

Clinical Psychologists' Narratives  
of Relatedness within a  
Multi-Disciplinary Team Context

Volume 1

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# Abstract

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The focus of this study was to explore how Clinical Psychologists narrate their experience of relatedness within a multi-disciplinary team. Mental health services in the UK are facing increased financial pressure and a necessity for all professionals to justify their role. In this context value often appears to be placed on the cheapest way of providing individual, independent care for clients rather than on the relational value of job satisfaction, joint working and therapeutic relationships. The aim of this study was to explore the experience of Clinical Psychologists and through this contribute to thinking around collaborative and interdisciplinary working.

This study was guided by eight individual semi-structured interviews which were conducted with Clinical Psychologists who work in Multi-Disciplinary working age adult Community Mental Health Teams and explored using Narrative Analysis. The participants consisted of seven females and one male who had been qualified between three and fifteen years and were working at various pay bands between 7 and 8c. Four relational narratives were found. These were connections to the self of the psychologist, connections to clients, connections with colleagues and connections with the system. The first relational aspect was how the Clinical Psychologists in this study storied their ability to remain connected to their own humanity and their personal values within the context of their Multi-Disciplinary Teams. The second level involved the stories about relationships and connections with clients, particularly thinking about the perceived impact and consequences of the other relational levels for the clients and their safety. The third relational aspect was the stories that Clinical Psychologists told about their sense of relatedness to their colleagues within their teams and the importance of having time available for this. Finally, the fourth level, which was evident within all the other relationships, was of the impact of the wider system and context. These stories emerged from the analysis process with the understanding that the interviews were co-constructed and represented multiple voices.

This study confirmed that despite a history of both research and legislation highlighting the benefits and values of inter-professional working and compassion the reality remains elusive. To achieve these aims there needs to be a shift in focus from short-term planning evaluating efficiency in relation only to perceived financial value, to thinking more widely and long-term about relational value. There is a need for investment and recognition of the aspects of team working that are less easy to quantify financially.

Further research could explore the experience of other professional groups within CMHTs, and other MDTs, and of clients. This would give a voice to individuals who did not have an explicit voice in this research.

# Contents

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<b>Overview</b> .....	<b>7</b>
<b>Introduction</b> .....	<b>9</b>
1.1 Use of Language .....	9
1.2 Researcher's Position .....	9
1.3 Literature Search Strategy .....	12
1.4 Definition of Key Concepts .....	13
1.5 Understanding of Groups and Teams .....	17
1.6 Health Care Teams .....	21
1.7 Community Mental Health Teams .....	30
1.8 The History of Clinical Psychology and their place within teams .....	33
1.9 The NHS and the Current Context .....	36
1.10 This Study .....	38
<b>2. Method</b> .....	<b>40</b>
2.1 Focus of Study .....	40
2.2 Design .....	45
2.3 Ethical Considerations .....	48
<b>3. Results and Discussion</b> .....	<b>52</b>
3.1 Overview .....	52
3.2 Considering the results in context .....	53
3.3 Introduction to Participants and Global Impressions .....	53
3.4 Emerging Storylines .....	66
<b>4. Conclusion</b> .....	<b>98</b>
4.1 Summary of Findings .....	98
4.2 Situating the Findings within the Current Literature .....	102
4.3 Clinical Relevance and Implications .....	105
4.4 Critical Review .....	109
4.5 Implications for Further Research .....	111
4.6 Final Comments .....	112
<b>References</b> .....	<b>115</b>
<b>Appendices</b> .....	<b>130</b>
1. Participant Information Sheet .....	130
2. Groups and Teams Literature .....	133
3. Sample Interview Questions .....	134

4. Consent Form .....	135
5. Transcription Sample .....	136
6. Initial Ethical approval .....	137
7. Revised Ethical approval .....	138
8. Debrief Sheet .....	139
9. Transcription agreement .....	140
10. Reflective Journal Extract .....	141
11. Themes and Quotes tables .....	142

# Overview

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When our focus is toward a principle of relatedness and oneness, and away from fragmentation and isolation, health ensues

[Larry Dossey, \*Space, Time & Medicine\*](#)

Multi-Disciplinary Teams are an established component of the National Health Service (NHS). Clinical Psychologists frequently sit within these teams alongside a range of professionals who will have undergone different training. There is existing research identifying some of the benefits and tensions of multi-disciplinary working within healthcare. However, there is little existing literature that explores the relationships between professionals working in these contexts. In particular there is a paucity of qualitative research inquiring about the relational experiences of Clinical Psychologists within these teams.

This study attempts specifically to explore the experiences of eight Clinical Psychologists who work within an adult Community Mental Health Team within the NHS. The participants consisted of seven females and one male who had been qualified between three and fifteen years and were working at various pay bands between 7 and 8c. Individual interviews were undertaken and the resulting transcripts were analysed using Narrative Analysis. Alongside this analysis there is recognition that a narrative account is created and co-constructed at every stage of the research. Mishler (1986) frames research interviewing as a dialogue where two active participants jointly construct both narrative and meaning. As a researcher decisions are made about the questions asked, what expressions are followed with further enquiry, how the transcript is analysed and what is finally included in this piece of work. These decisions are framed within the personal, historical, social and political context of the researcher and these will also be reflected on to hopefully illuminate these constructions further.

Below is an outline of the content of the following sections.

## **Chapter One:** *Researcher's position, introduction and literature review*

This chapter starts by offering a brief account of the researcher's theoretical position and the personal significance of the research. It also explores the current literature in

order to identify the clinical relevance of the study including its specific aims. Within this the key terms will be defined and the context of Clinical Psychologists, Mental Health Teams and the NHS will be explored alongside relevant group theory.

### **Chapter Two:** *Methodology*

This chapter begins by offering an explanation for the choice of a qualitative research method for this study and outlines the reasons for specifically selecting a narrative approach. The design of the study is then presented including a description of the study participants and a discussion surrounding the ethical considerations. Within this section the development of the research interview is considered which includes the involvement of pilot interviews and service user consultation.

### **Chapter Three:** *Analysis and Discussion*

The findings are presented within this chapter. Initially this is with global impressions of each narrative in order to give the reader a sense of each individual's personal account. The emerging storylines and group narratives are then outlined alongside links to literature and theoretical frameworks in order to offer a context within which the accounts could be further understood.

### **Chapter Four:** *Conclusions*

This final chapter returns to the research aims and offers a response to the research question raised alongside discussing the clinical implications of the research findings. The strengths and limitations of the research are discussed together with suggestions for further research in this area.

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# 1. Introduction

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## 1.1 Use of Language

The following doctoral thesis will be written predominantly in the third person but where appropriate, when reflecting on my role and explaining my stance as a researcher, I will use the first person. The first section on the researcher's position will be written from the first person perspective due to the personal and reflective nature of this.

In referring to the individuals that access mental health services I recognise the difficulties of selecting a term that would be satisfactory to everyone. I have made a decision not to use the term 'patients' apart from instances where I am summarising literature which uses this terminology. I have used the term client and service-user, although recognising that neither of these is perfect and that people may have different preferences.

The title of this research uses the term 'narratives' which will be reflected in the type of analysis that has been selected for this study. The term itself is identified as having disputed definitions which is complicated by it being increasingly used in popular discourse with different meanings (Squire, Andrews & Tamboukou, 2008). Riessman (2008) identifies that a story could be thought of as a single unit of data relating to an event, where a narrative can be seen as a system of stories that are told at a given time. I will use the terms somewhat interchangeably to reflect the use of both narratives and stories within the interviews and resulting analysis.

## 1.2 Researcher's Position

I recognise the importance of acknowledging my position as a researcher and the impact that this will have on the ongoing construction of this research. In the interests of transparency I will therefore now outline my theoretical position and attempt to describe some of the factors that led me to choose this research topic.

### 1.2.1 Theoretical Position

As all research is undertaken in conjunction with differing underlying philosophies, in accordance with Bentz and Shapiro (1998) it is important that the assumptions which form the foundation of a study are made explicit. I accept that I cannot separate

myself from my view of the world and this will, therefore, influence every aspect of the research process. I have reflected throughout the study on the influence that I bring and hope that through an effort to be as transparent as possible the reader is also able to reflect on this.

I am not sure that prior to my experience of the last three years on the Clinical Psychology doctoral course at the University of Hertfordshire I had ever tried to define my epistemological position. During the course of this research I have spent many hours discussing epistemology within a narrative peer supervision group in an attempt to define our positions and consider the influence of these on our research. In many ways I think I remain 'ontologically agnostic' (Martin, Sugarman & Hickinbottom, 2009) and with this feel that there can be no certainty and so it makes sense to me to remain open to multiple ideas. I recognise that the social constructionist stance of the training course has had an influence on how I see the world and the questions that I ask of it. In relation to my data I do not take a positivist view that there is one 'truth' that could ever be accessed about how it is to be in these teams or about what occurs within these. I think that in undertaking a study that examines the multiple perspectives held within a team it made sense to me to consider this from a theoretical position that values multiple ways to view the world. In relation to all this I would say that this study is informed by ideas from social constructionism (Burr, 2003).

As the researcher in this study I, therefore, consider myself to be a collaborator rather than an expert and the participants are recognised as co-constructors. Frank (2000) states that initial research interests proceed from a standpoint and, therefore, in order to promote some understanding of how my view of this research project has been constructed, I will attempt to explain what drew me to this area of inquiry.

### **1.2.2 Personal Significance of the Research**

I think I first became interested in multi-professional interactions as a result of my relationships with the people around me who were all involved in public sector work. My partner is a GP registrar, his mother is a nurse, his father a doctor in the pharmaceutical industry, my mother is a special needs teacher, my auntie a social worker, my cousin an occupational therapist and we have friends in nursing and

psychiatry amongst other medical specialities. When I first embarked on aiming towards a career in psychology I naïvely believed that, as we all wanted to give our working lives to try and make a difference in the lives of people in need, our opinions on how best to do this would hold further commonality. However, it became increasingly apparent during multiple conversations and debates that our views were often more divergent than when I spoke with people with no experience of this type of work.

I became curious about how multi-disciplinary teams are able to function when you take people with such different training backgrounds, experiences and value bases and ask them to agree on what to do for the best. I believe that as humans we are deeply relational beings and the interpersonal connections that we create, or do not create, are of importance. As psychologists we always highlight the importance of not stereotyping or prejudging others and the value of being open to understanding the influences that lead to a behaviour or opinion that we may not agree with. It has often struck me during my training that whilst we readily engage with these ideas when it comes to the client groups we work with, we are much less likely to do this with our multi-disciplinary colleagues. I have at times found myself speaking out in lectures to remind people that most people enter the caring professions because they care. I have wondered if being aware of our common humanity and spending time to consider what lies behind the perspectives of our team members may enable our impact within a team to be of greater influence.

### **1.2.3 Social Significance of the Research**

The Francis Report (Francis, 2013) highlighted that the failures of care and lack of compassion within Mid Staffordshire were reflective of problems within the organisational culture and not just a collection of individuals. Schein (1992) defines culture as a set of shared implicit assumptions that members of an organisation hold and that influence how they perceive things and what they think, say and do. The interactions at every level within an organisation both reveal and shape its culture and reflect what the organisation values (West, Eckert, Steward & Passmore, 2014). It therefore seems important to consider the day-to-day interactions of the staff within the organisations and to look at the relationships within teams themselves.

Although there is a large amount of research on groups and teams both within and outside of healthcare, the focus has often been on assessing and measuring outcomes. Teams can be viewed as a three-stage system where they utilise resources (input), maintain internal processes (throughput) and produce specific outcomes (output) with the output being used to evaluate team effectiveness (Mickan & Rodger, 2000). In an increasingly outcome-driven healthcare system it seems to be of relevance to consider the processes of maintaining teams alongside a focus on input and output and to think about the experience of being in teams and the impact of relationships within these. It is also useful to remember that mental health teams are dealing with vulnerable human beings, not predictable machinery. Øvretveit (1993) argues that when professionals are coping with clients in pain and emotional distress the group's structure and relationships are critical.

### **1.3 Literature Search Strategy**

The literature which is referenced throughout this study was obtained by inputting into databases key terms relevant to the focus of the project. These included Google Scholar, Psych info, Pubmed and Web of Science. Leathard (1994) identifies that various prefixes, 'multi' and 'inter' are used alongside the adjectives 'disciplinary' and 'professional' by researchers and practitioners so this was incorporated into the search strategy. Terms used included: relatedness, connectedness, relationships, relating, multidisciplinary, interdisciplinary, Clinical Psychologists, MDTs, CMHTs and interprofessional. Abstracts and references were scanned and, if they were considered relevant, they were downloaded and read. Relevant books were also downloaded or purchased.

Although the focus of this research is on Clinical Psychologists (CPs), it is exploring their stories and experiences within a multi-disciplinary environment. In order to both acknowledge this and to recognise that research has been carried out looking at teams by other professional groups, the literature search included accessing sources that originate within other disciplinary fields such as medicine and nursing. It is hoped this will provide a broader and more multi-disciplinary perspective but it is also recognised that this is a vast topic area and some of the literature will have less relevance within the field of CP. The following literature review is an attempt to

encapsulate some of the most relevant literature beginning with a broad introduction to research on groups and teams and moving towards a focus on the literature involving CPs based within Community Mental Health Teams (CMHTs).

## 1.4 Definition of Key Concepts

### 1.4.1 What is meant by the term 'Multi-Disciplinary Team'?

The literature highlights that there is not a straightforward definition of the term 'Multi-Disciplinary Team' (MDT). Øvretveit (1993) states that even the term 'team' is of limited usefulness as people mean many different things and Mistral and Velleman (1997) described the difficulties they had in determining teams within their research on CMHTs. Mickan and Rodger (2000) identify teams are usually a small number of people with a range of skills committed to a common purpose or goal. Øvretveit (1993) describes that within healthcare there are different types of teams with differing memberships including client teams, network associations and formal teams. In the formal team members meet regularly to co-ordinate their work for a specific client population. For the purposes of this study the focus is on adult CMHTs which fit this definition of a formal team.

A range of terms are used, sometimes interchangeably, within the literature including interdisciplinary, transdisciplinary, interprofessional and multi-agency. These have been defined in the following ways:

- The term multi-disciplinary refers to a range of health professionals who work together to address the needs of individuals accessing their services (Mitchell, Tieman & Shelby-James, 2008). The Pew-Fetzer Task Force (Tresolini, 1994), that explored relationships within the health professions, described multi-disciplinary care as parallel but independent care with each provider responsible for their own area.
- The Pew-Fetzer Task Force defined interprofessional care as being *more* coordinated with shared goals and resources whilst interdisciplinary describes the education process.
- Robinson and Cottrell (2005) distinguish multi-agency teams as those where members are employed by different agencies often with different conditions and pay scales.

- Finally transdisciplinary approaches require the blurring of disciplinary boundaries as each member is sufficiently familiar with the approaches of their colleagues, and challenges can be focused on as part of a broader context (Walker, Baldwin, Fitzpatrick & Ryan, 1998).

Considering this within the UK health service Raine et al. (2014) explain that MDTs are used widely across the NHS comprising of different professionals including doctors, nurses, social workers and psychologists. For the purpose of Boakes' (1998) doctoral study they define community MDTs as a team of four or more members from at least two disciplines that do most of their work outside of hospital but as a secondary or tertiary level of service. The introduction in this current study will consider the research on MDTs more widely where different professional groups are working together in some way. For sampling purposes the defined criteria were CPs working in what would be perceived to be a team made up of different professional groups and based within the community.

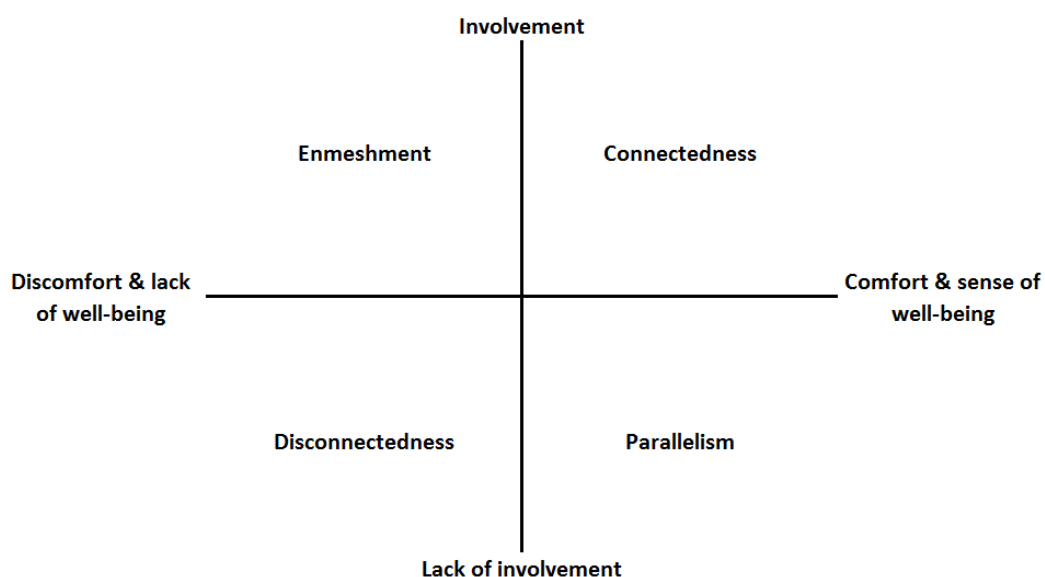
#### **1.4.2 How do we understand the term 'relatedness'?**

The Oxford English Dictionary (2015) defines relatedness as 'the state, condition, or fact of being related or connected'. It is highlighted as the noun, where 'related' is the adjective and is defined as being connected or having relation with something else. The Psychology Dictionary (2014) defines relatedness as the reciprocity of factors like trust and empathy between two or more individuals in a relationship.

Relatedness has been established as a basic human need according to attachment theory, psychological research and community psychology (McGrath, Griffin & Mundy, 2015). Alderfer's (1972) needs theory analysed the motivations of individuals identifying existence, relatedness and growth needs. In this model relatedness encapsulated good relations with others, feeling part of a group or community, sense of identity and concern to be seen as a valued member of a group.

A theory of human relatedness has been defined within nursing to address what they see as the pervasive human concern of establishing and maintaining relatedness, which is seen as a functional, behavioural system rooted in early attachment behaviours (Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993). This can also be

linked to self-determination theory which has been expanded by identifying three key intrinsic universal motivators, which are the need for competence, autonomy and psychological relatedness (Deci & Ryan, 2002). In this context they see relatedness as the universal desire to interact, be connected to and experience caring for others (Baumeister & Leary, 1995). Hagerty, Lynch-Sauer, Patusky and Bouwsema (1993) recognised that there was no broad theoretical framework for relatedness in adulthood so they created one using deductive and inductive strategies to review literature relevant to connectedness and disconnectedness. This model is identified as being helpful for understanding client behaviour and for creating more effective nursing interventions centred in the belief that human growth and development occur within the context of relatedness (Hagerty & Patusky, 2003; Miller, 1976). The focus is on how the individual experiences the quality of their interactions within a relationship. They identified four states of relatedness: connectedness, disconnectedness, enmeshment and parallelism. These states emerge when the two dimensions of relatedness, involvement-lack of involvement and comfort-discomfort, are placed on a grid (figure 1).



**Figure 1: States of relatedness**

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There are seen to be four major processes in establishing relatedness states: sense of belonging, mutuality, synchrony and reciprocity. The model suggests that the higher the levels of each of these the greater the experience of connectedness. The four processes are defined in the following way:

- Sense of belonging is involvement in a system where individuals feel themselves to be an integral part (Hagerty et al., 1992; Sedgwick & Yong, 2008)
- Mutuality is defined as the experience of shared commonalities of visions, goals or characteristics including shared acceptance of differences that validate an individual's world view (Hagerty et al., 1993)
- Synchrony encompasses a person's experience of congruence with their internal rhythms and external interactions to include psychological, physiological and human interaction rhythms (Hagerty et al., 1993)
- Reciprocity relates to the quality and intensity of an interchange with a view that equal exchange is optimal (Greenberg & Shapiro, 1971)

Within the psychodynamic literature relatedness can be seen in Klein's (1964) interest in an individual's relationship to the external world and attachment theory (Bowlby, 1969) which is viewed as a component of relatedness. Relationships where there is a primary focus on tasks and goals can be described as instrumental relatedness, where a greater focus on the relationship elements of warmth and affection would be indicative of expressive relatedness (Wynne, 1984). There is recognition, particularly within nursing, that it might be helpful to understand difficulties clients may be experiencing in relatedness (Stuart, 2013) but this has not been used to explore relationships between professionals within teams. Within organisational and management literature where relationships are focused on it is usually in the context of building 'productive' relationships (Elearn, 2008).

Øvretveit (1993) highlights the importance of relationships to the purpose of a MDT, both with clients and with other team members. He states 'these relationships are not secondary to the goal of the team, as they are in some project teams in industry, but are the means through which the client is helped' (Øvretveit, 1993, p55). The Pew-Fetzer Task Force (Tresolini, 1994) was formed in the United States amidst debates about health care reform to address the interdependence of biopsychosocial



issues in healthcare and consider their relevance in interprofessional education. In trying to understand the problems and possible solutions, a focus on relationships emerged; the foundation of these being that between the practitioner and patient but they also included the practitioner's relationship with themselves, their colleagues and the wider system and community.

It was recognised that relatedness is not a commonly used term so time was spent within supervision determining how to explain relatedness to participants. The dictionary definitions capture something about the outcome but do not include the processes and definitions within research stipulate *what* the processes are deemed to be. For the purpose of this study the researcher and supervisor defined relatedness in the following way in order to encourage participants to openly reflect on the processes but feel able to determine these themselves:

'the processes that facilitate or hinder a sense of connectedness (or not) within the relational context of multi-disciplinary teams' (Participant Information Sheet, appendix 1).

In considering this definition the terms relatedness, connection and relationships were all considered and explored and will at times be used interchangeably. The next section will offer an overview of some of the literature on groups and teams recognising that this is an area that has received a great deal of attention (some further information is included in appendix 2).

### **1.5 Understanding of Groups and Teams**

The study of groups is an area that has received a large amount of attention particularly within social and organisational psychology. Research has been undertaken that looks at the effects of the size of a group (Hinton & Reitz, 1971); group development (Hill & Gruner, 1973; Tuckman, 1965); cohesion (Forsyth, 1990; Lembke & Wilson, 1998; Janis, 1972); roles (Bales, 1950; Bormann, 1990); status (Bales, 1953; Slater, 1955); and leadership (Lippitt & White, 1943; Bass, 1990; House & Mitchell, 1974; Bryman, 1992). Although relationships may be thought about within these different areas it has not been the primary focus of any of these studies and often the method of analysis has been surveys and questionnaires. These studies also look at groups generically and are not about healthcare teams

specifically or CPs but highlight some of the issues that may be present within teams.

A team is a particular type of group and management theorists define it as being more task-oriented than other groups and having specific rules for its members (Adair, 2009). Adair (2009) also identifies other aspects of work groups including interdependence, interaction and the ability to act in a unitary manner. Within this definition there is an understanding that individuals within a group need the help of one another, need to communicate and will influence each other. This suggests that relationships and connection within teams are of importance to individuals and to the team's functioning. Øvretveit (1993, p160) states 'it is through communication that people do or do not relate to each other, problems in communication produce or are produced by problems in relationships'. Adair (2009) defines this need to develop and maintain working relationships as the maintenance need of the group. Losada and Heaphy (2004) carried out a study analysing communication in sixty management teams and found the most important variable explaining the difference between high and low performance was the amount of positive compared to negative communication, with positive communication being linked to higher performance. Thus inherent in this study is a recognition that the way that team members relate to each other is of importance. Although, Dutton and Ragins (2007, p3) acknowledge that we do not yet 'understand the dynamics, mechanisms, and processes that generate, nourish and sustain positive relationships at work'.

Several authors have suggested that an organisation's successes or failures are dependent on how effective its members are at working together in teams (Martin-Rodríguez, Beaulieu, D'Amour & Ferrada-Vileda, 2005). A review of the literature on teams reveals that progress has been made in understanding some of the factors that influence the ability of people to work effectively together in teams but not on the actual experience of being in teams and how this may change over time. More recently there has been an increase in scholarly interest in the relational aspects of organisations and recognition that the affective dimension of human interaction plays an important role in successful organisations (Martela, 2012). Considering this further Haslam (2004) identifies that research into organisations can be separated into four paradigms; Economic Approach, Individual Differences Approach, Social Cognition Approach and Human Relations Approach. They explain the economic

approach focuses on an individual worker's contribution to organisational performance whilst the individual differences approach does this but incorporates a consideration of psychological factors. The cognitive paradigm analyses psychological processes further, looking to understand organisational behaviour but there is an absence of the social, contextual and relational influences. The human relations approach addresses some of these gaps but Haslam (2004) argues that it misses the psychological processes within this so proposes the Social Identity approach as a fully integrated alternative. Due to the potential provided by the integrated nature of this last model this will now be considered in further detail.

