understand that I will not benefit directly from participating in this research.
- I understand that all information I provide for this study will be treated confidentially, unless the information I provide is related to me or someone else being at significant and imminent risk of harm.
- I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities - they will aim to discuss this with me first, but may be required to report

with or without my permission.

- I understand that due to the small sample size in this study, there may be circumstances under which entire confidentiality cannot be guaranteed.
- I understand that in any report on the results of this research names and locations will be disguised to protect confidentiality of individuals and the service. Significant effort will be put into presenting results in a way that everybody's identity is protected.
- I understand that signed consent forms and the original video tape will be kept safely in a locked space and only the research team will have access to this. The video and audio material can be kept up to 10 years.
- I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.
- I understand that if I have concerns about the conduct of the researchers involved, I can contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk) at the Tavistock and Portman NHS foundation.

Signature of research participant

- Signature of participant Date

Signature of researcher

I believe the participant is giving informed consent to participate in this study

Signature of researcher Date -

9.3.2 Participant consent form re participation in interviews

Consent Form for participating in a Research Study

Consent Part I I:

Consent to being interviewed and the interview being audio recorded.

Research Title

"Camhs MDT Team Members' Experience of communication within an MDT case discussion"

Research Team

Principal Researcher: Vanja Rossberg

(tel: 07910017994; email: vanjastipetic@gmail.com) 1st Supervisor: Dr Sarah Helps

2nd Supervisor: Dr Britt Krause

- I would like to speak to the researcher confidentially as part of my considerations to participate. Please tick here and provide your email address or telephone number here and the researcher will get in touch.

- I.voluntarily agree to participate in this research study.

- I understand that participation involves being interviewed about my participation in an MDT case discussion. It also involves the interview being audio-taped.
- I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
- I understand that this research is being conducted with ethical approval from the Tavistock Research Ethical Committee.
- I understand that there may be some parts or results of this study being published in journals or in other contexts of research publications.
- I understand that even if I agree to participate now, I can withdraw my consent up to 2 weeks after the interview has been conducted.
- I understand that I will not benefit directly from participating in this research.
- I understand that all information I provide for this study will be treated confidentially, unless the information I provide is related to me or someone else being at significant and imminent risk of harm.
- I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.
- I understand that due to the small sample size in this study, there may be circumstances under which entire confidentiality cannot be guaranteed.
- I understand that in any report on the results of this research names and

locations will be disguised to protect confidentiality of individuals and the service. Significant effort will be put into presenting results in a way that everybody's identity is protected.

- I understand that signed consent forms, interview audio-tapes and interview transcripts will be kept safely in a locked space and only the research team will have access to this. The video may be kept up to 10 years.
- I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.
- I understand that if I have concerns about the conduct of the researchers involved, I can contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)
-

- Signature of participant, Date

Signature of researcher

I believe the participant is giving informed consent to participate in this study

Signature of researcher, Date----------

9.4 Pool of interview-questions

1. Ideas for questions before watching the video:

So, the case discussion has happened …days ago; am wondering what it is like to call it to mind now?

How do you think the discussion went when you compare it do the discussions you usually have?

I wonder if you may have had some thoughts or conversations relating to the Case Discussion since then?

Have you got a first thing/ scene that comes up when you think about it? What out of the case discussion stuck to your mind most?

Would you say this was a typical case discussion in your team?

2. Questions for the middle part of the interviews (after participants have watched the whole video and whilst they started watching in the second round with the instruction to stop when something significant is happening)

Please can you let me know when you notice something in the case discussion, that seems important to you.?

Can you describe to me the process of communication during your discussion? How would you describe what went on?

What do you understand is going on here? What is important for you?

What do you think organizes people during MDTs and their way of contributing? When they are deciding if to speak , what to say and how to say it

What does it mean to you seeing/ hearing them saying this/ talking like that? What do you think it means for others to hear this?

How do you think the Psychiatrist/ the newest member in the team/ the team members who come from other countries might have heard this?

How do you think this exchange may impact on future case discussions? What did you notice that made you think that ?

Would you have thought the same if the other colleague would have said this? What made you think it has to do with?

Do you think there is a different way that one could understand this?

Having made sense of this exchange in the way you did; I am wondering how your future contributions in case discussions would look different if you would have understood this exchange differently?

Who do you think would agree/ disagree with you in this understanding? Is this common for you to agree with this person?

Do you think others expect you to agree with this person?

Is this common for your team/ for this relationship to deal with agreements/ disagreements in this way?

3. Questions for the ending of the interview:

Is there something that you or your team could do to improve communication in your case discussions?

What makes a good MDT case discussion

Would you think this was a typical case discussion for your team? Did any thoughts you had during this research process surprise you? Did any of the people involved in the case discussion surprise you?

I am wondering what you are making of this experience? (being filmed in case discussion, being interviewed re case discussion)

I am wondering what it has been like for you to be interviewed in this way?

9.4.1 Excerpt of analysis document at analysis step 8

Subordinate Themes	Distilled version of the main points made within the emerging themes
1.Following NHS Guidelines NICE guidelines are followed and evoke dilemmas Adherence to guidelines Some guidelines make alternative views appear negligent Alternative Views Hierarchical structures used to assert organisational values Hierarchical Structures	1. The team follows NHS NICE guidelines, which is a significant orientation when making sense of clients' mental health struggles and care planning 2. Experience of a challenge to include alternative ways of thinking into reflections, as these ideas may seem negligent when looking from a perspective of NHS-evidence-based thinking 3. Hierarchical structures are used in this and other teams to assert values that correspond with NHS-evidence-based thinking of clients 4. It is common practice that team works along NHS pathways and guidelines 5. Trust policy requires every child on the team's caseload to have a diagnosis 6. NHS structures favour action-planning vs communication that allows for reflection and considering values