### **1.5.1 Social Identity Approach**

The Social Identity Approach encapsulates two social psychology theories, that of Self-Categorization Theory (Turner et al., 1987) and Social Identity Theory (Tajfel & Turner, 1979). Social Identity Theory, a theory of intergroup relations, suggests that when we make comparisons between groups we attribute positive values to the in-group to achieve a positive social identity. Self-Categorization Theory explores how individuals become, act and think as a psychological group and define themselves by their shared social identities rather than their personal identity. The Social Identity Approach highlights that we perceive ourselves and others to be part of groups that are structured hierarchically in terms of how many others are perceived to be part of each group. Our membership to these groups helps us to create and define our place in society. This can be quite useful when thinking about health professionals as someone may see themselves as a CP, a therapist, a mental health professional, a member of the CMHT and an NHS worker and different people may define themselves in terms of one group membership rather than the other. Haslam (2004) highlights that an awareness that we are psychological group members and we act in relation to our shared social identities, in addition to our individual differences and personal identities, is important in organisations. Social-identity theory relates to the part of an individual's self-concept derived from their perceived membership to a certain group. This theory contains ideas about in-group favouritism and social competition, factors that are likely to have an influence on relatedness within MDTs depending on which groups a professional identifies themselves with. The Social Identity Approach provides some understanding about identity and group membership but accepts much of the explanation is not psychological and as an

approach it aims to work with other disciplines rather than attempt to explain everything (Reicher, Spears & Haslam, 2010). In aiming to elucidate the psychological explanations that may impact upon the relational processes and group identification within an MDT it is possible to consider a range of theoretical approaches including attachment (Smith, Murphy & Coats, 1999), a tripartite model of group identification as explained by Henry, Arrow and Carini, (1999), empathy (Batson et al., 1995) and compassion (Gilbert, 2010). The tripartite model considers cognitive processes of social categorisation, alongside affective processes of interpersonal attraction and behavioural processes of interdependence. Attachment theory explores the mental models individuals have of the self as a group member and of the group as a source of identity and esteem. The empathy model considers self-interest and collective interest and how we feel compassion for others that may influence prosocial activities. Although all of these models can offer interesting insights in relation to group identification and behaviour it appears the compassionate mind approach captures the range of these so will be further considered as a possible explanation of the relational processes that occur within groups (Gilbert, 2010).

### 1.5.2 The Compassionate Mind Approach

Section 1.4.2 outlined the importance of relational experiences and argued that humans have a basic evolved need to belong and be accepted in their intimate relationships and wider social groups (Baumeister & Leary, 1995). Gilbert (2010) identified that there are evolutionary relational factors that we share with other animals that demonstrate sociability but that our *new thinking* and self-aware brains influence the importance of our social relationships. Our self-awareness enables us to develop a self-identity which brings ideas about who we are, who we want to be and how we want others to see and relate to us (Gilbert, 2010). In this model our sense of self is linked to memory and to a feeling of consistency in our values and behaviours. In addition we are socially aware which enables us to make comparisons and we can evaluate ourselves as inferior or superior to others. These things emerge in relationships and are not static. Gilbert (2010, p46) states that 'our sense of disconnectedness is the price we pay for having a brain that gives rise to a sense of our being an individual self'. This model also highlights that we relate to our own inner emotions and motivations and can consider our self-interconnectedness.

Gilbert (2010) also highlights a key aspect of our humanity is our interdependence with each other. Our brains have evolved to such an extent that the way they are wired and develop is influenced by the caring they receive. This model states that when we receive warmth, kindness and compassion our level of stress hormones reduce and these things can sustain us and help us to bear the challenges we face. This suggests that relatedness within teams is an important consideration for both how we view ourselves and how we manage periods of stress and adversity in our working life.

The next section will consider health care teams specifically, the reasons for these being multidisciplinary and the challenges that working in MDTs can bring.

## **1.6 Health-care Teams**

### **1.6.1 Why have multi-disciplinary provision of healthcare?**

A number of key government papers and legislation have highlighted the importance of multi-disciplinary and multi-agency care and collaboration in order to share good practice and offer unified care (Department of Health, 1999; Secretary of State for Health, 1999; Secretary of State for Health, 2000). Across international literature there is an acceptance that the pursuit of collaborative multi-disciplinary care is a worthy goal (Jansen, 2008; Orchard, Curran & Kabene, 2005; D'Amour, Ferrada-Videla, Martín-Rodríguez & Beaulieu, 2005; Milbourne, Macrae & Maguire, 2003; Mental Health Commission, 2006). It is recognised that one of the key benefits of multi-disciplinary teamwork is the ability to integrate knowledge in order to try and provide optimal care (D'amour & Oandasan, 2005; NHSME, 1993; Jones, 1992; Poulton, 1995) and effective teams have been linked with optimal patient outcomes (Kalizch, Weaver & Salas, 2009). It is interesting to note that the origins of the word 'team' was an Anglo-Saxon term meaning 'family' which was applied to animals harnessed in a row as it was found they pulled better together if they were related (Adair, 2009). The importance of relatedness or connection for achieving outcomes is framed within the original meaning of this word. In this current study consideration will be made to whether relatedness can be achieved in non-familial contexts such as an MDT and the impact this has.

There is a recognition that current services are not sufficiently co-ordinated and arguments have been made for greater links with other agencies outside of health services and with the wider community (Department of Health, 2010). The NHS constitution was updated in 2013 with integrated care being one of the areas of improvement highlighting the NHS' commitment to working jointly with a wider range of organisations (Department of Health, 2013). The King's Fund (West et al., 2014) highlight that where multi-professional teams work together it leads to a range of positive outcomes including; more effective health care delivery, higher levels of innovation, lower staff absenteeism, stress and turnover and more consistent communication with patients. However, research has also shown that where there is conflict or a lack of collaboration amongst health care providers it can lead to negative quality outcome indicators, patient dissatisfaction and risk (Fagin, 1992; Lindeke & Block, 1998; Borrill et al., 2001). There appears, therefore, to be a benefit in creating teams that work together, whether related or not. The following section considers the research that specifically explores MDTs in the context of this study seeking to contribute to this research base. The professions of nursing and medicine have conducted a large amount of the research in this area which has predominantly been within hospital-based health care where CPs have tended to be less prominent.

### **1.6.2 Research into multi-disciplinary healthcare provision**

Robinson and Cottrell (2005) highlight that despite an emphasis within legislation on multi-disciplinary care and the rhetoric of evidence-based policy and practice there remains limited research in this area. Mickan and Rodger (2005) identified that although research into teamwork has developed to include multiple methodologies and to explore various aspects it has not met the quest for a prescription for effective teams due to an increasing recognition of the complexity of teamwork particularly within healthcare. The complexity may in part be associated with the relational elements that are less commonly explored. Jansen (2008) highlights the challenges of identifying methodologies and outcomes related to collaborative care stating these remain elusive in a rapidly changing healthcare environment. In the White Paper Saving Lives: Our Healthier Nation (Secretary of State for Health, 1999) they highlighted the challenges of having standards that were flexible enough to apply to individuals with different backgrounds and training, complicated by a lack of robust evidence on which to base these standards. As with research into teams generally

there has been a greater focus on objectives, outcomes and competencies rather than the relationships between team members or the 'sense of belonging' that individuals feel (Sedgwick & Yong, 2008).

Lack of clarity in this area is evident, for example Onyett (2008) highlighted that although the NHS staff survey indicated that 93% of staff work in teams, only 42% are in teams that fulfil evidence-based criteria for effective design with many working in 'psuedo-teams', teams in name alone. It is important to note the discrepancies between policies and practice when assessing the effectiveness in teams and considering resourcing issues. The definition of a team was based on work by West (2004) who suggested that teams need shared objectives, members who work closely together, members with different and defined roles, as many members as needed for the task but no more, opportunities for review and a team identity so others can recognise it as a team. Although MDTs are common within healthcare it is unclear how often these involve shared decision making, joint working and coordination of care (Lindeke & Block, 1998). A review of the effectiveness of health care teams in the NHS highlighted that in most other sectors teams tend to be divided when they reach twelve members but that in primary and secondary health care teams can have forty or more members, which are likely to divide into sub-teams (Borrill *et al.*, 2001). They identified the size of teams is important as bigger teams experience greater strain on effective communication with the optimal group size for free discussion being five people.

Bell (1999) conducted research analysing a number of multi-disciplinary child protection team meetings and highlighted the importance of, and inter-relationship between, the concepts of cohesion, integration and co-operation. However, they identified the difficulties of reviewing the literature in this area due to the range of different definitions used in the studies that highlighted different relationships between the terms.

Considering this further, West (2014) highlights the challenges of NHS care and having to move between teams and work effectively in the interests of patient care, maintaining compassion in relationships with service-users, carers and team members. They conclude that individual flourishing and organisational flourishing are inextricably linked, mediated by supportive and effective teams. If the mediating

factor between successful individuals and organisations is teams then this seems an important area of focus to consider whether individuals feel they belong or are connected to these teams.

This section has highlighted some of the challenges facing research in this area, the following sections will explore some of the areas that have been researched.

### **1.6.3 Sense of Belonging**

Although there has been limited research exploring relatedness within teams there have been studies that have explored the importance of a sense of belonging which was highlighted as an element of relatedness in section 1.4.2. Sedgwick and Yong (2008) explored Canadian student nurses' experiences of 'belonging' to the hospital team. They identified that daily interactions with the majority of the hospital team influenced their sense of belonging, creating safety and comfort; whilst not belonging brought experiences of anger, frustration and uncertainty about their profession. They also found status to be important and a need to accept one's position within this hierarchy to avoid rejection or ostracism. Here, one can see elements of Social Identity Theory and the need to find a position within a group. The authors highlight that rural nursing is grounded in team work so not feeling part of this is likely to have significant consequences. The study included a homogenous sample and used a qualitative methodology to explore individual meaning. However, it only included one profession and the sample comprised of twelve trainee nurses from a very particular environment. This may affect the generalisability of the findings and, in relation to status and hierarchy, the experiences of CPs may be different.

A few studies have been undertaken that identify the importance of 'belonging' and feeling part of a team but this has, thus far, tended to be within nursing and has focused on the impact of this for learning during training rather than ongoing professional experience (Sedgwick & Yong, 2008; Levett-Jones & Lathlean, 2008; Levett-Jones, Lathlean, Higgins & McMillan, 2009).

### **1.6.4 What are the challenges of multi-disciplinary care?**

CPs are placed within MDTs alongside various other professional groups but it appears this does not guarantee effective working relationships or optimum care. It is largely recognised that organisations in health and social care need to work better



across professional groups, specialisms and organisations to create truly integrated care, however, the reality seems more elusive (Markiewicz & West, 2015). The following sections will highlight some of the issues that have been identified within the literature.

#### 1.6.4.1 Different Values

One of the most important reasons people work in teams is to use their diverse knowledge, skills, training and experience to enable them to make the best possible decisions (West & Slater, 1996). Nolte (2005) identifies that although having team members from diverse professions can be very valuable, competitive attitudes and ideological differences often stand as barriers to effective teamwork. West and Slater (1996) describe a history of separate professional development that creates difficulties in team-working, with barriers arising around a lack of shared premises, professional elitism and unresolved differences of orientation between various agencies. The King's Fund (West et al., 2014, p18) highlight the need for clinical and non-clinical staff to work together 'without fault lines and schisms'. When there are 'fault lines' it becomes harder for team members to work collaboratively and it is likely that it will impact on relational issues. Mistral and Velleman (1997) stated that attention needed to be paid to these issues to avoid organisational and inter-professional difficulties that would lead to uncoordinated provision of services.

It is understood that professionals have separate training and development that imbues them with a set of beliefs and theoretical orientations that may not always be compatible. However, Valon (2012) believes those differences can be traced even further back to the decision to embark on certain careers. Valon states that behind these choices are the personal values, political ideas, cultural background, beliefs and personal factors of the person that affect how that person wants to work, the models they will choose and the way that they give meaning to human experience. Øvretveit (1993, p141) states 'professions both attract people predisposed to a given world-view and accentuate this way of seeing things'.

There has been a growing recognition of the importance of values-based practice within mental health (Woodbridge & Fulford, 2004). It is recognised that the values of the service-user are central in any decision but that this way of working is based on

mutual respect and attends to the values of all others concerned. The aim is to convert the different value perspectives from a source of tension to a resource for balanced decision-making.

#### **1.6.4.2 The Dominance of the Medical Model**

Considering the context of health care, Atwal and Caldwell (2005) highlight that within a MDT professionals have to negotiate ways to meet medical aims in addition to functional and social needs via a process of inter-professional interaction. Despite the rhetoric, it has been recognised within public health that there has been an absence of a true multi-disciplinary basis; those without medical backgrounds struggle to manage strategic change and act as leaders and often having low recognition of their skills and expertise (Secretary of State for Health, 1999). Proponents of the Positive Psychology approach argue that psychology has become entrenched in an illness ideology based on the medical model where human experience is pathologised (Maddux, Snyder & Lopez, 2004).

The medical model can be seen in much of the language used; health, illness, treatment, patients, diagnosis. Joseph (2007) sees this also perpetuated in the location of services in hospitals and clinics rather than within people's communities and homes. These difficulties are particularly present within inpatient mental health care (Bentley, 2014).

In talking about their experience of working on different wards, Johnstone (2011a) a CP, highlights the difference that a consultant psychiatrist might make to whether wards are run in a very 'medical' way or where they are more of a therapeutic community. They discuss complex responses including their need for 'tact' alongside feeling uncomfortable to be too explicit about their discomfort with certain treatment options or their opinions on some diagnostic labels. In a book on mental health ethics they summarise the dilemma as being one of challenge, compromise or avoidance in response to traditional psychiatric practices, highlighting the lack of guidelines for 'indicating when compromise turns into collusion' (Johnstone, 2011b, p102).

Many psychologists use psychiatric diagnostic terminology often defending it as a useful shorthand form of communication which feels particularly important within

multidisciplinary work (Cromby, Harper & Reavey, 2007). Some have argued that psychology's acceptance of their existence within the NHS, a medical system, is collusion with this model and their proposal of alternatives is often too gentle or entirely absent. Describing psychotherapy one CP states 'its strongest characteristic if not its defining expression, one of inane amiability' (King-Spooner, 2014, p167). It is possible that some of this 'amiability' may come from CPs feeling uncomfortable taking an 'expert' position and naturally seeing formulation as a tentative hypothesis which can undermine confidence or clarity in their ideas (Christofides, Johnstone & Musa, 2012). One study of nursing students found that when individuals felt valued and had a legitimate place in the team they were less likely to conform with poor practice and felt more independent in their approach and able to question things (Levett-Jones & Lathlean, 2008). One possible consequence of overlooking value is withdrawing from the team leaving them with reduced influence and legitimation. However, this study was looking at nurses at an early stage in their career and it may be the likelihood of conformity may decrease with experience.

A paper was published in the British Journal of Psychiatry arguing that patients could be put at risk if too much attention was paid to psychosocial models of care at the expense of a medical model (Craddock, 2008). The argument put forward is that the seriously ill patient benefits most from having a highly trained professional capable of administering a thorough, broad-based assessment leading a team to ensure appropriate management. The paper suggests that the psychiatrist is the natural leader of a MDT and there should be less distributed responsibility among team members as this may lead to devaluing of biological factors. This is in opposition to the King's Fund (West et al., 2014) recommendations for collective leadership where leadership is shared and distributed throughout the NHS. They describe needing to harness collective capability in order to make use of the skills, motivation and commitment of the entire workforce. Consultation with some service users also indicated that they valued the role of psychologists in offering a helpful counter-balance to the medical model (Onyett, 2007). This was felt necessary in order to promote effective individual service planning that could take account of multiple ways of understanding and be transparent about underlying ideologies that influenced these. Thus, a question can be raised about whether it is possible to balance team working with professional identity.

#### 1.6.4.3 Balancing Team and Professional Identity

Considering this, Onyett, Pillinger and Muijen (1997) suggested that an individual joining a CMHT becomes a member of two groups, the profession and the team, with identification being complementary or conflicting depending upon the culture of the groups. The following section explores the extent to which an individual might identify as a part of a MDT and as part of their professional group; namely CPs in the context of this current study. Within the Social Identity Approach these choices can then impact on one's self-conceptualisation. There is a balance to be achieved within MDT working in relation to team and professional identity, role and purpose. Since studies of team working began to emerge in the early 1990s, there have been debates about the degree of importance members can ascribe to their professional group and their team (Øvretveit, 1991). For example, Lindeke and Block (1998) explored this in relation to how nurses could maintain their professional integrity in the midst of interdisciplinary collaboration. Carrier and Kendall (1995) felt that working in this way required a willingness to give up exclusive claims to specialist knowledge if the needs of the clients might be met more effectively by other professionals. The pressures created by the current economic climate which will be discussed further in sections 1.8 and 1.9 may contribute to fears CPs experience around 'giving up' exclusive knowledge due to concerns around job security.

The extent to which an individual identifies with their team rather than the CP profession, for example, may impact on their experience of relatedness within the MDT environment. Markiewicz & West (2015) talk about 'committee working' rather than 'team working' where individuals come to multidisciplinary meetings with the aim of representing their specific professional interests resulting in competition for resources and decision making power which may not be the outcomes required of the team in the best interests of client care. One study found that CPs who maintained high team identification had significantly higher job satisfaction than those with low team identification regardless of professional identification (Boakes, 1998). Onyett (2003) suggests this balance can be problematic and that individuals need clear team goals in addition to a distinct role in reaching these in order to protect any valued professional identity alongside team identification.

Further, Sommerbeck (2005) highlights the need for therapists to have access to someone who can understand their experiences from a similar frame of reference suggesting a peer consultation or supervision group to counter feelings of isolation. In the British Psychological Society (BPS) guidance on working in teams they highlight that psychologists can work very well as part of a MDT and can assist with team dynamics more broadly, but that they need to retain their unique identity and remain connected to their professional group (Onyett, 2007). This has also been recognised in the sphere of interprofessional education where some argue that this is better placed after qualification when practitioners have developed their respective professional identities (Barr, 2002). Interprofessional education is defined as occasions where two or more professions learn with and about each other to improve collaboration and the quality of care provided (Barr, 2002).

It is also important to consider the impact that our relationships with others has on the way that we view ourselves. In the field of social constructionism the idea of selfhood has been seen as something that is contingent upon social interaction and negotiated with others (Burr, 2003). One study using a belongingness scale with student nurses found that when they did not feel welcomed, valued or accepted it often resulted in poor self-image as they internalised perceived views from others (Levett-Jones et al., 2009).

Further considering the balancing between team working and professional identity, one study explored how experiences within groups during training may influence the construction of personal and professional identities (Valon, 2012). Bruner (1990) puts forward an argument that individuals develop their sense of self in a relational context through their interactions with others from the same culture allowing them to create 'narrative meaning' and understand difference and divergence from this. It would be interesting to explore what impact there might be when a CP leaves the training environment and others from the 'same culture' and joins a team where there is much greater divergence of professionals and ideas; perhaps such a context may impact on issues of conflict and cohesion (discussed in section 1.6.4.1). Further, Atwal and Caldwell (2005) highlight that the ways in which a professional becomes part of a team varies widely and depends on how the services are organised. It seems that it could be important to have a greater understanding of this

process and the extent to which individuals retain a sense of integrity to their professional training.

#### **1.6.4.4 Lack of Training in Team working**

As is evident in discussions at a political level, after qualifying professionals often enter into teams with very little training or guidance on multi-disciplinary working. Team members come from separate disciplines, diverse educational programmes and rarely train together but teamwork is identified as being critical in ensuring safety, with teams making fewer mistakes when members are aware of each other's roles and responsibilities (King et al., 2008). The Department of Health (2015a) have identified that clinicians in training should be educated in effective MDT working as one of the elements crucial to creating safer clinical systems. Barr (2002) has suggested that training in MDT groups should occur after specific professional training, however, training in working in groups could happen within the individuals' professional training process. Training in team work is clearly an important issue, as Dr Kevin Cleary in his role as Medical Director for the National Patient Safety Agency highlighted that 'safety is not just about individuals but also about the systems they work in' highlighting that communication between teams is a critical part in ensuring safety (Department of Health, 2010, p2). The Department of Health (1999) highlight the importance of establishing good communication and consistency of purpose. The King's Fund (West et al., 2014) suggest that collective cultures in teams requires high levels of dialogue, debate and discussion in order to create shared understanding. It is also important to remember that increasing opportunity and quantity of discourse may not be enough to create a sense of collectiveness as this may be determined by the nature of the discourse and the interpersonal relations afforded by this. This section has considered MDTs generally, including within the training process, but the next section will specifically consider these issues in the context of CMHTs.

### **1.7 Community Mental Health Teams**

This research is specifically exploring the experiences of qualified CPs who work within adult CMHTs. Therefore, this section will detail some of the history of these teams to help create an understanding of the system that exists today recognising the contextual factors that can impact on relatedness.

The introduction of the White Paper, 'Better services for the mentally ill' (DoH, 1975) raised the profile of community care for patients with mental health problems stating that people are to be treated at home. Between 1959 and 1980, due to the introduction of new treatments, such as psychotropic medication and out-patient services, the number of hospital residents fell from 159,000 to 79,000 (Fagin, 2007). There was a shift in the perception of clients and recognition that their psychological concerns and social environment should be considered, requiring a wider range of skills alongside the psychiatrist and psychiatric nurses. Over recent decades, UK NHS mental health services have moved from largely hospital based uni-professional teams, to community based multi-disciplinary team provision (Lucas, 2004). CMHTs were formally introduced on a national basis in 1990 to provide integrated care in the community (Borrill et al., 2001). The Department of Health (1996) document 'Spectrum of Care' advocated MDTs as a key indicator of interagency work and required a CMHT be in place in each locality.

In the National Service Framework for Mental Health (Department of Health, 1999) they identify CMHTs as a MDT that offers specialist assessment, treatment and care to individuals within their own homes and the community. It identifies that teams should include nursing, psychiatry, social work, psychology and occupational therapy membership. In a study commissioned by the Department of Health into the effectiveness of health care teams it was found that only 12% of CMHTs included members from all those disciplines (Borrill et al., 2001). They identified effective group decisions were being made in the majority of team meetings and that clear leadership, high levels of integration, good communication and effective team processes all had a positive impact on stress levels.

The majority of research into interprofessional working has focused on physical healthcare teams looking at relationships between doctors and nurses for example. The findings from a number of studies that have looked at CMHTs and specifically included CPs will be detailed in the following section.

One study comprised of a questionnaire to elicit views about the role of CMHTs that CMHT professionals completed (Mistral & Velleman, 1997). They concluded that professionals held radically different views, and CPs significantly so expressing a

preference for a single profession team believing CMHTs did not allow optimum use of skills. Robinson and Cottrell (2005) undertook an Economic and Social Research Council funded research project to explore the reality behind the rhetoric of 'joined up thinking' by undertaking a multi-method study looking at multi-agency teams. One of the five teams that they looked at was a child mental health team and two comments were included from a psychologist stating they were unaware of status issues and also highlighting part-time members may feel they have less of a voice. They concluded their outcomes confirmed the literature on teams that shared team climate was dependent on the establishment of shared goals and values, task interdependence and effective communication. Another study looked at the idea of role blurring in three UK CMHTs, the sample included psychologists but it was unclear how many from the sample description were CPs (Brown, Crawford & Darongkomas, 2000). The conclusion they reached was that the encouragement of more generic working had the impact of making some individuals more insistent on their separate professional identities. One can thus see how complex the balance between team working and professional identities is as previously discussed in section 1.6.3.3.

This complexity in balancing was also identified in Boakes (1998) doctoral research study using a range of measures to explore CPs team and professional identification, job satisfaction and burnout in a range of MDTs with around 42% being adult CMHTs. CPs spoke of competition and mistrust with doctors feeling threatened and nurses feeling envious as they were expected to carry much heavier caseloads. In this study CPs reported both high job satisfaction and high emotional exhaustion. Their professional identification was higher than their team identification but contact with other CPs was not significantly associated with their professional identification. Onyett, Pillinger and Muijen (1997) also concluded that CPs had higher professional identification and lower team identification when compared to other MDT members. They also found least role clarity for social workers and CPs suggesting this might be because they are a minority profession and may see their professional identity as undermined by team membership.

Another doctoral research study (Lucas, 2004) looked at the role of the CMHT CP in giving and receiving support within mental health services. One of the themes



identified was 'in the same boat' which was described as being similar to people being placed together by circumstance rather than choice and struggling or having to adapt themselves to function within that situation. This study concluded that challenges emerged for CPs as they had to maintain contact with their team whilst holding sufficient distance to maintain their reflective function, recognising too much distance made them less accessible. It was suggested that support from an external peer group enabled the maintenance of this position with encouragement to hold on to the human, rather than technical qualities of support and the importance of CPs recognising their own needs was highlighted.

Considering specific CP techniques further, Christofides, Johnstone and Musa (2012) carried out interviews with CPs exploring the use of formulation, seven of whom were working in CMHTs. They highlighted that they felt sharing skills with other staff members was an efficient use of their time as it was likely to have a wider impact than just working with one client. However, they acknowledged the challenges of working with teams that may be 'set in their ways' or who had years more experience and felt they needed to build relationships first. Thus the issue of relatedness comes to the foreground again.

Considering this in relation to the impact on client care, the NHS Outcomes Framework for 2015-2016 has highlighted that ensuring people have a positive experience of care is one of the five key domains (Department of Health, 2014). The outcomes framework provides a national overview of how the NHS is performing and aims to improve accountability and quality by identifying current challenges. Patient's experience of community mental health services is the only area specifically highlighted under improving healthcare for people with mental illnesses. There is also an emphasis on improving people's experiences of integrated care. This highlights the importance of considering how teams work together to provide integrated care and particularly within community mental health.

### **1.8 The history of Clinical Psychology and their place within teams**

To further complicate things in relation to professionals within MDTs often having different values bases, professionals within the same discipline will also have differing views and this is particularly prominent in CP where there are multiple

models and theoretical understandings. Kimble (1984) highlights that within the field of CP there are differing views and values underpinned by a range of epistemological and political positions; this may further impact on how individuals within a team relate to each other.

A brief history of relevant aspects of the profession will be presented here but Cheshire and Pilgrim (2004) can be accessed for a more detailed history. Although the first psychological clinic opened in Pennsylvania in 1896 and CP had existed as a profession prior to the Second World War, it was this war that saw the profession grow in prominence. CPs were employed to assist with the recruitment and selection of service personnel. The establishment of the NHS took place in 1948 and a few CPs were employed in psychiatric hospitals. There was a focus on the use of psychometric testing and the establishment of CPs as scientists and researchers.

The development of the scientist-practitioner model emerged out of the Boulder Conference in 1949 and linked an understanding of people's psychological difficulties with a more positivist and medical approach (Albee, 1970). The 1970s saw the beginnings of a greater focus on the biopsychosocial model (Engel, 1977). However, there continued to be a dominance of the medical model within healthcare and in the 1980s demand outstripped supply and the government commissioned a review of CP, (Manpower Planning Advisory Group, 1990). In arguing for their status and expertise within healthcare a reliance on the concept of science formed part of this report.

The anti-psychiatry movement emerged alongside more reflective models and community-based psychology ideas causing further splits in values and ideologies of CPs. Hughes and Youngson (2009) highlight the aims of critical psychology in trying to challenge dominant discourses and systems maintaining inequalities and human distress. In addition they also argue that CP has to maintain and develop its identity, position and goals based on evidence-based practice and practice-based evidence using both the scientific-practitioner and reflective-practitioner models.

A review of CP services (Management Advisory Service, 1989) noted that CPs more than any other health professionals were active in offering support to colleagues through consultation, support groups, training and supervision which was often not recognised. In a study of multi-agency teams it was found all professionals, except

for psychologists, *gave* rather than *asked* for information, opinions and suggestions (Bell, 1999).

A number of professional articles were written around the time of the formal establishment of CMHTs in 1990 which questioned the place of CPs in them, suggesting a threat caused by generic roles and arbitrary case allocation resulting in role blurring and deskilling, or refusal to accept this leading to resentment and envy from other team members (Reiman, 1989; Anciano & Kirkpatrick, 1990; Clydesdale, 1990; Trepka & Marsh, 1990; Searle, 1991; Bradbury, 1996). Onyett (as cited in Mistral & Velleman, 1997, p237) reflected that CPs were well placed to offer a constructive critique to the debate about CMHTs but that at this stage it had been little more than a 'large and unqualified bucket of icy cold water'. White (2008) talks about interconnectiveness as being key between services as well as personnel but highlights the need for psychologists who are not 'precious' and who are happy to work with others.

There is a current need within the NHS for professionals to establish the specific value that they add. Tosi and Mero (2003) identified that the battle by nurses to be recognised as a profession could result in a profession-only, rather than a team focus; this shift could damage multi-disciplinary working. Due to the starting salary of a newly qualified CP and the growth in single therapy provision that can be achieved at lower costs this is a particularly pertinent concern for CPs. The New Ways of Working guidance (BPS, 2007) identifies CPs role in teams not just as therapists but as supervisors, consultants and trainers. The BPS (Onyett, 2007) published guidance on the work of psychologists in teams and suggested that the visible presence of a psychologist during meetings promoted the importance of a psychological approach. The Leadership Development Framework (BPS, 2010) and guidelines on the use of psychological formulation (BPS, 2011) both promote the leadership role of CPs within the NHS in promoting psychological thinking amongst MDTs. Research on the use of formulation in teams highlighted that many ideas were brought in an informal way through 'chipping in' during meetings or joint working (Christofides, Johnstone & Musa, 2012). It is this process that highlights a relational context to working.

Within this team context Johnstone (2011a) has promoted team formulation as a skill CPs can provide to enable staff to share and process their emotions. However, there is a recognition that although qualitative research suggests staff find this helpful there are challenges in how this could be researched in relation to demonstrating improvements in client outcomes. The BPS (Onyett, 2007) recommend team formulation as a powerful way of shifting cultures within MDTs. Relatedness may be a key factor in helping or hindering this process. Indeed, Sommerbeck (2005) recognises the tensions between different models and ways of working but sees their role as translating diagnostic language into the language of relationships alongside encouraging empathic understanding and compassion. They report seeing their place of work becoming more client-centred and feeling less isolated and invisible but recognise a precondition is often having a psychiatrist that is broad-minded enough to allow space and time for this. The issue of relatedness is pertinent, as Sommerbeck talks about the effects of feeling separated, isolated and invisible from the activities of the rest of the team that can lead to burnout. An inadvertent side effect of this is highlighted by Winslade (2002) when the role of helping others can ironically lead to psychologists being viewed by others as more *self-actualised* thereby restricting their ability to share their *own* emotions and vulnerability. This can lead to further isolation and, thus, should be kept in mind when exploring the interrelated processes of relatedness.

In considering the position of CPs and the interrelated processes of relatedness, it is important to also be aware of the wider system within which they are working. For the purposes of this research this will be the NHS so this will be considered next.

## **1.9 The NHS and the current context**

In adopting a social constructionist stance it is important to be aware of the context within which narratives and identities are formed. In understanding social identity processes the Social Identity Approach highlights that social structure, social context and society in general are fundamental (Haslam, 2004). This model recognises that how people define themselves, make sense of the world and act in relation to each other is an interaction of their individual and collective psychology with the socially organised environment in which they exist. Indeed, Borrill et al. (2001) explain that

research suggests the broader context within which teams work has an influence on their performance.

Considering more explicitly the organisational context within which the CP resides, the King's Fund (West et al., 2014) highlight that the NHS is being confronted by radically changing demographic pressures, hugely increasing demands and a need to build public confidence after several high-profile scandals in the context of large scale public sector financial cuts. Media reports highlight waiting times and failures of care which have led to a loss of public confidence in the NHS. A recent letter from the chairs and presidents of a number of the royal colleges including psychiatry and nursing and the BPS highlighted the high levels of sickness, the average member of NHS staff has a sick day every twenty-five days (Baker et al., 2015). They called for political parties to outline how they would create a culture that improves patient outcomes through building a supportive working environment. Thus, the issue of relatedness is implicitly within these calls for change.

The Health and Social Care Act became law in 2012 (DoH, 2012a) amidst controversy and fears that it removes the duty of the Secretary of State to secure and provide healthcare for all by changing the duty to 'promote'. It reduced government control and diverted responsibility to Clinical Commissioning Groups (CCGs) who determine which services are part of the health service and which are chargeable. These changes and the current economic and social climate create pressures for the NHS to run on a business model with the introduction of competition between services and value being placed on cost effectiveness. As highlighted in the previous section this has created insecurity for CPs in the face of cheaper single therapy training opportunities.

In contrast to the economic drivers of the NHS structures for care, the Francis Report (Francis, 2013) and subsequent concerns with the need to consider how a culture of compassion can be supported and encouraged within the NHS have led to some legislative shifts in focus. The Department of Health (2012b, p9) document 'Compassion in Practice' highlights a ten point strategy towards their vision. One of these points is 'collaboration at all levels' highlighting that 'working with others in our team is at the core' to ensure resources are utilised and a culture shift is achieved. It

also highlights another point of supporting staff wellbeing recognising that treating each other well is fundamental and there is a link between the value, care and communication between peers, and how service-users are treated. The General Medical Council is reportedly reassessing the content of generic training to place greater emphasis on areas relating to human interaction including teamwork and inter-professional learning (Department of Health, 2015a). Perhaps it is worth noting that these shifts in focus have a long term focus which may conflict with the short term economic drivers for evaluating outcomes in healthcare.

It is also important to be aware of the growing rates of mental health difficulties and the pressure that this is placing on services who continue to be unable to meet all the demands of their local communities. There are a multitude of explanations but it is recognised that many identified mental health problems should be seen in the context of growing income inequalities, changing patterns of family life, increasing job insecurity, the influence of the media on people's expectations, social pressures and a range of physical health conditions that affect wellbeing (Hall & Marzillier, 2009). The group Psychologists Against Austerity highlight that social and economic changes create five 'austerity ailments that impact on mental health: humiliation and shame, fear and distrust, instability and insecurity, isolation and loneliness, being trapped and powerless (McGrath, Griffin & Mundy, 2015). These all have relational qualities embedded within them. The election of a Conservative majority government has come with a pledge of a further twelve billion cuts from welfare benefits (Conservatives, 2015). All of these wider influences impact the context within which this research takes place and highlight the tensions between healthcare on a relational level and as an economic endeavour.

### **1.10 This Study**

The introduction has attempted to draw out, and integrate together a wide array of literature sometimes involving implicit discussions on relatedness. In an attempt to gain a greater and more detailed understanding of relatedness within MDTs, this study aims to explore the experiences of CPs working within them. Previous studies have considered certain aspects of team working including communication, effectiveness, burnout, cohesion and leadership. However, there is a gap in the literature when it comes to the actual experiences of CPs being in a team consisting

of different professionals and considering how connected these individuals feel and the clinical implications of this.

It is hoped that this study will increase understanding around the relational component of team working and the impact this has, the aim being to enhance team functioning and encourage best practice. Finally, this study hopes to help inform how, and in what way, services could be developed resulting in improved service-user experience and outcomes.

The main research question is:

**How do Clinical Psychologists narrate their experience of relatedness within adult Community Mental Health Teams?**

This will include the following aims:

- To explore the experience of Clinical Psychologists working in adult Community Mental Health Teams (considering change over time)
  - To give voice to the stories that Clinical Psychologists tell about themselves and consider the position and influence held by Clinical Psychologists
  - To contribute to thinking around collaborative and interdisciplinary working
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## 2. Method

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This section has been divided into three subsections. Firstly the rationale for using a qualitative methodology and in particular Narrative Analysis will be outlined. This is followed by a description of the design of the study and finally, ethical implications are considered.

### 2.1. The focus of the study

The focus of this study was to explore how CPs narrate their experience of working in MDTs and the relatedness they experience within these by considering their relationships and connectedness.

#### 2.1.1 Rationale for using a Narrative Approach

In deciding upon an approach for this study consideration was made of the existing research on MDTs. With this there was recognition that many studies of teams have utilised a quantitative approach primarily with survey questionnaires exploring concepts such as cohesion and team working. In looking at increasing understanding of how individuals during their careers as CPs perceive and experience their relationships with other team members it felt important to aim for the richness that can be accessed via a qualitative approach. It was also recognised that relatedness is hard to define and individuals will place varying degrees of importance on certain aspects so attempting to use, or design a questionnaire, that captured the complexity of this seemed to obscure some of the individual meaning-making. Qualitative approaches are effective in accessing meanings from the perspective of participants (Henwood, 1996) and can also be used to examine complex phenomena (Patton, 1990).

As the aim of this study was exploration rather than testing of pre-existing hypotheses it seemed appropriate to approach this with a qualitative research design. There are various different types of qualitative analysis and the choice of method tends to depend on the researcher's underlying epistemological position (Willig, 2008). In the process of determining what methodology would be most suited to this topic area Interpretative Phenomenological Analysis (IPA) was considered in



addition to Discourse Analysis and Personal Construct Psychotherapy Repertory Grids.

For the purpose of this study Discourse Analysis was deemed too time consuming reducing the amount of material that could be examined within a limited time frame (Potter & Wetherell, 1995). Discourse Analysis was completely unfamiliar to the researcher and would have involved a large amount of 'self-training' with no availability of a peer supervision group in this area (Harper, Connor, Self and Stevens, 2008). Studies have been undertaken using a Discourse Analysis approach within MDTs, one used focus groups but highlighted a possibility of further research to consider 'naturally occurring' talk (Westwood, 2010). For many reasons this was considered challenging within the scope of this research: it would have taken time to become established within a team to allow trust to develop enabling more naturally occurring talk, this would have only offered a picture of one team, it may not have been easy to consider the multifaceted aspects of relatedness and ethics around client identifiable information within meetings would need to be carefully considered. In considering the use of repertory grids this was again an unfamiliar area that would have required time for familiarisation. In discussion it was felt that recruitment may pose further difficulties as the aim would be to have the entirety of the team complete the repertory grid and for this to be repeated with a number of teams. This felt particularly challenging within a pressured NHS. Finally although IPA could have been used within this research study it was agreed that Narrative Analysis was appropriate due to the interest in change over time, relationships and identity. After much consideration and in depth discussion with multiple members of the research team it was agreed that Narrative Analysis offered something particularly useful in thinking about these specific research questions and this will now be discussed in more detail.

In taking a social constructionist epistemological stance it was important to consider an analysis approach that recognised there is no one truth but a construction that occurs within social interaction. The concepts of 'self' and 'identity' can be thought about as social constructions that are narrated through the stories that people tell about themselves (Freeman, 1993). Narrative Analysis tries to understand the processes by which we make sense of our world and recognises that since there is no objective reality, all knowing requires an act of interpretation (White & Epston,

1990). This also fits with the idea that individuals give meanings to their lives by telling stories about themselves (Bruner, 1990; Ricoeur, 1992). Telling stories about past events or experiences seems to be a universal human activity, which enables people to claim identities and construct lives (Riessman, 1993) and Narrative Analysis offers an opportunity to explore how individuals construct their identities through the act of telling stories (Ricoeur, 1988).

Johnstone (2011b) highlights many different ways of being in teams and that people have to adopt different strategies at different points in their lives and careers. It felt important, therefore, to explore changes over time and how these were narrated. As identified within chapter one (section 1.4.3.3) there are links between our relational experiences and how we perceive ourselves. Burr (2003) explains that social constructionism can present a picture of multiple, fragmented and incoherent selves present within different interactions whilst subjectively we often feel a coherent 'sense of self'. One explanation for this is that our memory allows us to create a sense of continuity and consistency through creating a narrative framework to structure our experience (Sarbin, 1986). In exploring someone's experiences of relatedness and connection it therefore feels important to explore the stories that they tell and how these link to how they narrate their sense of self.

The research aims identify a curiosity about narratives of professional and personal identity changes and how these are developed over time in relation to working within an MDT and the wider professional context in clinical psychology. Narrative Analysis focuses on experiences rather than events and allows multiple meanings in view of the wider personal, social and cultural contexts in which the stories develop (Andrews, Squire, & Tamboukou, 2008), which reflects the epistemological position in which this research is situated. Riessman (2008) is interested in how narratives and personal stories are tied up with the performance and negotiation of social identities in a common space of meaning which links with thoughts around what occurs when that 'space of meaning' changes.

Narrative research allows the investigation of how stories are structured, the ways in which they work, who the narrator is and how narratives are silenced, contested or accepted (Andrews, Squire, & Tamboukou, 2008). The research is interested in relationships within teams and Narrative Analysis recognises that stories situate

people in groups and storytellers will have imagined audiences in mind (Frank, 2012). This allows consideration within the analysis of the professionals and team members that are absent in the interview but may be present as an imagined audience. In exploring the co-construction of the dialogue an understanding can be gained of the multiple voices that find expression within a single voice (Frank, 2012).

### 2.1.2 Introducing Narrative Research

Identifying the beginnings of narrative inquiry offers as many different opinions as the approach itself but Riessman (2008) describes it as 'budding' during the 1960s but really 'flowering' in the mid-1980s where it emerged as a challenge to realism and positivism. Within this she highlights the multitude of developments and divergences stating 'today, the field is a veritable garden of cross-disciplinary hybrids' (Riessman, 2008, p14). It is recognised that within Narrative Analysis there are few rules for framing inquiries, obtaining and analysing data or presenting narrative findings (Squire, Andrews & Tamboukou, 2008).

Riessman (2008, p3) discusses oral storytelling and highlights how the speaker connects events into a sequence that is both consequential for later action and the meanings that the speaker wishes the listener to take away. Here the importance of a particular audience is highlighted and, in the current study, this consideration was important when thinking about the context of the interviews themselves.

A further consideration was Riessman's (2008) detailing of four types of analysis. Firstly, thematic analysis where the emphasis is on the content of a text looking at what is 'told' rather than exploring the 'telling'. Secondly, structural analysis considers the way a story is told (i.e. the 'telling'), with language as the main focus. Thirdly, interactional analysis considers the dialogic process between the teller and the listener and the collaborative meaning gained from the co-construction of a narrative. Lastly, performative analysis is an extension of the interactional approach where interest moves beyond the spoken word to consider how and why the storyteller is communicating in the way they are and how that involves the audience. Riessman (2008) highlights that the four approaches are not mutually exclusive and they can be adapted and combined.

### 2.1.3 The Approach of this Study

Mishler (as cited in Neander & Skott, 2006, p.297) notes that the researcher does not find narratives but instead participates in their creation. Developing the process of analysis is a difficult process due to the 'nature' of Narrative Analysis not having one clear method but many depending on one's stance and context. However, Yardley (2008) highlights a number of important validity criteria including being sensitive to the context of data collection, being committed to a rigorous depth of analysis, the concept of 'transparency' and its importance in allowing the reader to follow the stages of analysis and process of interpretation of the data and recognising the impact and importance of the findings.

Due to the nature of this research topic being more focused on an experiential approach a decision was made to not use an event-centred Labovian approach. Patterson (2008) highlights the challenges of treating the complexity and subtlety of the narration of experience as though it should have an orderly, complete structure.

Riessman (2008, p200) invites investigators to consider the multiple approaches of Narrative Analysis and then adapt them to the specific research problem. For this research the Narrative Approach used was influenced by Mishler (1997) who identifies the importance of exploring the following aspects of detailed transcripts:

- Use of language
- Contexts of production
- Structural features of discourse
- Acknowledgement of the dialogic nature of narrative interviews

Alongside the exploration of individual transcripts Mishler advocates a comparative approach that identifies similarities and differences amongst participant's stories. Plummer (2001) highlights that creating a 'community of stories' can help link people with shared stories which may be helpful if CPs are experiencing isolation in their experiences in teams.

### 2.1.4 Methodological Limitations

There are limitations within the narrative methodology, Bruner (1990) explains that narratives are plural, which may mean that when a person tells a story about their life, this may change dependent on the context or to whom the story is being told. It

is acknowledged that all stories will be incomplete since experience and subjectivity cannot fully make their way into language (Squire, Andrews & Tamboukou, 2008). Riessman (1993) emphasises that narratives are representations so there is always an interpretation but this is necessary and any 'truth' is always just one construction. It is important therefore to retain self-awareness as a researcher and consider issues of transparency. The use of regular supervision both with the project supervisor and a peer supervisory group alongside a reflective journal were employed to assist with this. This will be discussed further in section 2.3.4.

## **2.2 Design**

A qualitative design was employed using eight individual semi-structured interviews with CPs who work within an adult CMHT. The resulting data was explored using Narrative Analysis.

### **2.2.1 Participants**

Emerson & Frosh (2009) argue that Narrative Analysis is concerned with a 'detailed investigation of very small numbers of research 'subjects', whose processes of accounting and making sense of their experience is seen as being the intrinsic interest, rather than a source of generalisations' (p17). The participants recruited needed to closely match the criteria of the study therefore, a purposive sampling approach was employed. The participants needed to be qualified CPs with a minimum of twelve months post-qualifying experience who were currently working in an adult CMHT within the NHS. Trainees were excluded alongside the twelve months post-qualifying stipulation as this study aimed to specifically explore how relational issues impact after an individual has left the training environment. It was highlighted within the advertisement that the hope was to speak with CPs with varied amounts of experience. It was also decided to recruit participants that had no prior relationship to the interviewer because there was recognition that this could alter the stories that were told.

The decision was made to restrict the sample to NHS adult CMHTs to aid the creation of a more homogenous sample. Although homogeneity is not essential within Narrative Analysis the geographic location, structures of teams and organisational issues would already create variety within the sample and it may

become difficult to disentangle possible causes of divergence. Adult CMHTs were selected because much of the previous quantitative research has been carried out in this area. It was additionally viewed that MDTs are central to the working of the NHS and adult CMHTs isolate some areas of tension and disagreement that may be less evident within other teams. An example of this is the use of medication within children and adolescent populations where there may be less disparity of opinions than with adults.

Josselson and Lieblich (2003) have suggested that Narrative Analysis requires between five and thirty participants. For this study a decision was made to recruit between six and eight participants to help ensure the number was large enough to be able to consider differences and similarities. This was due to an interest in both individual narratives and how these are situated within wider collective stories. As there were limitations in the time scale of the study, it did not seem feasible to carry out detailed analyses if the sample was any bigger than eight.

To initiate recruitment, emails were sent out to heads of psychology within NHS trusts requesting that these be forwarded to the CMHT CPs. The email had a 'participant information sheet' which could be read in order to help them make an informed decision of whether to participate (see appendix 1).

### **2.2.2 Interviews**

The participants were invited to take part in a semi-structured individual interview at a convenient time and location of their choosing. This was to ensure participants were in the best environment to enable them to feel relaxed and able to speak openly whilst also recognising that convenience facilitates recruitment. However, there was also a recognition that when narratives are spoken, the time, the place, the occasion, the narrator, the audience, and the narrative become immediately intertwined (Chamberlain and Thompson, 1998, p10) and can be understood as 'purposeful social actions' in a way that written narratives cannot.

The narratives were considered in relation to their co-construction between the interviewer and the research participant (Mishler, 1997) as well as in relation to how they were shaped by the audience to whom they were told; namely, the interviewer,

the reader and the wider societal discourses. Narrative Analysis requires a relatively open form of interviewing which allows participants to thoughtfully talk about issues which are of interest to both the research and themselves. The interviews were designed to encourage development of narratives, with the understanding that narratives may also emerge spontaneously. A sample of the questions posed can be found in appendix 3.

### 2.2.3 Procedure

Before carrying out the interview the information regarding the study was reiterated and the participant was asked to sign a consent form (appendix 4). The interviews were all carried out by one researcher. All the interviews were recorded and stored securely on a password protected electronic file.

### 2.2.4 Transcription

Interviews were transcribed verbatim for both interviewer and interviewee and the corresponding transcription was checked for accuracy. Pauses and non-verbal expressions (such as sighs and laughter) were added in brackets and emphasised words were underlined. An example of an extract can be found in appendix 5.

### 2.2.5 Data analysis

Influenced by Emerson and Frosh's (2004) critical narrative approach texts were analysed in a series of steps, moving from a micro- to macro-levels of analysis. The exact course that the steps of the analysis took emerged over time in response to outcomes of previous steps. However, the central question which guided the analysis throughout was:

#### **How does this person, in this context, come to give the account he/she does?**

The steps of the analysis took place over several phases and were as follows:

- Multiple readings of the transcript alongside listening to the audio recordings to ensure emotional expression had been captured where possible
- Paying attention to content and identifying the themes of what was told (taking care to be open to emergent themes rather than predetermined ones)
- Identifying key structural elements of how the story is told, the language used, repetition, flow, consistency, emphasis and the narrative style

- Considering the performative aspects of the narrative by thinking about the real and imagined audiences the stories might be being told to and how this might relate to the narrative identity the interviewee wants to present
- Being aware of the dialogic nature of the interactions and exploring how these might influence how the narrative is co-constructed and influenced (noticing if any stories are silenced or absent)
- Once all transcripts have been analysed individually reading across these to notice commonality and divergence and identify any shared narratives
- Considering the individual and shared narratives in context thinking about the impact of the interview, the individual's career context and the wider societal discourses

There was a recognition that the analysis was dependent on decisions that were made and these may have been different at different times. The meanings are co-constructed and not static and the analysis could go on forever. As a researcher an end point was determined dictated by research timelines thus there is recognition that further analysis could bring forth other ideas.

### **2.3 Ethical Considerations**

Ethical approval was gained from the University of Hertfordshire Research Ethics Board on 15<sup>th</sup> October 2014; reference number LMS/PG/UH/00291 (see appendix 6). Further approval was gained following a change to the title of the study on 5<sup>th</sup> November 2014: reference number aLMS/PG/UH/00291 (see appendix 7).

#### **2.3.1 Informed consent**

There should not be any deception within Narrative Analysis so participants were provided with a very detailed information sheet (appendix 1) detailing the aims of the project and details of confidentiality prior to the interview. All participants were asked to sign consent forms to identify that they understood the information (appendix 4). Participants were also given a debrief sheet once the interview was complete (appendix 8).

#### **2.3.2 Confidentiality**

The interviews were transcribed either by the researcher or by a third party who signed a confidentiality agreement (appendix 9). The transcripts were downloaded from a Dictaphone and kept in a password protected electronic file. As far as



possible, all identifying information was anonymised in the transcriptions. Pseudonyms have been used throughout the project including in the analysis and report.

### 2.3.3 Emotional Impact

The participants were warned of the possible emotional impact of in-depth interviews prior to the interview and they were asked for assurance of receiving regular supervision. Participants were given the right to withdraw from the study and were offered a debrief sheet after the interviews. It was explained to participants that the project would involve a construction of their story and, if this diverged from their own construction, that this could be challenging for some individuals.

### 2.3.4 Interpretation of the interviews

The co-construction of the data was regularly discussed and closely observed by the supervisory team. This enabled movement towards a critical reflection of the interviews and analysis, encouraging examination from multiple positions and to use reflexivity in order to expand understanding (Gergen & Gergen, 1991).

However, the notion of validity and reliability used in quantitative research cannot apply to qualitative methodology as they are based on positivist assumptions, which assumes there is one objective truth *out there* (Burr, 2003). Instead factors of credibility are used through a process of transparency (Guba & Lincoln, 1998). Narrative Analysis allows the researcher to see multiple perspectives and conflicting layers of meaning, which, if brought together, enables them to understand more about individuals and social contexts. It was also important to reflect on the position of being the researcher and the aspects of 'self' that were influencing expectations and pre-conceptions and the narrative that was shaped throughout the analysis. The use of a research journal also allowed for ongoing reflexivity with a recognition that this would not eliminate all variables but would enable greater awareness and transparency (see appendix 10 for an extract).

Throughout the process there were discussions with both the academic supervisor and a peer-based narrative research group to ensure the coherence and plausibility of the interpretations that were being developed. As part of the narrative peer supervision group it was agreed to exchange one complete transcript and the

relating global impression to consider if the presented construction of their story seemed to be a reasonable representation of the transcript. It was agreed that both of the global impressions that were shared did accurately map on to the transcripts. Comments that were made around a narrative that had not been as clearly highlighted were incorporated and consideration took place within the supervision group including discussion around validity and co-construction.

### **2.3.5 Service-User Consultation**

Consultation with service-users of an adult CMHT was undertaken in order to explore how these issues may impact on service-users and consider whether there were any areas that they may be interested in being explored further. The two service-users consulted with were white-British, one male and one female and had volunteered for this role. They identified that they were often aware of conflict and issues relating to 'professional snobbery' and felt that this often led to the service-user becoming forgotten. They believed MDTs were necessary as, in dealing with people with complex difficulties, more than one approach is essential. However, they reflected that there was often limited joined up thinking and no agreed 'plan'. Thus, in reality their experience was dealing with an individual rather than a team. This highlighted that exploring relatedness in MDTs appeared to be an important issue that had far-reaching implications. One of the service users expressed a view that they had always felt therapists were battling against the system. They expressed interest in wanting to know how much clinicians felt able to help their clients when they were following directives that did not match their own sense of what would be helpful for the person in front of them.

In recognising that CPs themselves were the focus of this study a focus group was held with eight CPs working within the NHS to discuss the research aims and gather feedback on the interview schedule. The interview schedule was then piloted with a CP in order to gain feedback to enable further refinement. Following this feedback and having recognised the challenges of narrative interviewing a further pilot interview was undertaken to both gain further feedback and increase the confidence of the researcher. It was important as part of this refinement process to consider the aims of the study and the narrative approach. The interview schedule was refined to remove questions and create more open questions to encourage the emergence of

the participant's narrative rather than this being too constructed by the interviewer's pre-conceptions and interests. The schedule was also developed to encourage the interviewee to reflect on change over time and consider past, current and future narratives.

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## 3. Results and Discussion

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The following section contains the analysis of the eight interviews that comprise the research. A decision has been made to present the results and discussion together in an attempt to avoid repetition and promote clarity and understanding.

### 3.1 Overview

In this section a narrative impression of each individual's story will initially be presented followed by a summary of the collective stories that were constructed. This is done both as a way of introducing the reader to the participants and their contexts and also valuing the individual stories rather than automatically reducing these to only collective narratives. Riessman (2008) highlights the importance of treating accounts as units rather than fragmenting them into only thematic categories in order to honour individual agency and intention. Although it is impossible to separate the co-construction it is hoped that within the global impressions there is a core that the participant would recognise. Throughout this chapter reflections of the researcher will be offered on some of the ways in which the narratives were co-constructed. The importance of reflexivity is recognised in making sense of the active process through which research knowledge becomes produced (Plummer, 2001).

The presentation of the results is done with the knowledge that certain narratives have been privileged and there will be other narratives that have been left out or that the researcher or the participants have been less open to. It is recognised that relationships themselves are also not fixed or static entities but change over time and are influenced by situations and prior and current experience (Pullon, 2008). The data that is included is a result of the researcher's frame of understanding and it could have been presented in multiple ways generating different analysis (Frank, 2012). As the researcher the understanding of these interviews has shifted over time and consequently the analysis needs to be considered in context. Andrews (2013, p12) states when we revisit data 'we are different people, and the pasts of the data, and our own present reading situation, are as much 'another country' as are materials gathered in situations unfamiliar to us'.

### 3.2 Considering the Results in Context

In considering the narratives that will be presented it is important to consider what has shaped how the stories have been told. The wider context which surrounds the participants in this research is likely to have had a huge influence on the individual narratives of the participants. Frank (2012, p44) highlights *'the primary resources for telling a new story are the stories that are already circulating in the setting'*. In the introduction some of the broad historical, political and cultural influences on CPs, CMHTs and the NHS were outlined in particular the current financial pressures and cuts. All of the teams were going through or had recently been through a structural reorganisation and this was very present in their narratives. In the service user consultation at the start of this project they expressed feeling that professionals in MDTs are all 'vying for a piece of the pie' and this leads to them not listening or collaborating with each other and forgetting the service user.

The way interviews are set up is also likely to affect which stories are told, therefore, consideration will be given to the interview process and factors which were likely to influence how and which stories were told. Firstly, the participants were all CPs and were aware that other CPs were being interviewed. Secondly, they were being interviewed by a Trainee CP who was aware of many of the narratives available to the participants and who was able to understand the language that was used. Although having similar experiences can lead to assumptions and missed exploration of difference, Frank (2012) highlights that 'sufficient proximate experience of the everyday circumstances' in which people tell their stories is needed for research to enter into dialogue. It is also important to keep in mind the various relationships that existed between the participants and the interviewer. This introduces issues of power dynamics which were also present in other areas. For instance the interviewer was a trainee, this is likely to have influenced how the interviews were co-constructed.

### 3.3 Introduction to the Participants and Global Impressions

All names and identifying details have been changed to protect the anonymity of participants, their colleagues and teams. The sample consisted of eight CPs all currently working within at least one adult CMHT in the NHS. The participants worked for three different trusts in England and had all trained at different

universities. They had been qualified between three and fifteen years and were working at pay bands between 7 (Specialist CP) and 8C (Consultant CP).

### 3.3.1 Alice

Alice is a CP working in an adult CMHT at an 8B band. She is white British and in her late thirties and has been qualified for ten years. We met for the interview in a private room within an office.

Alice predominantly told a story of two teams she had worked within. She explained she had been with her current team for just under a year and worked mostly in the support and treatment team, 'mostly people with sort of fairly chronic personality problems'. She spoke about having been with her previous team through various roles, bandings, 'different guises' and through a change in base, 'but I suppose in one way or another, I'd been with that team since I qualified'.

#### Global Narrative Impression

Alice often did not offer long answers and did not tell richly detailed stories. Her narrative was frequented by many pauses, particularly after any questions and she would also check if she had answered questions, 'I'm not sure if this is the right answer to the question'. This suggested a strong sense of her audience and the interviewer and wanting to offer helpful answers.

Alice's narrative was characterised by a story of loss and sadness for the team that she had been forced to leave, 'we were a very close knit team and it was a real wrench leaving them'. Alice frequently told comparative stories: 'it's not like that anymore', 'it wasn't like that in my old team', 'that doesn't happen here' and 'back in my day'. When speaking of previous experiences of joint working Alice said 'we used to put our capes on and dash off' suggesting a sense of 'rescuers' who had been thwarted in their roles by the system and imposed changes.

Alice did reflect 'I think it is possible to look back and always think that what you had before was the golden age of whatever, um and I don't want to sort of idealise what things were like in my old team'. However, Alice's narrative was interwoven with the importance of relationships and support and a sense that her current team 'feels quite lonely now, you've got to stand on your own feet, there isn't anyone backing you up any more'.

Alice presented a view that teams should be 'close' but recognised 'you just can't create those kinds of working relationships overnight'. Alice told stories of other teams where colleagues had offered support on a personal level and this left her with the belief that work should not just be somewhere you come and do what you have to, 'I guess for me that sense of the importance of work being somewhere where you feel like you belong'.

Alice spoke of a dominant medical model and times where 'personally I get quite frustrated with the rest of the team for their lack of psychological thinking'. However, Alice valued team working and its contribution to her development, 'I think I would have been the poorer practitioner had I just worked in a psychology department'. She presented many joys and benefits of working in MDTs and although recognising some challenges felt these were all surmountable if the environment and structure were in place to support team working. 'I think it's more about the way the organisations are structured and it's very much about the physical um you know buildings and whether they are set up in ways that teams can work'.

Alice explained that she would not know how to do anything other than adult CMHT psychology and this was 'kind of what I envisioned being a psychologist would be'. She saw her role as being a resource for people that could help them to think more psychologically, 'you can help to provide the rest of the team with a little bit of understanding'. However, she highlighted that this did not feel as possible in this new team, particularly because everyone is so busy and she felt resigned to not knowing how to change this, 'nobody has the time or the inclination to take on any other kind of project given that everyone's you know, everyone's going flat out'. She appeared resigned in many ways and was not able to think what the future might look like in a team with 'no thread' joining anyone and expressed that it was 'a bit sad I think to think that you know is that chapter over and this is what the rest of my career's going to be like'.

### **3.3.2 Bethan**

Bethan is a CP working across two adult CMHTs who had just been appointed to an 8C band. She is white European and in her mid-thirties and has been qualified for six years. We met for the interview in a private dining room after she had finished work.

Bethan had worked previously in a non-health sector role and had been involved in research prior to her training. She spoke of a previous CMHT and her work on an inpatient ward but her narrative was focused mostly on her current experiences.

### Global Narrative Impression

Bethan's narrative was pre-occupied by the transformation process within her trust and the upcoming changes this would bring, including her having to leave her role and the team she had built good relationships with which were highly valued. She appeared to identify much more strongly with her 'teams' than she did with the Clinical Psychology directorate. Bethan storied this acceptance as something that her teams had allowed and she valued this in comparison to remaining as an 'outsider' and not wanting to be sat in the 'psychology silo'.

Bethan's stories frequently came back to her fears for the future and people with limited training and experiences working with very vulnerable and complex people and this feeling unethical. She appeared to feel her voice was not being heard and described it as 'a little bit like standing on a hill and shouting into the wilderness'. There was a sense that 'no one is captaining the ship' and feeling that there is no way to stop it from hitting the iceberg. Bethan spoke about the impact on colleague and client relationships and of this feeling 'very dangerous' and that 'people are going to die'. She used humour throughout but often in a dark way, perhaps to cope with this overwhelming narrative of impending, unstoppable danger. Sentences were often left unfinished which may have pointed to the areas that it felt too hard to stay with, 'but part of me is hankering after the days back when I was a lass as a newly qualified psychologist, we could ...'.

However Bethan's narrative also featured hope and a feeling that 'these things go in cycles' and 'it's a question of making the best of it'. She described having 'always managed to find a way of getting on with getting on'. Bethan spoke to and of her audience with her concerns about the prospect of how entering the profession might be saddening, intimidating and stressful.

Bethan's stories were predominantly about individuals rather than professional groups and the need for mutual appreciation of what everyone 'brings to the table'. Bethan spoke of feeling like an 'imposter' and that owning this had become a



strength but her fears were present around how she could maintain being genuine in her new role but also be containing 'for people who need me to be their safe haven'. The navigation of her sense of her personal and professional identity was evident with there appearing to be some discomfort with her new 8C role. The use of humour and swearing at times when she spoke of this appeared to allow her to step back from the professional position. There was a theme of 'survivor's guilt' with much of the focus on the losses everyone else, clients and colleagues, were experiencing, rather than on her own successes. She talked about how she has been leading from behind and taking positions of uncertainty but now not knowing what the very near shipwrecked future will look like.

### 3.3.3 Charlotte

Charlotte is a CP working in an adult CMHT at a band 7. She is white British and in her late twenties and has been qualified for five years. We met in a private interview room at a time she had arranged between two other meetings. She had been with her team for four years but this had included twelve months maternity leave. She had spent a year in a psychotherapy team after qualifying before joining her current CMHT.

#### Global Narrative Impression

Charlotte's narrative was very focused and responsive to the questions asked, with apologies anytime she felt she was going off track. Her story was slightly different as she only had one CMHT experience so her narrative focused on this.

Charlotte spoke about how she had seen her role change over time and linked this with increased self-confidence and recognition of the impact that she could have. She talked about as a newly qualified needing to prove something by seeing four people a day but this having shifted to seeing her team presence as more important. Charlotte felt this could be more useful 'as I suppose my thoughts and my questions could subtly change a nurse's or social worker's perspective working with you know ten clients'. However, Charlotte expressed her fears that it's hard to prove your worth in this way and there's a push in the system to take on more clients and this did not 'feel safe'.

Charlotte saw her role as giving the rest of the team space to think and reflect and 'perhaps give some care to our team too'. Charlotte spoke about her confusion over her identity as a CP feeling that she wasn't 'professional' enough and was too friendly with her colleagues.

Charlotte reflected on the differences between professional groups and the feeling that power and privilege do play out but that she feels very uncomfortable with this, 'I think there was one nurse said oh you have a nice car and I felt an enormous amount of shame because she's a band six nurse who has been doing the job for I think it's now thirty-five years and I was a band seven new psychologist, ugh, yucky'. She recognised the dividers within the system but felt different to the 'pretentious', 'aloof', 'expert' position that she felt typified a lot of psychology which she placed alongside psychiatry. Charlotte had been drawn to CMHT working because of a desire to 'get my hands dirty' and be 'on the front line'. She told of her attempts to level these differences through 'being human' and her efforts to create equality, like upsetting the seating structures in team meetings.

She was uncertain about the future as she feared it would remove her from the 'dirty' mixing bowl that typified the joy of team working for her.

### 3.3.4 Danielle

Danielle is a CP working in an adult CMHT at an 8a band. She is white British and in her early-thirties and has been qualified for four years. We met for the interview in a private therapy room. At the time of the interview Danielle was a few days away from going on maternity leave for the second time since qualifying. She had worked across three different CMHTS.

#### Global Narrative Impression

Danielle's narrative was very reflective with pauses and personal responses suggesting consideration of the meaning of the questions to her personally. She reflected that 'some of the stuff is really hard to put into words' and the process of being recorded had affected her fluency. She was able to think about her early experiences and story how these had impacted on her experiences in teams now, 'God, when you put that question around it, it absolutely um all stems from my experience of being in groups in my family or in my peer group'.

Danielle spoke of her career thus far having taken unexpected twists in terms of the teams she has ended up in and the times of her transition from these including leaving her first team, 'really I felt horrendous terribly abandoning and um unfinished and not how I would have chosen it in the event'. She told of having ended up in adult CMHTs without intending to go down this path and feeling she may have 'missed the boat' now to do anything different, '*if* I had a choice, I'd possibly transition to CAMHS'.

Danielle's story was full of reflections on the position of psychology and she spoke of trying to 'dispel myths', the use of humour to challenge and a 'humble stepping in to authority'. She reflected on the complexity of relationships across the teams, pay bands and professional divides but her determination to bring change. There was a sense within Danielle's story of the growth that she had undergone within teams in feeling able to be less apologetic, more assertive and able to hold her belief without needing others to agree, 'it frees me up to just um go in to teams differently anyway, I don't have to bend as much as I did'.

Danielle spoke of having 'stepped in to the shoes' of a band 8 in her first post-qualifying job and entering a medically dominated team and being very aware of feeling 'very young and very female'. Her current team experience was presented as 'freeing' as she described more psychological mindedness and being more personally disconnected allowing her to worry less and not be as 'apologetic'. Danielle's narrative felt very balanced with a fondness for the family-like nature of her previous team but recognising there was 'less room to breathe or be different or break out'.

Danielle's thoughts of her future story were uncertain and she expressed her concerns about the blurring of professional roles, 'all of a sudden, I'm not doing the work that I trained to do and somebody else who has had absolutely no training in it whatsoever is going to be doing it'. She wondered if they would continue to exist as separate 'plants' drawing on the same resources but always apart and not connected.

### 3.3.5 Ellie

Ellie is a CP working in an adult CMHT currently at an 8B band but she had just been promoted to an 8C role. She is white British and in her mid-forties and has been qualified for fifteen years. She works part-time and we met for the interview in her home on one of her non-working days.

After qualifying she had worked within an urban setting CMHT for eight years and had then moved to her current team in a rural setting where she had been for seven years.

#### Global Narrative Impression

Ellie gave richly detailed answers that told stories of 'then' and 'now'. Ellie recognised the influence of multiple factors within the systems and teams but also highlighted the role that she played, 'that's my personal style as well...somebody else would have been different'. She spoke of her preferences for skilling up others to provide psychosocial interventions and being able to offer work with families, consultation and training, 'there is a lot that a psychologist can do in a team but what gets privileged is individual therapy work'.

Ellie's narrative was also characterised by comparisons but again these were something she acknowledged and recognised, 'it can make the story telling a bit more [sigh] what am I trying to say, that you know I could paint the nicer team in a much better light because it's in contrast to the other team and that misses out some of what was good about the other team'. Ellie's story differed in that she was now in a team that she much preferred to her previous team so there was not the same sense of loss in her narrative. She highlighted the importance of the social aspect in both teams but felt she now had much better relationships so would engage in joint working more readily and reflected that the client care was directly affected by the dynamics amongst staff, 'within my current team, there's much more kind of team ethos about the patients, we work with this patient rather than you do'.

Ellie highlighted leadership within the team having a big influence and the impact of the wider system to challenge or accept difficulties, 'I think it's partly that um at a kind of higher level it is accepted that it is a difficult team rather than it is a difficult team that we need to do something about'. In her previous team she told a story of

personal and professional divisions and conflicts but felt much of these were caused and maintained by the systems, 'I just felt it was evidence of how much stress the team was under and how poorly managed it was and that there wasn't anybody taking a good oversight'.

Ellie described there always being a lot of change but having always felt there was a place for and a respect for psychology in the teams she had been in and she recognised this as a privileged position, 'there wasn't ever a point where I felt like this psychology voice wasn't welcome in the team'. She highlighted that she felt more integrated in her current team because she was based with them and preferred this set up, 'the more integrated you are to a team the less purist you are about being psychologist...that's never really suited me anyway'. She reflected on how she had changed over time, 'I kind of feel like um the experience gives me a bit more credibility, bit more able to take risks, bit more able to challenge'.

Ellie recognised that the constant change made it difficult to be able to see where things would go in the future. She positioned herself as having become less work focussed over time and having 'been very happy to just turn up at the team, do my bit and come home'. She expressed a feeling of lightness, laughter and freshness about her current team compared to the oppressive darkness of her previous team and there was an optimism that despite changes this 'sunniness' could continue.

### 3.3.6 Freddie

Freddie is a CP working in an adult CMHT in a band 7 post. He is white British and in his early-thirties and has been qualified for three years. We met for the interview in a temporary office where he had finished working for the day.

He had recently moved location and started at a new team which was his second post since qualifying. Although he had just be in one post prior to his current one the previous team had changed when a merge had taken place between two separate teams.

#### Global Narrative Impression

Freddie's narrative was quite disjointed at times and contained many hesitations. This seemed to be reflected in his story of his new team which had been separated

in to different bases and was undergoing a lot of changes in staffing so it felt as though nothing could get started, 'if you can imagine there's a sense of people not wanting to invest a great deal into things knowing that they could be off soon or someone new could be joining'. Some of his narrative lacked richness but it may be that this related to him having been qualified for the shortest time of the participants. His narrative focused on many of the practical elements of being in a team and he did not offer many personal reflections. He was the only male participant and was also the only participant to mention gender, 'and the guy who started...was gay and...his personality was to some extent quite different...I think he possibly like clashed with this sort of kind of macho sort of culture'.

Freddie told a story from his first team of having to reassure people and get to know them on a personal level because of a professional distrust, 'I think their fear was that a psychologist joining their team that I was in some way going to I don't know, going to expose them or to criticise them in some way for what they were doing'. He felt this had been a result of psychology being very separate in its 'ivory tower' prior to his arrival. He talked of things being 'a little bit cold at the beginning' but that they had become easier as people started to 'warm to the idea'.

Freddie explained that after the teams merged the team leader had purposefully placed the CPs each in different offices, 'so in terms of kind of like our influence in the way that people worked would be hopefully for lots of different people um so really go the opposite way of psychology being separate'. Freddie saw the challenges of psychology being separate and not having an input into the team but his more recent experiences had also helped him to recognise the benefits of having some space away from the team to be able to 'reflect'.

Freddie's story of his current team was of separateness, 'it feels like a group of nice individuals but for me it doesn't feel like a team, not at all'. He spoke of his role feeling like a fine balance, 'it's kind of helping people adapt to change in a positive way instead of just banging on about how bad things are or how wrong things might be but equally not wanting to say everything is great and everything will be fine'.

Freddie felt the future of his role would be focused on 'payment by results' and CPs as therapists and 'the idea of how many people you can see'. He thought this would exclude the wider remit CP can offer and would lead to less team work and more

separation, 'that doesn't kind of encourage team work, that's going to encourage people again that people saying this is my patch and this is my territory, we do this sort of thing don't you take that'. He spoke of a factory and 'everyone working very hard on their part of the production line but not really talking to the person next to them'.

### 3.3.7 Grace

Grace is a CP working in an adult CMHT in a band 7 post. She is white British and in her early-thirties and has been qualified for four years. We met for the interview in a private office.

The team that she was in was her one and only post qualification post and she had always worked part-time within that team although she highlighted there had been changes within that time. Her trust had recently gone through a restructuring process.

#### Global Narrative Impression

Grace's narrative was very honest and reflective with her both examining herself and the profession of psychology alongside the wider team. She described psychology as 'a service within a service', identifying firmly as a CP but seeing and valuing their place in teams. She used a lot of sarcasm and humour which appeared to reflect both a muted anger and a relative acceptance of the current challenges of the system. She spoke of psychology having always seemed separate to the teams and a feeling this gets encouraged in the training in thinking about unique skills but also in the tendency to self-reflect and take a meta view, 'and it gets absorbed and thus does become something where a bit of you is churning away having a bit of a formulation or a bit of an overview of things and I think that that's slightly, just that cognitive experience very slightly distances you from events'. She felt CPs can feel they are doing something more 'deep, meaningful and profound' but recognised this sometimes was a defence against the distressing feeling of 'how little we can offer people', 'I think if what gets you through this feeling that what you're doing is in some way um quite special then maybe that's just a coping mechanism really'.

Grace told stories of not actively engaging with the team, avoiding becoming too embroiled in things which she felt her part-time hours and being at a different site to

much of the team aided her with, she described this as 'only trouble trouble when trouble troubles you'. She had reflected on having learnt not to make promises or feel she needed to be as 'obliging' in her time since qualification.

Grace reflected on psychology being valued within the team but that sometimes this added pressure because it was seen as the 'last chance saloon'. She spoke of the differences between how she viewed psychology and how others perceived it. She described a lack of realism at times with people wanting to explore their childhood and address these issues in twenty sessions which 'can't be done', 'it's very unsatisfying really um for clients and for um therapists often'.

She told a story of the increasing pressures on the service leading to psychology having to say no, 'so mainly at the moment we're just churning through assessments and therapy and ceaselessly having to close down what we can offer'. She felt these problems continued to exist for the whole team feeling they were all competent professionals and 'any short-fallings are due to the fact that they don't get the support that they need; they don't have the time; they're under too much pressure'.

Although Grace spoke a lot about the position of psychology as a whole she also reflected on the aspects of her own personality that she brought to her role, 'that you know absolutely gets into how I work in a team which is I love having these people around, it's really great, I really value them, I don't actually want them in my face the whole time and I don't want to be in their face all the time...yeah your personality just comes in with you doesn't it'. She storied both the positive and negative aspects of working alongside colleagues, 'it was you know really good to be being there and they would, they would speak to me casually all the time about clients and I would speak to them casually about clients' but 'just endlessly struggle to finish reports or have thinking time um anything like that because you know even if you're in the mood for working quietly, someone else is in the mood for a coffee break'.

Grace saw herself remaining within teams although she thought she might specialise at some point in to one aspect of adult mental health. She thought if the Conservatives were elected this may lead to psychology services being tendered which she felt was a 'terrible' idea, 'psychology is much better embedded in the NHS I think it would be a bit tragic really'. She continued to feel that 'CMHTs just endlessly appear to be undergoing some kind of restructuring that the team itself does not



want' and this was experienced like a family going through a painful divorce, 'it does leave some sort of scarring, it's not like you're off in to a brave new world...people live in fear of more changes'.

### 3.3.8 Hazel

Hazel is a CP working across two adult CMHTs in an 8C band. She is white British and in her early-forties and has been qualified for sixteen years. We met for the interview in a private meeting room. Hazel was late due to having been held up at another meeting.

Hazel described initially having an interest in systemic working and the only jobs at that time being in adult mental health though she would have preferred to go in to older adults or physical health. She had been part of a number of teams since qualification and had held leadership positions within the trust.

#### Global Narrative Impression

Hazel's narrative was disjointed at times with changes of subject midway through sentences. Hazel spoke of her multiple roles within the trust and her many varied experiences. There was a sense of having a great deal to say and think about and being very busy which may have affected the pace and structure of her speech.

Hazel told a story of a childhood growing up in residential schools, 'where the team is everything so in fact the team and the school is part of your family'. Hazel identified very much as part of the MDT and saw her place as a therapist more than a CP which was something she had become more comfortable with, 'I remember being more worried out of training than I am now um where I've got a much stronger sense of my identity, probably less of an identity of a therapist it's probably more uh, there's probably more of the multi-disciplinary team in me now than there was then but it worries me a lot less than it did then because that was a new set of clothing I was trying on at the time'. She spoke of her training and interest in systemic ways of working and this had been a continual part of her professional self. She believed this model encouraged her to take a different position within teams, 'you're more likely to see your ability to influence something from a marginal position because that's the whole systemic model'.

Hazel identified the importance of needing to be within a team to influence it and change the culture and keep a narrative of multiple perspectives. She spoke of really valuing being in MDTs and not wanting to work in any other type of service, 'I think there's a lot of goodness that comes out of those different perspectives where you really work through things, you might not always get your own way but you really work through those decisions and you have a sense of people really thinking so it's a joy to me'.

Hazel felt the challenges in the newly restructured teams because of their size and being spread across offices and a wide geographic area and everyone being 'too busy to think about things as a team'. However Hazel spoke of holding a position of power that made her more known and gave her different allowances, 'because I'm quite prepared to pick up a phone to a consultant psychiatrist where I'm a consultant psychologist but I can imagine if I was lower in the hierarchies we're in it might not be quite so easy'. She also spoke of an 'ironic' effect of the changes having been to create a stronger identity for therapy services with psychiatrists and the medical model having less dominance, 'I think our psychiatry colleagues have probably stepped out of these teams a little bit more, I have less sense of them in the service than I would of then, which is a big sadness actually'.

Hazel feared the cost of CPs threatened their survival but highlighted her hope that therapists could be more involved in consultation and indirect working if systemic changes occurred, 'people tend to produce what you measure, so if you measure therapy sessions, that's what they produce, but if you want more working together collaboratively around a client then you need to measure that in some way'. Hazel felt they were at a 'crossover time' so felt uncertain what the future would look like but felt the big teams were like a 'whale, because it's so large, and you know, whether a whale knows what goes on at the tip of its tail at the front I'm not quite sure and yet it is all connected, what the front does, does influence the back'.

### **3.4 Emerging Storylines**

The following section presents the dominant co-constructed collective narratives that emerged from the analysis. These narratives will be presented alongside consideration of how these stories are told and how this relates to the broader context in which they are co-constructed. Throughout this chapter references will be

made to the available literature to situate this research within the research and knowledge base relating to teams. Each section includes quotations taken from the interviews. The quotations are referenced using the name of the participant followed by the page number on the typed transcriptions.

Table 1 below outlines the shared narratives that emerged from the analysis. The framework was achieved by noticing the aspects of relatedness that participants spoke about and considering similarities and difference. The stories of connection and disconnection were at different levels which mapped on to the Pew-Fetzer Task Force (Tresolini, 1994) findings that identified four important levels of relationship in healthcare: the practitioner's relationship with him or herself, the client-clinician relationship, the relationships between members of the healthcare team and relationships with the healthcare system. For the purposes of presenting these emerging narratives they are separated into these four levels, however, it is acknowledged this is an artificial separation as these levels do not exist in isolation and continuously interact.

Table 1. Outline of Shared Narratives

Overarching themes	Sub themes
Self	'Just being human'
	'You have to be in it to change it'
Clients	'It's not safe'
	'The clients then can feel contained'
	'We all bring different things to the table'
Colleagues	'Corridor conferencing and kettle conversations'
	'It came down so much to individual personalities'
	'It doesn't happen overnight'
	'A very welcome space'
System	'A lot of pressure to get things done'
	'There isn't any time for thinking'
	'The teams are all changing'
	'An element of hierarchy'
	'Maybe it's more to do with the structure'
	'There needs to be permission'

The first level looking at relatedness and connection with the *self* includes stories of 'just being human' and 'you have to be in it to change it'. These stories relate to a

desire of participants to be themselves within their professional roles and to promote change within a system by advocating their own values.

The second level identifies relatedness to *clients* which includes 'clients then feel contained', 'we all bring different things to the table' and 'it's not safe'. These stories highlight the participant's concerns for the individuals seeking support and the importance of relationships for improving client experiences and promoting safety and providing holistic care.

The third level includes stories of connection with colleagues and covers shared stories of 'corridor conferencing and kettle conversations', 'a very welcome space, 'it came down so much to individual personalities' and 'it doesn't happen overnight'. These stories focus on the importance of time and being in an environment where informal conversations can occur as well as the role of different personalities and how open or welcoming individuals are to difference.

The final level explores the relationship with the context of the wider system and includes 'there isn't time for thinking anymore', 'the teams are all changing', 'an element of hierarchy', 'maybe it's more to do with the structure', 'a lot of pressure to get things done' and 'there needs to be permission'. These narratives relate to the impact of systemic changes leading to more pressure and less time to make connections alongside the impact of the types of relationships and the balance of power within teams.

A diagrammatic representation of the findings can be seen in *Figure 2* overleaf. These narratives emerged in the process of analysis alongside a consideration of the literature that highlights the multiple levels of relationships that need to be considered within healthcare. During supervision of this research time was spent thinking about how to capture the complex and circular levels of these intra and inter relationships. The supervisor of this project spoke of ideas about relationships occurring within, between and around individuals. Alongside this the systemic idea of coordinated management of meaning (Pearce & Pearce, 2000) was thought about, this recognises the inter-relationship between varying levels of contexts but presents these within a hierarchical rather than a circular model. It was from these discussions and consideration of these varying ideas that the following visual image emerged

which represents the inability to separate these interactions out as they all occur within the context of each other.



*Figure 2. Emerging Narratives*

The four levels of relatedness will now be explored in further detail. The following themes emerged from considering all the participants' narratives but they will be demonstrated by a selection of quotes. A table of further quotes supporting these narratives can be found in appendix 11.

### 3.4.1 Self

The following section will consider the first level of relational connection that is narrated by participants, that of self-to-self relating and connection.

#### 3.4.1.1 'Just being Human'

*'I think it made me realise how much I need a secure base, how much I need a space in which I can be myself like I am with my warts and my strengths and my weaknesses'*

*Bethan, p12*

In this extract Bethan refers to a 'secure base' which is the same expression she uses to describe the room and team members where she is currently based; due to a process of reorganisation she was moving base in a number of weeks. Bethan does not explicitly state her fears around the loss of her secure base yet it is implied in the repeated use of the expression 'how much I need' when she already states the impending loss of this and her concern about how she will continue to be 'genuine' in her new role. In one study of student nurses the expression 'safe place' is used to describe experiences where they feel they have a legitimate role and feel included, connected and secure (Levett-Jones et al., 2009). Moss (1994) highlights that teams provide a safer context when individuals are able to express the stress and anxiety they are likely to experience, and where creativity is more likely when team members feel safe and can express themselves. Individuals may feel more ready to challenge, critically appraise each other's work and take risks in collaborative work when they feel safe (Boakes, 1998). Grace speaks of the importance of being able to be yourself within your professional role:

*'it is possible I think for different personalities to kind of make it work for them so you know you can be much more involved and present and on the floor so to speak, wandering around chatting to people or you can be much more head down getting on with things...But you know within reasonable boundaries I think it's wise for a team to kind of let people kind of do it the way that feels best to them really'*

*Grace, p21*

Grace describes her personal identity as not being an 'extrovert' and despite identifying as a CP does not feel this has to determine who she is as an individual. In the extract above Grace highlights the value of diversity, not only between professional groups but within them, suggesting that being genuine leads to greater job satisfaction. Participants of one study exploring support within CMHTs describe the importance of being a 'human being' not just a CP, recognising friendship and compassion as being facilitative (Lucas, 2004). The participants narrate the extent to which they identify both their connection to their profession and their teams. This varies amongst the participants with some describing a closer alliance to one rather than the other but all appearing to be able to negotiate this. Lucas (2004) suggests it may be important to maintain both same discipline and multi-disciplinary identities and the context one sits within may be important. All participants except Freddie (who describes *'no sense of team whatsoever'*) are based with their multi-disciplinary colleagues rather than within a same discipline office or service. One study identifies team identification as more important for job satisfaction than professional identification which may reflect that, post training, CPs spend more time with the team than other CPs (Boakes, 1998). It may also be that 'being human' and considering the centrality of their personal 'self' allows them to manage some of the conflicts within their professional roles. As identified within section 1.5 the Social Identity Approach considers the experience of belonging to multiple groups and the tension this creates. Kahn (1992) states how organisational members can be authentic and fully present at work, expressing their full humanity and bringing their personal selves into their role performance. Considering this further Alice states:

*'we're quite a sort of support for each other on a personal level as much as anything else, so I guess for me that sense of the importance of work being somewhere where you feel like you belong... it wasn't somewhere where you just kind of went in, did what you had to do, and go home, which I imagine a lot of people's jobs are, you know, we were close, we knew about each other's lives'*

*Alice, p11*

In this quote Alice appears to be highlighting the different aspects of relatedness that are introduced when defining relatedness (section 1.4.2). Wynne (1984) speaks of

instrumental relatedness, which focuses on tasks, and expressive relatedness, which focuses on affective relationships. It appears here that although Alice continues to be able to achieve tasks it has become a more mechanical process. Bernthal and Insko (1993) discuss the multidimensional nature of group cohesion and operationalise two constructs: task cohesion and socio-emotional cohesion. Socio-emotional cohesion is thought to provide interpersonal attraction and pride in group membership. The importance of relatedness for staff wellbeing is not a new idea. One study of a multi-disciplinary mental health team identifies that individuals who communicate extensively about work yet maintain few informal supportive relationships have higher burnout (Leiter, 1988). Lack of social support at work is identified as a predictor of burnout amongst mental health nurses (Cronin-Stubbs & Brophy, 1984) and Thomson (1987) believes relationships with colleagues are of central importance in either exacerbating or mitigating work stress. One can see this unfolding in the following quote:

*'I've lost a lot of just sort of personal support really and feeling like umm you know there are people in my corner if things are difficult, there isn't that sense here and when there's a bit of a crisis or an emergency you can't find anybody here. It does feel very, it feels a very, it feels quite lonely now. You've got to stand on your own feet. There isn't anyone backing you up any more'*

*Alice, p9*

The next theme considers how participants narrate their attempts to stay connected to their values by finding ways to promote these within an MDT environment.

#### **3.4.1.2 'You have to be in it to change it'**

*'the staff members have said 'I don't want to go to that team meeting because the discussions are so awful and you know I can't listen to that way of talking about um the work that we're doing the people, it doesn't feel very healthy or happy' well my conversation is 'well how is not being there going to help to improve that in any manner''*

*Hazel, p8*



Hazel's use of direct speech in this extract pulls the listener in to the narrated moment and builds credibility. Her response to the distress experienced within a very medically dominated team meeting is quite blunt reflecting Hazel's strong views. There are arguments about whether you need to be within a system in order to change it or whether you are better able to be effective and take a critical stance from outside (Holmes, 2002). In exploring experiences of CPs on inpatient wards this conflict is identified between being part of a team and remaining outside it to avoid becoming submerged and losing their own perspective (Bentley, 2014). Hazel is quite clear on the need to be present and affect change from within. Likewise Danielle highlights the effectiveness of this strategy:

*'it wasn't a direct acknowledgement that you could see the ideas that you've brought. When other members of the team then start to use those or talk about them, or you see, you hear, when they're sitting next to you, talking to their service users, some of that language and some of that thinking creeping in to their conversation, you sort of, I end up thinking job done. That makes me happy'*

*Danielle, p9*

Many of the participants spoke about their desire and belief in their ability to facilitate change although recognising this could be a challenge. Whilst these appear quite subtle 'quest' narratives (Frank, 2012) there is a real sense of achievement and importance depicted in Danielle's expression of 'job done'. Danielle highlights being in the team in order to influence and notice that influence. Alice narrates her experiences of influence in the following way:

*'it's only by sort of trying to interject your point of view and say what you think is happening and based on what you know of the patient's history, that you can help to provide the rest of the team with a little bit of understanding and make a suggestion of what we ought to do to try and manage this situation'*

*Alice, p13*

Although Alice is again quite tentative and subtle with the use of expressions like 'trying to interject' and 'a little bit' there remains a sense that something, however slowly, is happening through their presence within the teams. This is in contrast to

the staff reflections in a narrative study exploring the experience of CPs on an inpatient unit who express feeling the system cannot change (Bentley, 2014). This study is also based on eight participants and it is not possible to say if this reflects differences between the impact a CP might have in a community as opposed to an inpatient setting. Sometimes this relational sense from others, that a CP can be a catalyst for change, seems unachievable:

*'yeah I think you get it reflected back to you and you you kind of automatically do a bit of a comparison in your mind with how you view yourself and occasionally it's the same but quite often it chimes rather differently and you think oh look they think I can do this and I absolutely cannot'*

*Grace, p16*

Grace highlights a challenge of being within a MDT enhancing her self-awareness in relation to others, she notices how others perceive her as a professional. The use of the word 'chimes' suggests it is quite a revelation, perhaps an uncomfortable one. Danielle speaks of being seen '*as a bit of a breed...all part of a very similar mould*' and it taking time to be seen as an individual (p2). Considering this further Goffman (1959) highlights that strain can occur in interactions when an individual's identity is not congruent with the feedback they receive from others.

This completes the section relating to self, the following section focuses on the next layer of relatedness in MDT settings, how these interactions impact on the clients.

### **3.4.2 Clients**

#### **3.4.2.1 'Clients can then feel contained'**

*'Yeah and I also think the clients then can feel contained, think there's an understanding, seeing us manage disagreements at having different viewpoints and being able to work it through they can feel really thought about and cared about whereas they have a sense of no one dares say something if something's not quite right it's very negative for clients if you don't do that'*

*Hazel, p11*

Hazel highlights here the recognition that clients are often aware of the relational aspects between staff and can be impacted by how this is managed. Evidence shows clients and carers prefer the service provided by a MDT in the community rather than standard service provision (Onyett & Ford, 1996). Hazel suggests that there is something therapeutic in being thought about by multiple people who care enough to stand up if they disagree about how something is being managed. Gilbert (2010) highlights that knowing you exist in the mind of another can stimulate the soothing system and make things feel more secure. Alice highlights the impact when the actual staff do not feel secure:

*'I mean only to emphasise I suppose that I think that whatever's going on among the staff does ultimately have an impact on the patients and that if we don't feel supported or contained or you know that there is kind of constant turnover of staff, that it really does affect them, and I think uh that's not a message that's got through...so I think doing something about the state of teams is really pretty critical so I hope that somebody with some influence will read what you've written up'*

*Alice, p13*

Alice is quite emphatic in her concerns about the impact of relational issues amongst colleagues and the wider system having a significant impact on relationships and the experience with clients. She uses the word 'critical' and shows an awareness of a desired audience in her comment about 'somebody with some influence'. Perception of audience can impact on the stories that are told but it is also clear that Alice feels that this is a story that *needs* to be told. Alice's sentiment echoes that of Alison Beck, Head of Psychology for a London trust who identifies that the Francis Inquiry makes it possible to say that staff experience matters as well as client experience and that you cannot have one without the other (DoH, 2015a). A study of culture and behaviour in the NHS also identifies the close relationship between the wellbeing of staff and outcomes for patients (Dixon-Woods et al., 2013). This wellbeing can be achieved within a relational context both with peers and the wider organisation. Suchman and Williamson (2011, p1) states that clinicians are more likely to treat clients and carers as partners if they are experiencing the same kind of 'respectful,

collaborative and participatory treatment backstage'. Diversity within the team, also impacts on the perceived care of clients and will be discussed next.

### 3.4.2.2 'We all bring different things to the table'

*'So I had a few cases where there are practical things that need sorting out, financial things that need sorting out, relationship things that need sorting out, medication things that need sorting out. Sometimes things like respite stuff and no one person can do all of that. And so if there is just one person working with that patient, they're just going to get a bit of what they need'*

*Ellie, p17*

Ellie lists issues that may need considering with each client highlighting the benefits of a biopsychosocial approach that MDT working offers. She highlights the risks of not working together for the client resulting in them only getting a bit of what they may need. In the introduction (section 1.6.1) it is highlighted that a major reason for establishing MDTs is to address as many of an individual's needs in order to obtain optimum functioning and improved health outcomes (Mitchell, Tieman & Shelby-James, 2008) or 'sorting out' as Ellie repeatedly states. The participants predominantly speak of valuing MDTs and their roles within them yet highlight the need to respect each other's differences and value what everyone brings. A counter narrative that is present is 'not understanding each other's roles' highlighting that although value is gained through the different training and skills that each profession brings this very difference is also a source of misunderstanding and conflict. Nolte (2005) highlights that attitudinal differences can create challenge within teams. Freddie considers this further:

*'I think one of the main challenges is people working in different ways, I think, um, and sometimes I think to remain kind of reflective about that I think so not trying to be too um judgemental over it'*

*Freddie, p11*

Øvretveit (1993) advises that the only way to resolve conflict is for practitioners to devote themselves to really understanding the other person's feelings or view by asking questions and hearing what they say believing that this, in itself, changes the

relationship. This open listening, respect and attempts at understanding are the same values espoused in the client-practitioner relationship and it may be that if practitioners experience this relatedness with their colleagues it will impact their openness to their clients. Bentley (2014) highlights that when staff members feel invalidated it becomes impossible to extend compassion to others. Teams need to understand the competencies of other team members and respect the diverse views on mental health, treatment and care (Mental Health Commission, 2006). Clark (1994) argues for explicit training to enable professionals to understand what he calls the *cognitive maps* and *value maps* of others. Bethan highlights this importance of allowing multiple views:

*'My way isn't the only right way, there are lots of ways of crossing the river and whenever I find myself getting annoyed at somebody's need for certainty and hierarchy I try to remind myself of that'*

*Bethan, p13*

Thus, Bethan acknowledges here an understanding and respect for the multiple ways that a client may be helped. Pullon (2008) highlights one solution to managing conflict is this understanding of the common goal of working for the client. Grace (p11) is able to voice a narrative that remains unspoken by other participants and speaks of a 'societal influence' that can create a '*everybody I think you know can engage in a bit of wand waving thinking that there's something you do that's special*'. Grace highlights that despite extolling the virtues of respecting everyone's approach sometimes CPs still perceive they are offering something special:

*there is something where psychology absorbs somewhere along the way that what they're doing is more deep and meaningful or more profound or more something um than what other people are doing...Psychologists are holding the whole of the person and the you know this that and the other. So I think there's a bit of that thinking maybe that what we're doing is more interesting or uh more complex um than what everyone else is doing, a bit, I think really, [whispers] secretly [laughter]*

*Grace, p11*

Grace struggles to identify exactly what it is that 'psychology absorbs' but offers some explanations. She starts off distancing herself from this by the use of 'they're' yet later shifts to saying 'we're' suggesting a possible uneasiness which is highlighted again when she whispers 'secretly'. This is followed by laughter and the use of humour again may highlight discomfort with this alternative untold story that does not necessarily sit easily with the portrayal of CPs as non-hierarchical. Danielle seems to be able to hold onto these positions:

*'I really don't agree with this changing teams in to amorphous blobs where there's no delineation between peoples' professions...doesn't make any sense to me that people can't hold on to and value what they trained in and be proud of it and just pretend like we're all the same. Clearly we don't have the same skills. Off on a rant! It's madness. I feel like the system is more mad than the people that we see'*

*Danielle, p12*

In this extract Danielle suggests that she values what other professions bring but also feels pride in what she as a CP can offer in trying to find a balance between these tensions. She compares the system and the clients suggesting there are more problems in the system than those that they are trying to support people with. Danielle expresses her frustration at the impact wider systemic and collegiate relations are having on the quality of what is being offered to clients with a blurring of roles. The need for individuals to have well-defined roles is identified as being important for team functioning. It is also proposed that confusion over individual roles impacts on how well individuals perform and function as team members (Antai-Otong, 1997).

The following section considers the relational impact for clients in relation to safety.

#### **3.4.2.3 'It's not safe'**

*'um it feels that in trying to help kind of like certain people you need people from more than one profession you need that there, you need that in terms of managing risk I think so yeah that in terms of a professional sense I think is vital for safe and like effective practice... there being less teamwork I think it's more risky I think if I'm honest because the vast majority of big enquiries in to*

*all sorts of failings of services always repeat the same thing a kind of lack of communication'*

*Freddie, p16*

All participants speak about risk and safety as a shared narrative that seems present within the systems they are working in. Freddie speaks here of 'big enquiries' many of which make their way into the media and public consciousness. Freddie is speaking about communication but also about being able to share the risk with other team members. Jeremy Hunt in his role as Secretary of State for Health (Department of Health, 2015b) highlights one of the biggest causes for poor care is when no one takes responsibility for a vulnerable patient. He states the lack of clarity and accountability is particularly problematic in the community. Grace speaks of this disengagement with distress and fear of risk within the wider team:

*'I think sometimes they end up just being seen by psychology and there is no sense of the rest of the team being interested or involved ... They think 'what can I do for them'...and uh really want to disengage from them. 'Um and have you, you have it now, you have this client'. And that is a challenge, that's just everybody struggles with that stuff. No-one wants to be left holding someone they can't help, who feels risky. It's not a pleasant sensation is it really?'*

*Grace, p15*

In this extract Grace is reflecting on the pressures that the team members experience, particularly in relation to complex clients and risk. Grace highlights the loss of competence people can experience when working on their own with clients with complex needs and the desire to disengage. In the context of increased pressures and reduced time these staff members are looking for ways to have one less client to think about. NHS employers are developing an NHS-specific measure of emotional wellbeing to be used with individuals and teams to consider their own wellbeing and the impact this may have on the delivery of effective, safe and compassionate care (DOH, 2015a).

The following sections explore the next layer, how participants narrate their relatedness with their colleagues.

### 3.4.3 Colleagues

#### 3.4.3.1 'Corridor conferencing and kettle conversations'

*'it wasn't a daily thing but in a, in a light touch corridor conferencing kind of kettle conversation there was always space to have those conversations not for hours but certainly while the kettle boiled and because things didn't build up that was enough'*

*Bethan, p11*

Bethan highlights the impact that informal meetings can have for containing difficulties and saving time in the long-term by avoiding difficulties developing in to something unmanageable. All the participants speak about cups of tea and informal meetings evoked well in Bethan's humorous terms 'corridor conferencing' and 'kettle conversations'. The value of informal moments is repeatedly highlighted. For example, in a study by Milbourne, Macrae and Maguire (2003) they identify that when team members no longer had a shared geographical base it removes any natural context for informal exchange. In a Canadian study of health care team effectiveness participants describe valuing comfort between team members, communication based on respect, members that pull together in times of greater demand and a sense of fun (Delva, Jamieson & Lemieux, 2008). Pullon's (2008) study also identifies the ability to have fun, socialise and laugh as being indicators of functional relationships.

Alice speaks of the impact of friendship:

*'because we knew each other well and were friends, I think we felt comfortable enough sometimes to have really quite blunt conversations, to the point of arguments with each other, and it might be all sniffy for a couple of days, and then we'd fall back in with each other, because that's what you do whereas I don't have that kind of relationship with some of the people here that you can have hum dinging arguments and then expect to be able to get past it and work together, yes, it's not like that'*

*Alice, p6*



Alice suggests here that friendship with previous colleagues enables greater honesty and expression of concerns and disagreements in their MDT working; knowing the relationship could survive facilitates this. In a UK review of MDT effectiveness freedom of cross-disciplinary interaction is associated with reductions in team stress levels (Borrill et al., 2001). Ellie recognises these differences from having been part of a team that were quite disparate and she had sat in a different office to now being in a team that are facing the same pressures but appear much more cohesive:

*'I think the team probably feel very supported by one another. When I sit in team meetings and somebody says 'I'm on the duty rota on Friday but actually I've got a dentist appointment and I'm taking the day off, is there anybody else that can cover', in the old team people would have been looking at the floor, looking out the window, in this team everybody gets their diary out and people look down their diary and somebody says 'look I can shuffle this and that and I'll cover you'. So people are very generous in responding to each other and that I think is very admirable. Um and it's been a big lesson for me because I had got into a very protective mentality in the other team, I was very protective about my time and my caseload and managing that because it felt so pressured. And this team has really taught me to be much more flexible and generous'*

*Ellie, p16*

Ellie's narrative, which is told through a vignette of team meetings, reflects the impact that her relationships with her colleagues and the environment within this new team have on her relationship with her self and what she values highlighting what she has learnt from her new colleagues' generosity, this then enabling her own ability to be 'generous'. Hazel considers when opportunities for relatedness are not available:

*'Oh it's always a different team and always a different profession you don't generally get it for the people that you see and of course one of the problems with the new teams is there are people you just don't see so it's very easy then to you know... it's just somewhere to locate that upset feeling you might have yourself'*

*Hazel, p5*

Hazel speaks of the relational impact of environmental issues offering a way of understanding the conflict between individuals and professions which manifests in resentment or belief that others are 'less busy' (p5). When teams are not based together or there is no time or facility for shared space or interaction it is more likely that conflict will occur as it is difficult to get to know individuals beyond professional symbols, stereotypes and divides (Lindeke & Block, 1998; Borrill et al., 2001). Bell's (1999) review of the literature on interprofessional working identifies that co-operation is most likely where professionals get to know each other well and there is a strong likelihood of frequent contact with spatial proximity providing opportunities for interaction. Another literature review establishes one of the key conditions for collaborative practice is the availability of time to interact and spaces to meet (Martin-Rodríguez et al., 2005). Causes of poor communication, which has an impact on both team relationships and client safety, are often related to people being located at different sites, there being no clear team base or buildings not being designed to make contact easy with formal and informal meeting areas (Øvretveit, 1993). Perhaps it is the relational factors that may be the implicit drivers to greater cohesion and productivity.

The following section explores the relational impact of how other professionals relate to the ideas of psychology.

#### 3.4.3.2 'A very welcome space'

*'I was really lucky from the first six months in when the ward manager changed to somebody who had been one of the senior nurses and who was really quite pro psychology as opposed to slightly baffled by it... that two of the three shift leaders were also quite reflective and thinky and, two different professions and it just made it a very welcome space to try things out'*

*Bethan, p8*

Bethan highlights here the ideas of luck and permission which are present in her narrative; this 'allowed' her to take a certain position in teams. This is suggestive of an external locus of control (Rotter, 1975) that is less dominant in some of the other narratives as seen in section 3.3.3.4 below that highlights earning respect over time. For Bethan having people being pro psychology enables her to feel accepted within

her teams. Maslow (1987) highlights within his hierarchy of needs the importance of belongingness and acceptance and, if not present, the impact this has on our self-esteem and ability to achieve and perform. Martela (2012) highlights the importance of 'caring connections' which they define as mutual validation, being present and opening up towards the other. Ellie discusses her experiences of this happening:

*'So they're very respectful of psychology as a resource, they are very respectful of me, I'm used very well in the team so I've got a much more diverse role than I feel I was allowed to have in the previous team... and I have a regular slot on the team meeting agenda to update about all my cases'*

*Ellie, p13*

In this extract Ellie also highlights the impact of the team's openness to psychology that determines the role that she is able to play which she was not 'allowed' in her previous team. The narratives of Ellie and Alice clearly reflect teams that work on a relational level, and teams that do not – the impact of these are far reaching (see section 1.6.1).

The next section looks at the impact of individuals rather than professional groupings.

#### **3.4.3.3 'It all came down so much individual personalities'**

*'by the time I left I felt kind of fairly connected I think um certainly definitely wasn't any divide in terms of like professionals it's more kind of like individuals if that makes sense um there were certain individuals within the team that I felt connected with and certain ones I didn't, I don't think that was reflected in terms of their professional centres or way of working'*

*Freddie, p5*

Although the participants speak about power which can sometimes lead to conflicts emerging between groups there is no sense of a consistent divide between any professional groups. Freddie expresses here that his relationships are determined by differences within the individual rather than from peoples' professional body or theoretical orientation. The Mental Health Commission (2006) argues that although professional skills are important these can be developed but if an individual at some

core level does not believe in team working then no amount of training will make them an effective MDT member. The relational context is important for team working, indeed, Mickan and Rodger (2005) state mutual respect develops where team members are open to the talents and beliefs of each person in addition to their professional contributions. Sedgwick and Yong (2008) also found that although professional capability is important in gaining acceptance in a team, individual characteristics such as friendliness are equally important. Bethan speaks about the individual characteristics in her relationships:

*'I think that I think every team is different, every team room is different, we sit in four different rooms at the moment and the, the feeling in terms of how it is to sit there, is like a different mini team in each of them. Not with animosity or anything but I think similar people drifted together to kind of have the working relationship with the working environment that they found most comfortable... The relationships I've had with other professionals are, I think, as individual as each of the other professionals'*

*Bethan, p3*

This extract from Bethan's interview illustrates some of the complexity of studying teams that is highlighted within the literature (see section 1.6.2). There is also a sense that team relational cultures develop differently with individuals like Alice and Ellie describing whole teams with good relationships in contrast to other teams with reduced relatedness between members. Indeed, Atwal and Caldwell (2005) describe the variation within teams relating to leadership, culture, participation and service organisation.

The following section now highlights the process that occurs over time and the aspect of consistency needed to develop these relational connections.

#### **3.4.3.4 'It doesn't happen overnight'**

*'I think that you just can't create those kinds of working relationships overnight. They only kind of evolve over a period of a long period of time and going through a lot together you know, you have the happy times together, where you have a laugh, or you might have something really unpleasant, like*

*a suicide, or something that you will have to come together over... yes, takes a long time to get to that level of intimacy with people'*

*Alice, p4*

Alice speaks about the impact agency staff have on the ability to build up relationships with colleagues and clients who had 'three or four care co-ordinators in the last few months' (p5). The importance of shared experience and support, beyond a professional working relationship, is highlighted when working with people in distress and the need for consistency. Tajfel (1981) highlights the importance of being emotionally attached to a group for an individual to feel they belong and their social identity and group membership to become part of their self-concept. Bank (1992) identifies that the time and effort required for individuals to establish positive working relationships, in order to build up trust necessary for collaborative multi-disciplinary working, is often not recognised. One study of multi-agency teams highlights that individuals from different backgrounds with different language and ways of understanding service user issues cannot be expected to work together from day one and need time investing in team building and the creation of a shared language (Robinson & Cottrell, 2005). Johnstone (2011a, p36) recognises the importance of time and has established some principles from her own experiences in adult mental health alongside discussions with trainees. These include taking your time, gaining credibility through taking on challenges, choosing battles, finding allies, challenging ideas not people, remembering the vehicle of change is the personal relationship with the service user and building respectful relationships with teams before attempting to change anything. Grace illustrates her experience of the effects of some of these principles:

*'I think there's still some people around in the team who have known one another for quite a long time and have worked together and have probably worked together in easier times so know that that person is good, know that that person is hard working, know that that person is good with clients and therefore they respect and trust them'*

*Grace, p8*

This was a narrative repeated by a few of the participants of relationships improving over time and this enabling the earning of respect as an individual rather than just expecting it as a CP. This is indicative of a greater internal locus of control (Rotter, 1975), that even when there is initial hostility this can be overcome. Pullon's (2008) study of interprofessional relationships between doctors and nurses also highlights the importance of demonstrating professional competence. Ellie highlights that professional competence is important for her establishing relationships:

*'my relationships always are kind of slow burning ones. So I don't know whether somebody else would have been different but it felt to me like what was important was just slowly building a reputation and trusting that I would, that I do a good job and that that would eventually be recognised. And it was'*

*Ellie, p10*

The next layer will now be considered by exploring participants' narrations of the relational impact of, and their connections to, the wider system which the professionals reside in.

### **3.4.4 System**

#### **3.4.4.1 'The teams are all changing'**

*'There was a lot of change going on but there always is. So at the time it felt like this was an unusual thing because I was newly qualified but actually it's continued to be all change all of the time. So I think I had felt that at some point everything would settle, um but it never and it never does in teams anyway because the staff were always changing, if nothing else...So we had some fairly big organisational changes, we had location changes, we had team manager changes'*

*Ellie, p2*

Ellie speaks of the unsettling nature of being in teams and, over 'time' the constant need to readjust. Literature suggests that organisational change is linked with mental health worker stress due in part to heightened role ambivalence or conflict (Lucas, 2004) and these are thought to be greatest in the initial months following a reorganisation (Gulliver, Towell & Peck, 2003). One wonders what impact this

continued adjustment has on Ellie when she speaks of ‘...change all of the time’. Other studies highlight the impact of the organisational context and in particular organisational change on the experience of employees and their job satisfaction (Harper, Manasse & Newton, 1992) with changing membership threatening the stability of teams (Lemieux-Charles & MaGuire, 2006). Considering the different circular layers within figure 2 (p71), Ellie (p2) also highlights the huge impact of change for the client as there ‘wasn’t good consistency of care’ and ‘there was a lot of practice bordering on quite risky because patients weren’t being seen enough’; and Freddie considers the emotional impact of change for the staff left behind:

*‘it almost seemed like everyone was in mourning because of the people that had gone...and why people are reluctant to maybe share when they are struggling is I don’t know maybe it’s often a bit of atmosphere of um almost like divide and conquer almost that sense of, maybe this seems overly negative but, every one kind of looking after themselves, making sure that they’re ok... it’s all very individual focused, and wanting to make sure they can keep their job’*

*Freddie, p9*

The theme of loss is present in a number of narratives in relation to the processes of change inherent in the continual transformation and reorganisation within the NHS. There is recognition of the psychological impact of change, understanding that all change involves elements of loss (Frances, 2008). One participant describes it as ‘an act of vandalism to have pulled the teams apart as they have done’ (Hazel, p18). Collective team identification is related to the emotional significance that group members attach to their membership and it is proposed this grows by allowing teams to develop a shared history rather than changing their membership frequently (Van der Vegt & Bunderson, 2005).

The next section explores the relational impact of hierarchical structures within a system.

#### **3.4.4.2 ‘An element of hierarchy’**

*‘but I am aware of a strong power divide where it’s the psychiatrists, on top and I’m at the bottom, so like as in like powerful to powerless and so I guess*

*at the start I would stay in the powerless position but now I'm much more assertive and I try to be in an equal and sort of try to bring him or her down to here'*

*Charlotte, p4*

Charlotte demonstrates the change over time in readjusting hierarchies. Her spoken words are accompanied visually by drawing it out on a white board as she spoke about the previous hierarchical nature within her team. Interestingly, during the pre-interview service user consultation of this research, one of the participants reflected on the position of psychiatry stating they would like to see them 'swimming with the team not bobbing at the top'. In health care, status and prestige is often associated with title, thus placing doctoral CPs in a position more closely aligned with psychiatrists. Øvretveit (1993) describes 'practice autonomy' where CPs and psychiatrists have greater discretion about the type of work they do and the balance of time spent on certain activities. Assumptions about status are also derived from the history of each profession and its public image (Bell, 1999). It is proposed that the growth of certain professional groups as 'expert' cultures both divides disciplines from each other and cuts off service users and the general public from discourse (Lindeke & Block, 1998). There is recognition within some of the participant's narratives that restructuring processes are often placing CPs at higher bandings within positions where they hold responsibility for training and consultation. This places them in an 'expert' position as Danielle explains:

*'in that restructuring psychologists have actually ended up with more posts at higher bandings than they did before, which wasn't expected and the nurses in particular, but also the OT's, umm, and some of the social workers, a lot of them are facing down bandings...The psychologists, myself included, I think work hard to just sort of acknowledge the injustice [pause] how can you acknowledge it if you're not talking about it? [pause] It makes it very hard to be part of your teams because you want to umm acknowledge what they're going through, I've just said it haven't I, what they are going through, because I'm not going through it, so you've got this massive elephant in the room'*

*Danielle, p2-3*



In this extract Danielle uses a rhetorical question with pauses before and after illustrating that she is fully considering this issue for the first team and questioning her perception of her role as a CP within the change process. She also emphasises the word 'they' recognising within this a difference between the professions despite her desire to join with them and acknowledge how difficult this process is. Hatcher and Leblond (2001) highlight the challenges of differential power relations and the undermining impact these can have on collaborative working. In a Department of Health commissioned review of the effectiveness of teams the report concludes that NHS organisations need to become team based rather than be hierarchical (Borrill et al., 2001). When power and hierarchy is spoken of in the participants' narratives this is often in relation to the medical model and psychiatry. Speed (2011) speaks of the use of the term 'patient' as being accepting of the medical model and privileging biological factors. Five of the eight participants use the term clients, two participants (Alice and Ellie) use the term patients, whilst Bethan switches between patient and client. It is difficult to determine the factors that influence the choice of language used. Charlotte, Danielle, Freddie and Grace all qualified within the last five years so it may be that the shifts in terminology are related to training and changing societal discourses rather than pressure within teams. However, Hazel uses the word client throughout and had been qualified for the longest period.

Considering the top of the hierarchy, Ellie speaks about the impact of leadership:

*'we didn't have very good leadership which meant, from the team manager's side of things, which meant that the psychiatrist became very powerful. Um there were a couple of nurses in the team who were very old school nurses and I think that then supported the powers that psychiatrists have because those particular nurses were used to deferring to the doctors.'*

*Ellie, p2*

Ellie speaks about relational shifts with hierarchies over time, with younger nursing staff challenging the hierarchy and being less deferential. She ascribes many of the problems within the first team to poor leadership. A lack of leadership has been identified as one of the inhibitory factors in multidisciplinary community teams especially when no one takes overall responsibility (Øvretveit, 1986). Øvretveit (1993, p121) further states that 'more team problems are caused by inadequate

team leadership than any other single factor'. Freddie speaks about the impact of status when considering how he relates to his colleagues:

*'it was just different I think in that context and maybe it felt, well it was interesting really there's maybe something, it felt I was talking with the consultant psychiatrist whereas when it was the support worker it felt like I was speaking to x or I was speaking to x and maybe that kind of sums it up'*

*Freddie, p7*

As Freddie starts to explain why his relationships differ between certain professionals, namely psychiatry, he pauses and within this pause there appears to be a realisation of the effect of status that he has not been consciously aware of. In status-differentiated groups it tends to be higher status individuals who speak most (Berger, Rosenholtz & Zelditch Jr., 1980). Forsyth (1990) also suggests that an individual's status within a group affects their interactions with higher status individuals speaking more within meetings and communications from a lower status to a higher status person being more guarded and briefer. Effective communication is essential for high quality care with communication failures being a common cause of inadvertent harm and it is shown that people do not feel comfortable communicating openly within hierarchical structures (Leonard, Graham & Bonacum, 2004). Danielle evocatively narrates an experience of this in a previous team:

*'I think spoke to how um how unsettling or unnerving it would have been to try and take on the might of the psychiatrist actually. It didn't feel like it was worth the effort, or worth the risk. She was also quite litigious and she would have come after you personally I think, it was very destabilising having that kind of first psychiatrist I described. It's a really unsafe um environment to be in I think in part maybe that was some of what the team was responding to, that lack of safety'*

*Danielle, p16*

The next section looks at participants' awareness of the organisational structure and the effect this can have on the relationships individuals are able to develop.

### 3.4.4.3 'Maybe it's more to do with the structure'

*'the multi-disciplinary bit isn't the biggest part of it if you've got, you know, people are people, and I think if you set organisations up such that a team culture can flourish, the fact that you come at things from different points of view, umm, ought to be something that you can thrash out, so you can come to an understanding over'*

*Alice, p11*

Alice and Hazel, are two of the most experienced participants at ten and sixteen years post-qualification respectively; they both describe their belief that coming from different theoretical positions could enrich the debate and discussion rather than obfuscating it. Øvretveit (1993, p139) highlights the inherent conflict of views stating 'a multidisciplinary team without differences is a contradiction in terms' but recognising the point of a team is to find ways to combine these. Lindeke and Block (1998) state that when a genuine commitment to collaborate exists the effort required in reaching an understanding, where there is a full expression of various views and values, results in productive discourse and creative thinking that enriches the caregiving process.

*'The real benefit from teams comes not just from coordinating separate professions' activities, but from combining them in new and creative ways, and producing a sum which is greater than the parts'*

(Øvretveit, 1993. p140)

Romer and Whipple (1991) highlight that when individuals begin working together they encounter multiple interpersonal, physical and institutional barriers. The participants speak about all of these barriers, placing differing degrees of emphasis on each of them. The impact of individual personalities and team members being in different locations has already been considered as has the context of the wider system. It is important to remember that working in mental health is challenging work and staff of all disciplines struggle with experiences of frustration and failure. Staff feelings of frustration and a feeling that services can perpetuate difficulties is a strong theme in one study using team formulation (Hood, Johnstone & Musa, 2013). Øvretveit's (1993, p4) book providing practical advice for managers about setting up

multidisciplinary community teams highlights the ‘profound’ influence of the organisation stating that ‘given the right conditions *personality* factors play a relatively small part in problems of cooperation’. Danielle highlights the changing conditions for teams that are shifting opportunities for relational connections with colleagues and reducing spaces to consider clients:

*‘the team’s autonomy has been really eroded by a lot of these changes that are happening, so they’ve brought in a team so some unknown people in the ether screen all the referrals...but it means that, when it comes in to the team meeting, we don’t have any agency at all now to accept or reject referrals. We have to accept everything that comes through most of which are inappropriate, so it’s a massively disempowering environment’*

*Danielle, p6*

Danielle speaks of the disempowerment not having agency in decision-making creates and also highlights that this removes part of the context of MDT working. Grace (p9) highlights the impact of procedural changes with referrals to psychology no longer being discussed in team meetings ‘which means your face doesn’t become familiar to people’; and Bethan speaks of feeling powerless alongside her concerns about the impact of systemic changes:

*‘will be replaced by the new standard of possibly more separate, more compartmentalised, more target-driven environments...my perception of what it can be like affects my or feeds into my degree of disgruntlement about what it can no longer be like due to all sorts of external factors that are outside of, well possibly the NHS’ control’*

*Bethan, p12*

The following section explores the impact on the different layers of the circle from pressure within the system.

### 3.3.4.4 'A lot of pressure to get things done'

*'that stops me connecting to the team but also when the team is stressed and they have a lot of pressure to get things done they stop taking time to talk and to think as they're doing other stuff, you know, like paperwork or stuff'*

*Charlotte, p1*

Charlotte's narrative is of a balancing act between the pressure to see more clients and her belief in the greater importance of her work with the professionals in the team that is less quantifiable. It is recognised within both the education and health sector that pressures on performance and outcomes can overwhelm the time and effort required to develop co-operative working practices (Milbourne, Macrae & Maguire, 2003). The Mid Staffordshire enquiry that culminated in the Francis Report (2013) highlights how business focused cultures as opposed to client focused cultures can result in warning signs being ignored. The impact of the wider culture and climate on teams and their members is only now being recognised at a policy level yet within research the atmosphere or climate of teams has long been linked to performance. This suggests that it has only recently been heard by policy makers. Threats to effectiveness can arise when resource constraints lead teams to over-emphasise control and efficiency at the expense of creative thinking and innovation (Borrill et al., 2001).

Johnstone (2011a) highlights team formulation as an approach that she believes has great potential for changing culture within mental health settings. Here formulation is seen as a useful way of making the most of their limited time. Hazel recognises an ability to affect the culture but expresses her concerns for the limits of these when teams are under pressure:

*'for me the thing that most troubled me about that was that lack of influence on the culture of the team...because you know in moments of doubt we all kind of relapse in to what we were first trained in to, you know our core, the heart of ourselves almost and if your heart of yourself is a nurse or a social worker you're quite likely to revert to doing that whereas if your heart of yourself in your working life is a therapist you're going to hold on to that regardless. I think there's teams where there's pressure, they often the nurses*

*and the social workers with those skills often don't use them because they're pushed in to doing the nursing and social work part of themselves'*

*Hazel, p16-17*

Hazel's concerns relate to the context of more allied health professionals being expected to undertake therapeutic training or work with clients. Hazel is uncertain about how easy it would be for nurses or social workers to maintain the more recently acquired therapeutic skills more quickly reverting back to their original core skills in the face of mounting pressures to see more clients. She believes this may lead to clients ultimately being offered less and only receiving part of the care they may need.

The next section explores the extent to which the wider organisation encourages or show awareness of the importance of the relational aspects of MDT working.

#### **3.4.4.5 'There needs to be permission'**

*'I think the organisation has encouraged that really because there's become now a sort of, a culture from management that having two people working with a patient is not time-efficient, it's wasteful and why would you have two people doing an assessment when you could only have one ...there is a bit of a drive to have as little involvement for a patient as possible'*

*Alice, p5*

Alice places a lot of responsibility with the larger organisation believing that an emphasis is being placed on short-term financial efficiency rather than quality of care. A narrative that exists for some participants is the extent to which the organisation grants permission for joint working or encourages a valuing of psychology. Øvretveit (1993) discusses the need for organisations to recognise the challenges of MDT working and understand the role that they can play in establishing a structure that encourages co-operation and enables creative potential to be achieved. Adair (2009) highlights the importance of teambuilding events in order to develop informal relationships within teams. Even established teams need to be supported and encouraged to engage in opportunities for training and development to manage changes, with time invested in team building activities (Robinson & Cottrell, 2005).

Ellie reflects on the extent to which she perceives the Trust to be supportive of the profession:

*'I think generally psychological therapies are, have always been well regarded in the Trust... I don't think I've ever encountered anybody that I felt was really very against psychological therapies. Um and it would be quite difficult now anyway because I mean there's been so much publicity and Government initiative around psychological therapies that, and the patients are talking about all the time, it's on the internet, what the NICE guidelines are about and people are asking for what they want now...whether it's just the sort of wider context of the way mental health work has been thought about.'*

*Ellie, p10*

Whilst Ellie was very clear that the Trust has always been accepting of psychology she also reflects that they may not have a choice in this due to wider societal discourses. Participants express a general current acceptance of psychology having a place within teams particularly for consultation. However, they were far less likely to talk about current examples of joint working with most of these stories existing in the past. The final section considers an important factor in joint working and relational connections feeling much harder to achieve over time.

#### **3.3.4.6 'There isn't any time for thinking anymore'**

*'not through ill will but through lack of capacity, lack of capacity, lack of space to think because space to think is something commissioners understandably don't pay for [laughs] ...there's just too much stress in the system for there to be any give, for people to have any thinking space and it feels a bit, no it feels very dangerous, I think people are going to die and I'm not looking forward to the prospect [laughs]'*

*Bethan, p11*

Bethan's laughter in this extract disguises her distress, emphasised by her use of the term 'very dangerous', that she experiences in relation to the impact and feared consequences of the current system. There is a wealth of evidence supporting this risk-laden potential. Excessive workloads have a detrimental impact on morale and

effectiveness (King, LeBas & Spooner, 2000). Staff within health services report they are often overwhelmed by their workload and feel unclear about their priorities (Dixon-Woods *et al.*, 2013). Johnstone (2011a) states that the part that routinely gets squeezed out in busy teams is providing a space for thinking and for processing feelings. Øvretveit (1993) highlights that when practitioners are under pressure they spend less time informing, negotiating and consulting with others just when many of the benefits of teamwork could emerge. Interestingly as part of the pre-interview service user consultation the two participants identify that targets and time restrictions hinders the ability to find time to sit down and build team unity together. Charlotte expresses her concerns about the targets nursing staff are faced with:

*‘some of the new nurses see sixty odd clients and they haven’t got the time to actually you know care and actually think about what they are actually doing, it seems as if at times a tick box real culture yeah so you know my aim is to give the staff some space to think and to reflect and to plan and also to perhaps give some care to our team too’*

*Charlotte, p2*

Charlotte recognises that other members of the MDT have particularly high caseloads and pressures to see a certain amount each day leading to a ‘tick box’ culture and counteracts this with time provided for reflection. This is echoed in Bethan’s narrative when she speaks of a social work colleague who is also a CBT therapist and needs to fit twenty-five contacts in to each week:

*‘so he’s saying that he’s finding himself kind of saying a lot of the same things to a lot of the same people and it feels a lot more like a therapeutic relationship by numbers than what he would normally do and that just depresses me’*

*Bethan, p10*

This suggests that when clinicians have less time they are less able to engage with the relational aspects of their care for their clients as well as with each other. In another study of the experience of CPs within MDTs, participants identify that the support they gave team members provides a ‘space to think’ (Christofides, Johnstone & Musa, 2012, p429). However, they also acknowledge that it can be



easier to be with people in a lot of distress if you take a detached view of it rather than thinking too deeply about what is going on for them. Another doctoral research project exploring the experience of CPs within inpatient MDTs highlights the 'understandable defence' that 'the staff team is organised in a particular fashion against thinking and feeling' as there is minimal space to consider the causes of people's distress (Bentley, 2014, p91).

In a document entitled *Compassion in Practice* the Department of Health (2012b) identifies the importance of recognising and addressing the 'emotional labour of care', that is, caring for vulnerable people is inherently stressful and emotionally demanding. They highlight the need to find time and space for individuals and teams to reflect, share experiences and seek support to build emotional resilience. Yet, the narratives in this current research indicate that the system is moving away from this position of space provision, with Bethan additionally speaking of her belief that this space is currently being squeezed out:

*'Yes I think there's a difference in that we're still highly functional but there's less emotional energy to go round, there's less space for self-soothing, very much thinking about it for example in a compassion focused way the threat system of the organisation and of the team is much more activated than the containing and self-soothing system and the resource gathering system has to have its place because it's internally dictated and that's just one of the realities that we live with so while there was in highly functional teams I think more space for mutual soothing and decompression and sanity break and reflection there's just less space for that right now'*

*Bethan, p12*

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## 4. Conclusion

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This project was guided by the research question ‘how do Clinical Psychologists narrate their experience of relatedness within adult Community Mental Health Teams?’ To answer this question it was necessary to look at the wider context and consider what might be influencing individual narratives. The CPs who took part in this research all work for the NHS, therefore, this context was given particular consideration.

### 4.1 Summary of the findings

- How do Clinical Psychologists narrate their experience of relatedness within adult Community Mental Health Teams?

In approaching this study I had anticipated that the stories of relatedness would be about the relationships between MDT colleagues and I had been curious about how these narratives would be told. However, from the analysis of the eight interviews of CPs working in CMHTs four relational narratives were found. These were connections to the self of the psychologist, connections to clients, connections with colleagues and connections with the system.

To place these in context, it is important to recognise the current dominant societal narratives that may have impacted on how the CPs in this study told their stories and what stories felt important to tell.

The coalition government of 2010-2015 launched an austerity programme intended to reduce the budget deficit (MacLeavy, 2011). In a poll of more than 300 top managers and directors of NHS care bodies 99% have warned that cuts to social care funding are loading extra pressure on the health service (Brindle, 2015). Media reports are of a failing NHS with longstanding problems of understaffing, financial trouble and poor care (Taylor & Campbell, 2015). In June 2015 the leader of the British Medical Association, Dr Mark Porter, highlighted that these problems and the need for whole regions to be placed in ‘special measures’ would only increase ‘if the government continues to pursue its drive for yet more efficiencies instead of properly addressing inadequate

NHS funding in the face of rising demand' (Triggle, 2015). These interviews took place in the context of continued cuts, pressures on systems and reorganisation, with all the participants, despite working in different teams, having been through a restructuring process within the last two years. I will now go on to discuss the dominant narratives from the research findings in turn.

The first relational aspect was how the CPs in this study storied their ability to remain connected to their own humanity and their personal values within the context of their MDTs. The participants spoke of the importance of making personal connections, being able to be themselves, receiving support which enabled them to connect with the emotional demands of their work and an acceptance of their flaws alongside an acknowledgement of their strengths. For many participants these stories were told with a focus in the past and how things had been by using comparative 'now and then' narratives to highlight the differences. In this narrative there is recognition of the need for change within the wider system to make time and to value the human connections CPs (and potentially other professionals) make with their colleagues that allows them to be more present in their work with clients, alongside and acknowledging their own humanity and needs. The participants' recognised challenges associated with being a minority professional group within an MDT but told 'quest' stories (Frank, 2012) of remaining connected to their value base and seeing their role as introducing alternative views and stories about their clients. There were stories of needing to be present in meetings, of preferences for being based with the teams and wanting to be an accessible resource. In the context of narrating a sense of powerlessness at times to influence the other relational levels, the potential to remain connected to one's values and the importance of self-to-self relating was highlighted. The counter narrative expressed by a couple of participants was the pressure this could place on CPs both in relation to their clinical time and the additional need for a reflective space away from the team.

The second level involved the stories about relationships and connections with clients, particularly thinking about the perceived impact and consequences of the other relational levels for the clients. These were the stories told about clients by CPs so they were only able to story one side of the relationship;

however, the two service users who were consulted with at the outset of the research did express some similar concerns. The dominant narrative from the participants was that relational aspects within teams and systems do have an impact on the people that are accessing them. There was a concern about the safety of clients in the narrative of needing to both have and respect multiple viewpoints to ensure all of client's needs can be recognised and met. The concerns with safety also linked in to the relationship with the wider system with participants speaking of their concerns about a lack of resources, poor consistency, pressure on targets and being asked to train or consult people who may not want to gain or may lack skills in providing therapeutic support to people with complex needs. These stories were often narrated with humour and the use of laughter which appeared inappropriate but seemed to reflect a discomfort with the concern participants felt and the distress and risk they were dealing with.

The third relational aspect was the stories that CPs told about their sense of relatedness to their colleagues within their teams. There was a narrative about the importance of informal conversations and having both the time and physical space to enable this. The view was this allowed things to be contained, staff to feel supported, and enabled greater connection and an understanding of other professions which led to less conflict. The participants were very respectful in their narratives relating to their colleagues speaking of how they valued other professions and felt many of the challenges came from individual personalities. This fits with a picture of CP being able to view things holistically and consider and value multiple perspectives which may have been an important narrative for participants to present. There were two parallel narratives that spoke of how relationships were formed and maintained and participants varied in how far they located an internal or external locus of control in this. Those who presented a more external locus of control spoke of individual personalities being opposed to psychology or being medically dominated and there was a sense that the CPs' way of working was not understood or valued. Others told stories of needing to earn respect, prove themselves, reassure people, find ways to become part of a team and located their own ability to manage this even within a seemingly hostile environment.

Finally, the fourth level which was evident within all the other relationships was of the impact of the wider system and context. The relationship to the wider management, trust, the NHS and the government was evident within all the participants' narratives. These stories were often told with a resigned humour or muted anger which reflected a sense of powerlessness to the constant changes and wider economic pressures that some believed were outside of anyone's control. The impact of these pressures was reflected in the relationships CPs felt able to have both with their colleagues and their clients. There was a sense that there was no time to think nor feel nor engage in joint working creating frustration in people when they believed they were offering substandard work. This seemed to echo the frustration that service users spoke of at the outset of this research. There was a narrative that the wider system appeared quite separate to the day-to-day occurrences in the team and there was no sense of participants being connected to the levels above or having any way to address these difficulties. All of the participants storied their past and present experiences yet struggled to consider their future narratives speaking only of uncertainty. This was evident in not having time to reflect due to the daily pressures being experienced and may also reflect the wider context of short-term measures and 'fire-fighting' with no capacity to think about long-term consequences.

This seems evocative of the experience of depression: powerlessness, hopelessness and a lack of future. It is difficult to tell whether this is indicative of a systemic depressed state where the entire system feels powerless in the face of external pressures or individuals feeling depressed within a system. Clare Gerada, past-chair of the Royal College of General Practitioners, is explicit about this stating 'if the NHS were a patient, it would have depression' (Wilkinson, 2015, p.841). Gilberts' (2010) model highlights the need for compassion to enable us to cope with stress and adversity. It may be that compassion is important not only for the clients but to enable the staff to be able to continue to offer attuned care.

## 4.2 Situating the Findings within the Current Literature

The results from this study have been presented alongside the research in section 3 in order to promote clarity by situating the findings in the literature. This section will build on this by returning to the literature identified in the introduction to consider the extent to which the findings from this research sit alongside the current literature base.

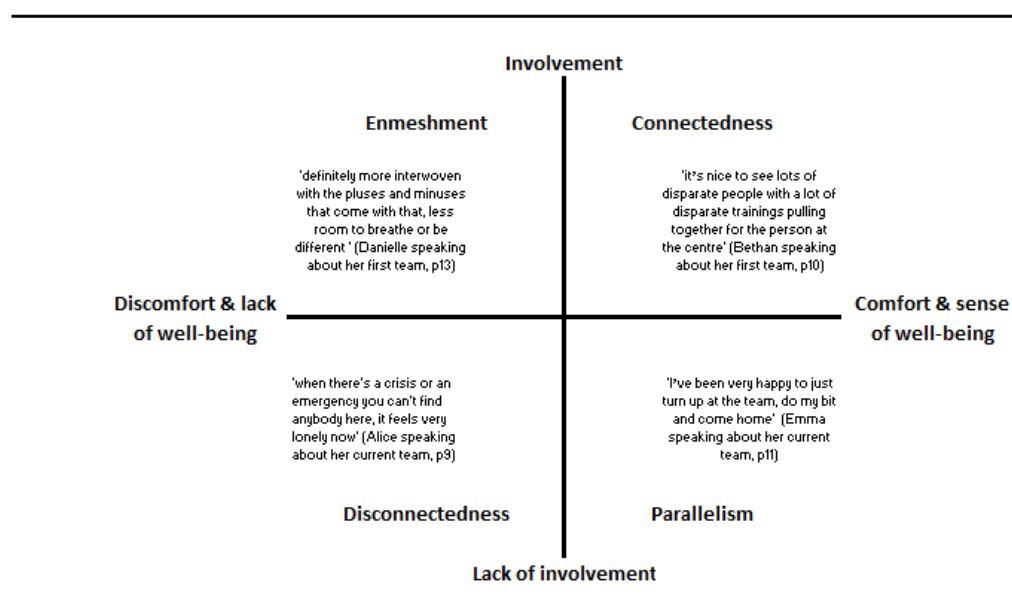
### 4.2.1 Relatedness

A decision was made to use the term relatedness which was defined for the purposes of this study as ‘the processes that facilitate or hinder a sense of connectedness (or not) within the relational context of multi-disciplinary teams’ (Participant Information Sheet, appendix 1). In choosing this term it was felt that the words ‘relationship’ or ‘connection’ on their own did not capture the complexity of the research interests as they focused on one aspect. It was felt that by using a less familiar term it allowed participants to create their own associations about the nature of the research. The words connection and relationship can also carry assumptions through their familiarity about a focus on a self-to-other relating. In the light of the findings bringing a focus on the multi-layered aspects of relating, *within, between and around* (see section 3.4), the term ‘relatedness’ allowed for this broader consideration. Participants discussed processes that facilitated and hindered these varying levels of connection. The term itself allowed the research to remain broad and definition and narratives to remain open to participants. Due to it being an unfamiliar term to many participants they often naturally focused on aspects of the definition such as relational and connectedness and narrated their stories in these terms which is mirrored in the writing of the results and discussion.

The participants discussed aspects that mapped on to Alderfer’s (1972) needs theory in considering our need to have good relations with others, feeling part of a group, our sense of identity and concern to be valued. It was apparent in the research findings that when participants did not experience these things they felt less contained, less able to enact change and less invested in their work which links to self-determination theory (Deci & Ryan, 2002). Research has often focused on outcomes and team effectiveness rather than relationships. However, it may be that

these ideas are linked, the concept of self-efficacy and motivation and learning theory suggest that we need self-confidence and belief to achieve (Bandura, 1997). The participants reflected that their feelings of connection with their team members and the extent to which they were valued did influence the position that they were able to take. It seems that when relationships encouraged an atmosphere of acceptance, participants were more confident, efficacious and motivated to share their knowledge and skills and engage in effective joint working.

In section 1.4.2 research was described that had identified a model of adult relatedness states that has been used in understanding client behaviour and considering appropriate nursing interventions (Hagerty et al., 1993). The participants in this study described the relatedness within the teams they were working in and it is possible to map these descriptions on to this same model. Examples of this are outlined in the figure below:



**Figure 2: Examples of States of relatedness in the Research Findings**

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Although it would have led to an over-simplification of the participant's narratives to consider their stories about their teams through only this lens it is interesting to see that these relational states could be applied to the professional's experience alongside the client's relating as a different way of using this model.

### 4.2.2 The Current Context

The participants described a culture of change and pressure which was identified in section 1.9 with reference to reports by the King's Fund (West et al., 2014), Department of Health publications (2015a) and contemporary media reports (Baker et al., 2015). The participants were all working in different teams and across three trusts so this suggests that the context of increased pressure on services is a reality for many that is having a real impact on the relatedness clinicians experience. The Francis Report (Francis, 2013) identified that systemic and organisational issues were at the root of problematic cultures developing rather than it being possible to identify problematic individuals. The stories that participants in this study told described problematic contexts and most of the difficulties existed within an entire team. Participants described teams that related and functioned well and other teams that did not, suggesting that issues could become very systemic and cultures pervasive.

### 4.2.3 Research on groups and teams

In considering the rationale for the significance of this research (Section 1.2.3) the need to more explicitly consider the internal processes of teams (Mickan & Rodger, 2000) was identified. The findings highlighted participants' beliefs that not only was working in teams essential for client's wellbeing but also that the relationships between colleagues and the wider organisation have an impact on the care that is provided. The participants reflected their belief that what was happening amongst the team did have an impact on the clients. Indeed, the client also benefitted when team members could address their own multiple needs. This supports literature that asserts that problems are produced in relationships (Øvretveit, 1993) and relationships are central to how an organisation functions (Martin-Rodríguez, Beaulieu, D'Amour & Ferrada-Vileda, 2005). This study contributes further ideas about the experience of being in teams particularly in the context of multiple professionals working together in a complex area such as mental health.

The Pew-Fetzer Task Force (Tresolini, 1994), which was mentioned briefly in section 1.4.2 when defining relatedness, was established to explore and address the complexities of interprofessional work in the United States. The key areas this study identified were the practitioner's relationships with their colleagues, their patients and



their communities although it also discussed a need for self-awareness. This study was not in my awareness whilst the interviews were analysed but in reading through the literature review I was reminded of its relevancy to the results that had emerged. This idea was developed and expanded within this study to include the relationship to the self as a fourth key relational element and the relationship to the community to include the wider organisational and societal context. The results and the visual representation of these (figure 2, p69) are also a novel way of understanding the interrelatedness of all of these aspects.

An area that is less explicitly spoken about within the literature is the impact that these levels of relatedness have on a professional's ability to maintain their relationship to their own values and the importance this self-to-self relationship can assume when individuals are surrounded by disconnection in other areas. Gilbert (2010) highlights the importance of our social relationships and how this can link to our sense of self and our self-interconnectedness. The Compassionate Mind approach illustrates that warmth, kindness and compassion are central for managing stress and adversity (Gilbert, 2010). The participants were facing these challenges and identified the benefits when these relational elements were present in their teams.

The following section will identify some of the recommendations for effective team working that emerged from the participant's narratives, an area as identified in section 1.6.2 that has often remained elusive.

### **4.3 Clinical Relevance and Implications**

This research provides an understanding of how CPs experience working within CMHTs. Their narratives reveal the relational impact of the systemic pressures and highlight the importance of relatedness and connection at multiple levels.

The group 'Psychologists Against Austerity' highlight that important indicators of a psychologically healthy society are agency, security, connection, meaning and trust (McGrath, Griffin & Mundy, 2015). It is possible that these indicators are also relevant for determining a psychologically healthy team where individuals feel they have the power to make decisions and shape the future, they feel safe, they feel connected and able to connect, their role is meaningful, purposeful and valued, and they experience trust enabling strong interpersonal relationships.

The aim of this study was to provide insight into the experience of CPs working in adult CMHTs, to give voice to the stories that they tell considering the position and influence they hold within teams, and to contribute to thinking around collaborative and interdisciplinary work

The participants were speaking from their experience specifically as CPs within an MDT and they told stories both of challenge in their roles and of the joys it has brought. The narratives highlighted that having different management to the rest of the team often left them feeling responsible to challenge situations within the team where they perceived power imbalances. They highlighted that people within leadership and management that were respectful of and valued psychology made their role much easier. When this was absent they spoke of a reduction in joint working, consultation being less efficient, difficulties in communication, clients not having access to therapies, the withdrawal of psychology and the absence of a psychological perspective.

The question has been raised about whether the medical model can sit alongside a psychological or therapeutic model or whether they are too contradictory and, thus, prone to producing unhelpful conflict. However, despite the challenges and the uncertainty about whether it was possible for CPs to remain in CMHTs, the participants spoke of the value of MDTs believing CPs *should* remain within them. Whilst the participants' recognised different and contradictory views they still believed that, where the appropriate structures and systems were in place, these differences could be used constructively. The participants highlighted:

- the need for time to be able to talk and understand each other's rationale to enable the development of a respect of difference
- the value of getting to know each other on a personal level to be able to balance this knowledge in times of professional conflict
- the importance of trust, comfort and support to enable individuals to be themselves, ask for support and admit the things they do not know or the mistakes they have made
- a recognition that gaining respect, trust and openness takes time and that locum staff and constant organisational changes impede this

- the benefits of being based with a team for the purposes of communication, accessibility, avoiding misunderstandings, informal exchange, feeling a valued part of a group and joint working and thinking
- support and recognition within the trust of both the value of joint working and interventions such as supervision, consultation and creating time to think together about clients – it is an essential use of time rather than an inefficient one
- valuing each individual's areas of expertise and appreciation that it is not safe to assume anyone can provide this
- a concern that a system driven by targets and statistics creates pressures that prevent engagement with important aspects of the role that are not measured, for example relational ones
- the necessity for good leadership to be able to challenge power imbalances and domination of individuals or models and to consider relational influences within a team to circumvent negative cultures developing
- being able to become part of a team so as to influence it through asking questions, interjecting viewpoints, challenging language that is used, being present in meetings and supporting staff to be more able to think, feel and care

The above list highlights important clinical implications of this study. The values of compassion and improved inter-professional working have been established in policy yet there remain questions about how to achieve these aims, particularly when the concept of time is tied up in economic value. It may be that some of the above suggestions may identify some areas that could be considered within future research. Possible solutions to some of these challenges may be:

- recommendations and support from professional bodies that CPs should both remain within MDTs as a core member and be physically based with teams to encourage informal meetings to take place

- support from trusts to make time for relationship building and team development through recognising the value of this for effective clinical practice and outcomes alongside increased staff retention
- the identification of teams with high staff retention and exploration of the factors that may influence this in order to reduce the use of locums and agency staffing
- leadership development and training with a particular focus on promoting relatedness within teams and understanding group dynamics and team cultures
- the introduction of inter-professional education to support a greater understanding of difference
- clearly defined roles and specialities to prevent role blurring, unsafe practice and devaluation of core professional training
- the use of team formulation to create space to think together and encourage interprofessional working
- measurement of joint working so that this is recognised as valued and promoted as an essential activity alongside other outcome measures, this could include peer supervision, case discussion, collaborative work, MDT meetings and team formulations
- a reduction of caseloads to prevent burnout and unsafe or ineffective care.
- undertaking research in relation to these areas and those identified in section 4.4 to create a greater evidence base to substantiate the benefits of making these changes

However all this requires time and money which are currently in short supply and there is often an unfortunate focus on short-term savings rather than long-term gains. A recent play by Michael Wynne based on interviews from 'those connected to every aspect of the NHS' highlighted 'that's one of the problems with the NHS that we've got now is - it's run on a five-year cycle, so there's no

incentive to do anything, is there, long term' (Wynne, 2015, p55). However, it is worth remembering the cost of 'the waste that comes from teams locked in conflict and poor communication' (Øvretveit, 1993, p144).

#### **4.4 Critical Review**

Through the use of Narrative Analysis this research has developed a deeper understanding of the experiences of CPs in CMHTs. To my knowledge, this has not been previously undertaken and, therefore, fills a gap in the literature. It is hoped that this study will help to inform commissioners and deliverers of services, that change is necessary and what, and, how this change could occur. Although qualitative research does not adhere to the same notions of reliability as used in quantitative research it is still important to consider the credibility of the research findings. I will now explicitly consider Yardley's (2008) validity criteria and how they applied to this study.

##### **4.3.1 Sensitivity to Context**

I am aware that as the researcher I am exploring issues that are relevant to the profession that I am training within and due to join shortly. I am also aware that I was writing and editing during the election of a Conservative majority government which may have influenced which parts of the context were especially important to me. The interviews themselves took place prior to the election and it may be that some of their stories would have been different had they taken place after this, perhaps becoming even more aware of the systemic context.

##### **4.3.2 Commitment and Rigour**

The results from this study were derived from eight co-constructed interviews and rely on personal interpretation. The narratives, therefore, cannot be generalised. However, they can be used to inform and develop ideas about what is likely to improve services. The interviewees are all qualified CPs with, between them, over sixty years' experience of more than fifteen different CMHTs. The extensive training that CPs undertake which includes awareness of teams and systems creates a value in hearing these voices and the positions they take in relation to CMHT working.

It is also useful to remember the selection bias within the sample as those who volunteered for the research may have had particularly positive or negative perceptions or experiences of team work. In exploring participants' reasons for volunteering many said they remembered their own experiences of recruiting for research and wanting to make this process easier for others. However, this could also lead participants to tell stories that they believe are most useful or relevant to their perception of the researcher's aims.

#### 4.3.3 Transparency and Coherence

There are limitations within the narrative methodology, however, throughout the research, I have attempted to be transparent about the methods I have used and any subjective bias I may have brought into the analysis. The use of a narrative peer group, supervision and a reflective journal aided this process. I have also included a transcription sample to illustrate some of the analysis process (appendix 5) and an extract from my reflective journal (appendix 9) to further aid transparency. It is however, possible that as themes emerged within individual transcripts I was more likely to spot these in later transcripts and although I tried to remain open other stories may have been silenced. In an attempt to address this I returned to transcripts and listened to the audio multiple times to ensure that the narratives were emerging from the data and to try and consider alternative stories. This was also aided by sharing global impressions with two narrative colleagues as an additional validity check.

In undertaking eight interviews of at least an hour in length a large amount of data was produced. In combination with this the steps of analysis as outlined in section 2.2.5 covered multiple aspects of Narrative Analysis including structural, thematic, performative and dialogic alongside a comparative approach across transcripts. Although, this meant that there was a comprehensiveness to the data and analysis process it created challenges for writing up the results within the limitations of this particular study. It felt important to reflect the words of the participants and the narratives that they chose to tell so there was often a thematic focus within the results. Although throughout the results section I have attempted to reflect on aspects of performative, structural and dialogic analysis where this felt particularly pertinent. A decision was also made to integrate the

results with the literature in order to add credence to the findings. Although, there is a risk with this that certain data may be highlighted or excluded I spent a lot of time in supervision considering how to manage these challenges and feel that the outcome created a coherent story of our co-constructed narratives situated in the current context. A decision was made to include the table of themes and quotes in appendix 11 in order to highlight the emergence of these themes from the data and from all of the participants.

#### **4.3.4 Impact and importance**

In the introduction both the personal and social significance of this research were outlined (sections 1.2.2 and 1.2.3). In the current context (as explicitly referred to in sections 1.9, 3.2 and 4.1) of increased burnout and decreased compassion it appears important to consider how relationships within teams may impact on client care. The majority of health professionals within the NHS work within MDTs so the potential impact of research in this area is wide-ranging.

It is likely that the quality of the study would have been improved if I had transcribed all the interviews myself as it aided my familiarity with the transcripts. However, this was not possible within the time constraints of the study and multiple readings of the transcripts and listening to the audio ameliorated many of these possible effects.

#### **4.5 Implications for further research**

Further research could be carried out using a similar methodology to explore the experience of other professional members of MDTs and importantly of the service-users. The service-user consultation highlighted some interesting issues that overlapped with some of the narratives that emerged from the participants and it would be useful to explore these further. It would be helpful to consider the experience of all members of the MDT to highlight which issues are experienced generically and which might be more profession-specific. This could provide further insight into the system that is currently in place and help to develop ways to improve it. It would also give voice to some of the individuals that did not have an explicit voice in this research particularly as the results highlight how much these multiple voices interact and overlap. It could also be

interesting to carry out similar research within a clinical health setting where there is usually an even more diverse MDT, constantly changing teams due to shifts and an often understandable predominance of the medical model due to the physical health setting.

Although the aim of this research was to explore individual's stories of their experiences within groups there is a question of whether it is possible to make sense of people's social identities through a focus only on individuals (Haslam, 2004). It may be useful to conduct further research that made use of a focus group design to consider how the stories differ within the group context. This could be carried out with the whole MDT as a group to explore which narratives are silenced as many participants spoke of issues of power and hierarchy not being openly discussed.

#### 4.6 Final comment

In reflecting on the process of undertaking this research I have spent time reading through my reflective journal. This has enabled me to remind myself of my original interests and aims when I embarked on this study. I had been interested in gaining a greater understanding of the different professional positions and motivations and in exploring the individual humanity underlying a professional role. I had wanted to consider what Hochschild (1979) refers to as *emotion work*, how we monitor emotions as part of our impression management and choose the kind of self we present to other people. I wondered if different professions have different permissions in relation to this emotion work and I was curious about the impact if we were able to gain a greater understanding of each other's humanity and what underlies our choices.

Time constraints and the recognition that it may be easier for a CP to speak openly to a trainee CP than to ask other professionals to speak with me meant my access to other professionals was only via the stories told of them. The idea of feeling misunderstood by other professionals was certainly evident in the participants' narratives but there was an absence of the voices of the rest of the MDT. Rachel Naomi Remen highlights that in the medical culture there is a focus on training in cognition, knowledge and technical skills but other aspects of our common humanity are neglected often leading to a loss of work satisfaction (Tucker, 2005). Rachel



Naomi Remen has developed a curriculum 'The Healer's Art' that is taught in the US and a number of other countries to enable students to reconnect to the values that motivated them to choose medicine as a profession (Remen, 2014). It appears that a focus on financial 'value' threatens to push us all away from some of our values and the essential importance of relatedness within the human context.

*'Healthcare, at least as much now as it was sixty-five years ago, depends on human-relationship-based care and that just doesn't fit with capitalism which is about replacing labour with capital'*

(Wynne, 2015, p70)

The current conflictual demands for a 24/7 culture, constant savings and increased quality to include compassionate care place unachievable standards on an already stretched health service. The concerns over cutbacks, possible privatisation of the NHS and the ongoing need for 'greater efficiency' have an impact on relatedness within teams and ultimately on the work with clients. Dartington (2010) writes about the lack of compassion and humanity in the care of vulnerable people and links it to a general breakdown of community and connectedness occurring in society as a whole as a result of market economics. This highlights the interactional process that as individuals and within the wider system we are all connected and impacted by each other as the circular model of the results exemplifies.

As one participant put it:

*'because if you go with the idea of ultimately services being put out for tender so different services essentially kind of competing for, competing against each other well that's going to mean, that doesn't kind of encourage team work, that's going to encourage people saying this is my patch and this is my territory, we do this sort of thing don't you take that which is kind of very market style model I think'*

(Freddie, p16)

It seems that systemic pressures, that stop professionals from connecting with themselves, their clients, their colleagues and the wider system in order to challenge what is happening or to address power imbalances, may affect how able a range of individuals are to stay connected to their values. It seems vital to provide some thinking space within this context so clinicians can contribute to improvements within services through making use of the multiple perspectives and experiences they bring.

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## Appendix 1

UNIVERSITY OF HERTFORDSHIRE

### Participant Information Sheet

Project Title:

#### **Clinical psychologists' narratives of relatedness within a multi-disciplinary team context**

I am a third year Clinical Psychology Doctoral student at the University of Hertfordshire and I am looking for participants to help me explore the experiences that qualified clinical psychologists have of working within multi-disciplinary teams. You are being invited to take part in a research study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. Thank you for reading this.

#### Aim of the Study

The purpose of this study is to explore experiences of relatedness within multi-disciplinary teams and the factors that affect integration.

In this context the following definition of relatedness will be used: 'the processes that facilitate or hinder a sense of connectedness (or not) within the relational context of multi-disciplinary teams'.

It is hoped that through narrative inquiry an in depth insight will be gained that will help to inform future research and service development which will ultimately add to client and staff experiences.

The specific aims are as follows:

- To explore the experience of Clinical Psychologists working in adult Community Mental Health Teams (considering change over time)
- To give voice to the stories that Clinical Psychologists tell about themselves and consider the position and influence held by Clinical Psychologists
- To contribute to thinking around collaborative and interdisciplinary working

#### What is involved?

If you agree to take part in this study you will be asked to take part in an informal interview with me which will last up to 1- 1 ½ hours. I will ask you to tell me your stories of working in multi-disciplinary teams in your role as a clinical psychologist. This may involve talking about your professional role, identity, values and experiences of decision making

The interview will be audio recorded and then transcribed by me. In the event that I use a transcription service I will ensure to use a reputable service that will have to sign a confidentiality agreement. The data will be stored on a password protected and secure computer.

I will then analyse the data. I will use a method of analysis which will involve using direct quotes from your interview, however all names will be changed and all identifiable information will be removed to ensure confidentiality.

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#### Who can Take Part?

To take part in this study participants must be a qualified clinical psychologist who trained and received their qualification within the UK. Participants must also have been qualified for at least 12 months and have direct experience of working within a multi-disciplinary team.

#### What are the possible disadvantages, risks or side effects of taking part?

It is unlikely that you will experience any disadvantages from taking part, however, it is possible that personal emotional distress could occur during the interview. It is advisable that you consider how it may feel to share your experiences before taking part.

The interviewer will check with you whether you are happy to continue the interview at certain points and you can request to terminate the interview at any time. You are free to withdraw any information you give at any stage during the process.

If during our interview you disclose anything which gives me concern for your welfare or the welfare of others I will have a duty to seek support from appropriate services, however I would always discuss this with you first.

#### What are the possible benefits of taking part?

You will be able to express your views and share your story of working in multi-disciplinary teams as a Clinical Psychologist. The contribution you give will be heard and valued and will hopefully lead to recommendations, service planning and further research on effective team working.

#### Voluntary participation

Participation in this study is entirely voluntary, which means that you have the right to withdraw your participation at any time and you do not have to give a reason.

#### Confidentiality

Any data you give as a result of this research will remain confidential and anonymous and will be used only for the purposes of this study. All data will be anonymised and kept in secure storage in accordance with the University of Hertfordshire's data storage policy.

#### What will happen to the results of this study?

The data collected in this study will be used in a third year Doctoral Psychology project at the University of Hertfordshire. In the event that the results of the study are published participant's names will not be used and all identifiable information will be removed.

#### Who has reviewed this study?

The project has been approved by the Psychology Ethics Committee at the University of Hertfordshire (Approval Number **LMS/PG/UH/00291**)

Who can I contact if I have any questions?

For further information about this research please contact Katherine Nutt, Trainee Clinical Psychologist at [k.nutt@herts.ac.uk](mailto:k.nutt@herts.ac.uk) or my supervisor Dr Saskia Keville, Clinical Psychologist, University of Hertfordshire on 01707 284232 or at [s.keville@herts.ac.uk](mailto:s.keville@herts.ac.uk).

**Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.**

**Thank you very much for reading this information and giving consideration to taking part in this study.**

## Appendix 2

### Literature on Groups and Teams

The psychologist Kurt Lewin (1890-1947) coined the term 'group dynamics' to describe the way a group becomes a unified system where individuals react to changing circumstances within the group and may act in different ways. Group influence has been construed within some literature as leading to a loss of the rational self which is replaced by the collective unconscious (Haslam, 2004). Luft (1984) has looked at group dynamics and identified that a role may be assigned by "*covert collusion*" and that "*role is imposed by the context, by the person and by others*" (p.21). Linked to this the team phenomenon of 'groupthink' has been identified where teams become more concerned with achieving agreement than making the best decision. This can most commonly occur in teams where a leader is particularly dominant (Janis, 1989). Brown (1988) highlights that team members are subject to social conformity effects which can lead them to withhold their opinion if they feel it is contrary to the majority view. It has been suggested that in order to avoid exclusion by others people conform, obey, comply, change their attitude and try to present themselves in a favourable light (Baumeister & Tice, 1990). It may be useful, therefore, to explore relationships between team members and consider the extent to which they may experience inclusion or exclusion and the possible implications of this.

In the field of organisational psychology and management literature there is an emphasis on effective team working and communication and cohesion play key parts in this. In more recent years there has been some focus on the quality of those relationships and the impact of our working relationships on our mental health and development of our identities (Dutton & Ragins, 2007). In the United States there is a group called the Positive Relationships at Work micro-community who describe themselves as a community of scholars dedicated to research in this area. Their aim is to identify how to create human connections in the workplace as a source of individual and collective growth (<http://questromworld.bu.edu/prw/>).

One challenge identified by West (2014) and the Aston Organisation Development team who aim to use evidence-based approaches to help develop effective team working, is the sheer volume of writings about these topics. They highlight that a lot is being written about leadership and teams with many emerging ideas; thus, it can be challenging and overwhelming to know what is the most important focus.

## Appendix 3

### Sample Interview Questions

- When you volunteered for this study were you thinking about a specific team?
- Can you tell me about the teams that you have been a part of since qualification (what is the team that you are currently part of)?
- Could you tell me about your experiences of relationships or connection within these teams?
- What is similar or different about your earlier experiences of teams to now?
- How have your feelings of connection influenced your position within multi-disciplinary teams over time?
- Have there been any challenges within your experiences of multi-disciplinary teams and if so can you tell me about these?
- Have there been any benefits or joys within your experiences of teams, can you tell me about these?
- What do you feel you have gained or lost through your experience of teams (over time)?
- What previous team experiences have shaped the way you experience teams now?
- Are there other types of groups that you've been in that have been similar or affected how you experience teams? (family, peers, training, other teams, professional or personal...)
- Where do you see your role as a clinical psychologist within a multi-disciplinary team going in the future?
- What was the experience of this interview like for you?
- Is there anything you have not said which you feel you would like to add?

## Appendix 4

### Participant Consent Form

**Title of Research Project:**

**Clinical psychologists' narratives of relatedness within multi-disciplinary teams**

**Statement by Participant:**

I have read and understood the information sheet provided about the study

I fully understand what my involvement will entail and I have had any questions I have about my participation answered and am satisfied with this.

I am aware that my participation in this study is voluntary and that if I decide I would like to withdraw from the study I can do so at any time without judgement or having to give a reason.

I understand that if I do not wish to answer a question or discuss a topic that I have the right to refuse to do so without judgement or having to give a reason.

I have been made aware that all information I provide will be anonymised and securely stored in order to protect my confidentiality

I have agreed for my interview to be recorded, transcribed and analysed.

I understand that the data gathered from my interview may be published as part of a piece of academic research but that should this happen my identity will be anonymised.

I have been provided with the relevant contact details should I have any questions, need any further information or need any clarification about the study or my involvement.

Participant's name .....

Participant's signature ..... Date.....

**Statement by Investigator**

I have explained this study and the possible implications of participation in it to this participant without bias and I believe that the consent is informed and that they understand the implications of participation

Investigator's Name .....

Investigator's Signature ..... Date .....

University of Hertfordshire Ethics Approval Protocol number:

**aLMS/PG/UH/00291**

# Appendix 5

## Transcription Sample

154 quite a problem. This person took over all the air space. There isn't a character like  
 155 that so much here. That's just a quirk of (yes) who you get in the team I guess.  
 156 I: Yes. And so that felt kind of more personality rather than professional?  
 157 A: Maybe. I mean he was a consultant psychiatrist so I think that perhaps there is  
 158 something that goes with the role that they feel under pressure to be leaders and set  
 159 examples and you know guide the rest of the team (hmm) but, yes, it was very much  
 160 a personality quirk as well (laughs)  
 161 I: And did the umm / there's kind of differences that you umm notice now and you're  
 162 saying kind of obviously about having noticed that things have got busier.  
 163 A: Hmm.  
 164 I: Do you think, if you were umm back in the team in [redacted] that things  
 165 would be different now anyway or do you think kind of it is very much about the  
 166 cultures of the teams?  
 167 A: Umm I'm not sure if this is the right answer to the question but I suppose I think  
 168 that you just can't create those kinds of working relationships overnight. They only  
 169 kind of evolve over a period of a long period of time (hmm) and going through a lot  
 170 together (yes) you know, you have the happy times together, where you have a  
 171 laugh, or you might have something really unpleasant, like a suicide, or something  
 172 that you will have to come together over, or there'll be times when you help  
 173 somebody with their personal problems and you just don't build that up, you know, it  
 174 happens over a long space of time (yes) and I think the fact that some of us, you  
 175 know, there were other social workers I can think of, in the team, that I'd known since  
 176 I qualified (hmm) umm / yes, takes a long time to get to that level (yes) of intimacy  
 177 with people (hmm)  
 178 I: And so you can think of kind of specific times when you were kind of going through  
 179 those difficult times with your previous team?  
 180 A: Oh God, yes, definitely, yes, yes.  
 181 I: Yes. Umm / I mean I guess the / it's kind of the thought in my head when I was  
 182 asking that question was whether that team would have less of that time now  
 183 because of general pressures on systems or whether, because of those  
 184 relationships that are built over time, and that different culture within the team, they  
 185 may have protected that more than /  
 186 A: I think it's difficult to say, I mean, because (hmm) since the / the Trust, what they  
 187 called their Transformation Programme, where they restructured everything, all the  
 188 structure of the teams, that's why I moved out of that team. I'm told, by the  
 189 psychologists that are there now, that it is all quite different (hmm) and that they are  
 190 incredibly busy, umm, so whether it would have survived the changes (hmm) that's  
 191 difficult to answer, I can't say really (yes, yes, okay).  
 192 I: Umm and kind of the next thing I was sort of thinking about was umm sort of how  
 193 your feelings of kind of connection within the team have influenced the position that  
 194 you perhaps take, umm, so thinking about umm in the previous team that you  
 195 obviously felt quite connected to all of the team members, whether that changed the  
 196 position that you took within the team?  
 197 A: Umm I mean I'm not sure. I think my role has changed so much. I've got a lot  
 198 more management responsibilities now and I supervise a lot more people or line  
 199 manage more people (hmm) so I suppose I have to take a slightly different position  
 200 in that sense (hmm) umm but otherwise, no, I suppose I try to still be a kind of  
 201 resource for people to think psychologically about their cases and whether they  
 202 benefit from therapy and just as a person sort of be someone that people feel that  
 203 they can come to (hmm) umm not sure if that answers the question?

*Handwritten notes:*  
 - Individual characteristics (blue)  
 - my interest? was this whole it was going / what she was saying! (orange)  
 - early interview struggling to bracket some of my interests (red)  
 - Importance of time coming together (green)  
 - her way of being? (red)  
 - Avoidance of difficulties? (red)  
 - interest in pressures she had mentioned but may be silenced another story (red)  
 - through curiosity for me to face (red)  
 - face (red)  
 - part beam (red)  
 - change over time - identity sense of self & role. (red)  
 - Loss? (blue)  
 - loss challenge (blue)  
 - why not explored? (red)  
 - Awareness of me & my aims... (red)  
 - Team 1 (black)

*Left margin notes:*  
 - Identity of psychiatry? (pink)  
 - Personal knowledge High & low Loss! (blue)  
 - Repetition pertinent area not explored? (green)  
 - story of learning emerges (green)  
 - big Pause (green)

*Bottom legend:*  
 - content (blue)  
 - Audience (orange)  
 - structure / language (green)  
 - identity identity (red)  
 - co- construction (red)  
 - emotions (blue)  
 - quotes (yellow)

4



## Appendix 6

### Initial Ethics Approval Form



UNIVERSITY OF HERTFORDSHIRE  
HEALTH & HUMAN SCIENCES

#### ETHICS APPROVAL NOTIFICATION

**TO** Katherine Nutt  
**CC** Dr Saskia Keville  
**FROM** Dr Richard Southern, Health and Human Sciences ECDA Chairman  
**DATE** 15/10/14

---

Protocol number: **LMS/PG/UH/00291**

Title of study: Clinical psychologists experience of cohesion within multi-disciplinary teams

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 15/10/14

To: 30/09/15

**Please note:**

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

## Appendix 7

Revised Ethics Approval Form

UNIVERSITY OF HERTFORDSHIRE  
HEALTH & HUMAN SCIENCES

### ETHICS APPROVAL NOTIFICATION

**TO** Katherine Nutt  
**CC** Dr Saskia Keville  
**FROM** Dr Richard Southern, Health and Human Sciences ECDA Chairman  
**DATE** 05/11/14

---

Protocol number: **aLMS/PG/UH/00291**

Title of study: Clinical psychologist's narratives of relatedness within a multi-disciplinary team context

Your application to modify the existing protocol **LMS/PG/UH/00291** as detailed below has been accepted and approved by the ECDA for your school.

Modification: Change of title wording to be more appropriate in line with the use of a narrative methodology.

Change of title from: "Clinical psychologists experience of cohesion within multi-disciplinary teams" to "Clinical psychologist's narratives of relatedness within a multi-disciplinary team context"

This approval is valid:

From: 15/11/14

To: 30/09/15

**Please note:**

**Any conditions relating to the original protocol approval remain and must be complied with.**

**Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.**

**Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.**

## Appendix 8

### Participant Debrief Sheet

Thank you very much for taking part in this study. This sheet contains information about the study for you to take away and refer to.

#### **Title of the Research**

**Clinical psychologists' narratives of relatedness within a multi-disciplinary team context**

#### **DEBRIEFING INFORMATION:**

Thank you very much for participating in my project. By sharing your own experiences, it is hoped that your story will help us gain insight into experiences within multi-disciplinary teams and the factors that affect integration for clinical psychologists. It is hoped that through narrative inquiry an in depth insight will be gained that will help to inform future research and service development which will ultimately add to client and staff experiences.

The information you provided will be treated as confidential, and after analysis, the material will be destroyed. However, in case of publication, the material will be kept under strict confidentiality for 5 years (in line with University of Hertfordshire regulations). As a participant, you have the right to withdraw the information you have provided at any time.

If you require any further information or wish to be informed of the outcome of this study please do not hesitate to contact me:

Katherine Nutt

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#### **Or my supervisor:**

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**Thank you for participating in this study.**

#### **Further support**

It is hoped that you have not experienced any significant distress as a result of this interview but if you have it may be helpful to seek further support from family, friends, your supervisor, colleagues or an organization such as the Samaritans 08457 909090

Thank you very much for your participation, your contribution to this study and to future service planning is invaluable.

Katherine Nutt

Trainee Clinical Psychologist

University of Hertfordshire

University of Hertfordshire Ethics Approval Protocol number: **aLMS/PG/UH/00291**

# Appendix 9

## Confidentiality Agreement

University of  
Hertfordshire



Doctorate in Clinical Psychology  
University of Hertfordshire

### Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Katherine Nutt, Trainee Clinical Psychologist

And

H W Secretarial Services

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed: *H Williams*  
Name: H. WILLIAMS HW SECRETARIAL SERVICES  
Date: 20/4/15



## Appendix 10

## Reflective Journal Extract

21<sup>st</sup> February 2014

We had our first elective research workshops today and I attended the Narrative Sessions. Having created 3 presentations for our class presentation session I am still feeling undecided but today really helped. We spent time thinking about how we have become who we are and we had to write a narrative description which we then shared with a partner and had a look at theirs to practice doing a narrative analysis. I really liked that you did not lose the sense of the whole story told by focusing only on themes but it was also really powerful to notice words and structure, how things were said. It feels it has also brought us all much closer as a narrative peer supervision group which makes me reflect on how powerful this analysis can be even with what seems like a relatively innocuous topic. It feels really important to remember this when I start my interviews and analysis and the discomfort that comes when it feels someone has mis-constructed your story ... I have been thinking a lot about who my participants should be and the impact of me sitting within the psychology profession and also the tension with having to let go of my interests in order to see what emerges ... I think most of these questions are not narrative!

- Narratives priv. legd.
- Values & sense of self within prof
- how clients talked about - DA
- decision making
- how feel about psych/plac in terms
- anx / suic / MH / pressure
- ↳ how gets passed around teams
- (states - active) CAT reciprocal roles
- ↳ strain on Prof / MDR work is challenge
- Atmos of change / uncent / stress
- ↳ how manage / impact
- CLINICAL RELEVANCE
- Impact of other Prof talk to Psych

- how are medics / psych etc positioned in team
- how U stand / make meaning of psychological distress?
- how Prof's see selves - impact on decisions
- Why choose helping profession
- what does it mean to be in a helping profession
- who has more / less influence
- what would break down interprofessional barriers
- how work pre-decision making
- humanity of professionals
- Peoples exp of teams

## Appendix 11

Table of themes and quotes

Overarching Narrative	Stories	Participants	Quotes
Self	'Just Being human'	Alice	'we're quite a sort of support for each other on a personal level as much as anything else, so I guess for me that sense of the importance of work being somewhere where you feel like you belong... it wasn't somewhere where you just kind of went in, did what you had to do, and go home, which I imagine a lot of people's jobs are, you know, we were close, we knew about each other's lives'
		Bethan	'I think it made me realise how much I need a secure base, how much I need a space in which I can be myself like I am with my warts and my strengths and my weaknesses and that's influenced how I am as a professional amongst my teams...I think being able to come in after a tough call or a tough appointment and say urgh I need a biscuit and sitting down and having a chance to decompress and getting some good advice that's good'
		Charlotte	'I try to manage all of that stuff by just being human, and so I you know so I talk with people about poo and you know I join in with what they chat about so telly...Other stuff, yeah, other quite normal, shared stuff'
		Danielle	'they can't so easily counterbalance what you bring as a psychologist with their human side so I think you're probably in for a more tumultuous time, getting more stuff thrown at you, because people don't need to care about you, they don't need to sit next to you, you just waltz in, do what you want and waltz out again and they can bitch as much as they like...They don't know you in the same way I suppose'
		Ellie	'I found it quite nice to be in a team where I could say God I don't know what's going on with this person either, shall we have a bit of a chat about them...Sometimes you need that context to try and make sense of why people are behaving the way they are in a team meeting or talking about a case or approaching a case in a particular way. You know you know if somebody's really stressed they're going to be approaching their work differently. Um so that kind of out of work gossiping was really useful to me'
		Freddie	'well I found, what was helpful for me, was I found that taking an approach of um forming more, I don't know how to put this, almost more like, a more human relationship with

			people... it's those sorts of connections that seem to again kind of like make me seem like less of an outsider in that way...and then from there really then people started to approach me about cases they might be struggling with or need some help with'
		Grace	'it is possible I think for different personalities to kind of make it work for them so you know you can be much more involved and present and on the floor so to speak, wandering around chatting to people or you can be much more head down getting on with things...But you know within reasonable boundaries I think it's wise for a team to kind of let people kind of do it the way that feels best to them really'
		Hazel	'Well I think it's about all, all the supportive elements...I'm spending quite a lot of time making those connections...but for me that's part of enhancing the clinical role...  there's nothing that makes you feel more cared about than somebody bringing you tea'
	'You have to be in it to change it'	Alice	'it's only by sort of trying to interject your point of view and say what you think is happening and based on what you know of the patient's history, that you can help to provide the rest of the team with a little bit of understanding and make a suggestion of what we ought to do to try and manage this situation'
		Bethan	'So it's about not getting lost in a world where we can deliver an intervention and people can be better afterwards and that exists in isolation. So I'm lucky in that the teams I've been in have all allowed me to become part of them as opposed to being the psychologist who comes in'
		Charlotte	'I sometimes find psychotherapy services slightly pretentious and aloof and I'm the type of person who likes to get stuck in, you know, get my hands dirty... it's nice to always get pulled in to could I go to a ward review and I have even more scope to ask those tough and controversial questions...And can we do something differently so much so that you know it changes something for the actual client'
		Danielle	' it wasn't a direct acknowledgement that you could see the ideas that you've brought. When other members of the team then start to use those or talk about them, or you see, you hear, when they're sitting next to you, talking to their service users, some of that language and some of that thinking creeping in to their conversation, you sort of, I end up thinking

			job done. That makes me happy'
		Ellie	'I'd always felt a little bit anxious about being removed from my psychology department and being based with the team but actually it's been fantastic so the communication about cases is <u>really</u> quick...Um I have a lot of informal conversations just waiting for the kettle to boil, that sort of thing which I've never done before. Um so that again was a surprise to me that there would be so many advantages to being situated with the team'
		Freddie	'I got the sense that sometimes this happened to psychology, because of this conflict or dynamic, psychology would kind of like remove itself from this and that's when psychology then has less input to the team ...so I think sometimes because of that conflict psychology can sometimes remove itself and can be seen as quite separate from the team'
		Grace	'I did like being accessible to people and feeling like you're a resource that they can use...Um and as I said these other nurses I'd have to see them a significant number of times, you know to build up the same relationship as you had with someone you were actually sitting with...I don't have time to go and do all that kind of stuff anyway'

Overarching Narrative	Stories	Participants	Quotes
Clients	'The clients then can feel contained'	Alice	'I mean only to emphasize I suppose that I think that whatever's going on among the staff does ultimately have an impact on the patients and that if we don't feel supported or contained or you know that there is kind of constant turnover of staff, that it really does affect them, and I think uh that's not a message that's got through...so I think doing something about the state of teams is really pretty critical'
		Bethan	'we got to think and I think the patients got better care as a result... I don't know how I would fit twenty-five contacts in to five days and still have time to think or do all the necessary recording or so he's saying that he's finding



		himself kind of saying a lot of the same things to a lot of the same people and it feels a lot more like a therapeutic relationship by numbers than what he would normally do'
	Charlotte	'they haven't got the time to actually you know care and actually think about what they are actually doing, it seems as if at times a tick box real culture yeah so you know my aim is to give the staff some space to think and to reflect and to plan and also to perhaps give some care to our team too'
	Danielle	'and the other challenge of course is just providing an alternate view to um a purely psychiatric one, you know, the heart sink cases or the personality disorder clients where people are just, feel manipulated and frustrated and like all their attempts to help them have been thwarted ...and how can I, how can I help you to like your service users more and also be a bit more respectful of them'
	Ellie	'well the two teams that I've worked with have been very different in terms of the dynamics so the first team that I worked in, there were lots of difficult dynamics between the staff. Um I didn't feel that the patient care was particularly good and that contrasts very significantly with the current team where there's very good relationships and a much better level of care provided I feel... I've got a lot better understanding of the importance of having good relationships in the team and <u>how</u> much an impact that plays on patient care'
	Freddie	'yeah I think it does have an impact, what I found initially was, I think I've been kind of like more, I think I've had to be, I feel like I've been very honest with clients I think, with the people that I see, um and I think they've really appreciated that... I think they don't want to be patronised and they don't want to have wool trying to pull wool over their eyes because yeah it just won't work'
	Grace	'people who are sent with like you know a million problems and wanting to explore their childhood and you think yeah, in twenty sessions? You know like we can't, there's just not realistic so you end up having to try and kind of pick at little bits out to kind of do, it's very unsatisfying really um for clients and for um therapists often'
	Hazel	'Yeah and I also think the clients then can feel contained, think there's an understanding, seeing us manage

			disagreements at having different viewpoints and being able to work it through they can feel really thought about and cared about whereas they have a sense of no one dares say something if something's not quite right it's very negative for clients if you don't do that'
	'We all bring different things to the table'	Alice	'We've all done our separate bits and nobody's trod on anybody else's toes or disrespected somebody else's input, umm, and its worked very nicely, so I think that you can have several cooks involved with a patient, so long as you know there is a culture of respecting each other's differences, then there's no reason why you shouldn't have good multi-disciplinary work I think'
		Bethan	"it's nice to see what everybody can contribute, what everybody brings to the table, somebody having an idea and it's nice to see lots of disparate people with a lot of disparate trainings pulling together for the person at the centre of it' ...certainly my [current] CMHT feels a bit like a melting pot, we're all in it together and we've all learnt things from each other and uh we are significantly more as a whole than we are as individuals'
		Charlotte	'And you know now our social worker and our AMHPs I go to ask, I've just been to see xxx and I'm concerned about this, this and this, bla, bla, bla, do they need a crisis team referral or a Mental Capacity Assessment, so it's really containing to share the skills and concerns'
		Danielle	'I really don't agree with this changing teams into amorphous blobs where there's no delineation between peoples' professions...doesn't make any sense to me that people can't hold on to and value what they trained in and be proud of it and just pretend like we're all the same. Clearly we don't have the same skills. Off on a rant! It's madness. I feel like the system is more mad than the people that we see'
		Ellie	'So I had a few cases where there are practical things that need sorting out, financial things that need sorting out, relationship things that need sorting out, medication things that need sorting out. Sometimes things like respite stuff being.. and no one person can do all of that. And so if there is just one person working with that patient, they're just going to get a bit of what they need'

		Freddie	'Also I think you can learn things from other people I work with... yeah I think it's mainly I suppose what I've gained is more knowledge and a wider base of knowledge and understanding different ways of doing things and different approaches'
		Grace	'that's definitely been part of the role...which is to try and be there to you know bring whatever you've got to the table just as the OT is bringing what they've got, just as the psychiatrist etc... I think it's you know it's good. They've got a different perspective on things. They know stuff about stuff I don't know about um which is always helpful'
		Hazel	'it's about just reminding yourself sometimes of just other ways of looking at things so it's so easy to forget something really practical and sensible and I mean I learn so much from my colleagues um and also things just become possible, I'm quite a practical psychologist anyway and I would really miss those practical people being around... I think the world is not just made up of a therapy point of view, there's more to it than that'
	'It's not safe'	Alice	'I think we were talking in a meeting this morning about it's only as we move forward that we'll start to see whether suicide rates really have gone up I think they have umm after a period of having gone down. I think it's only perhaps as we hit the year mark that we'll start to see whether staff sickness rates have gone high and stayed high'
		Bethan	'because it's, we're trying to square the circle, there is not enough to go round and there's a lot of risk and we have to do this and it's too late to not go ahead with it... I think my role will be about making sure that I make myself heard and that if I'm not heard I say it anyway as an audit trail so if things go desperately wrong I can have the bitter satisfaction of being able to say, I said this at the time and nothing was done and it sounds like awfully defensive practice and I don't like it but I think it's going to be part of the role'
		Charlotte	'the trust want us to stay, no to be, more part of erm teams but I'm scared that if I stay a part of a team I can't do all the statistics, then I can't see four people a day and do all this this this so it feels ever so privileged to be as part of a team but I'm anxious I'll be told to climb out and see six people a day as I guess it's hard to actually prove my worth'

			here...Yeah and I'm just scared it isn't quite safe'
		Danielle	'I agree with umm consultation and supervision as much as possible and where people are interested and have a skill base that they want to develop... I would absolutely promote that, if that's what they want to do, but when it's imposed from on high, and they haven't signed up for it, I and they're not trained in it, umm, I think it starts to get very unsafe'
		Ellie	'But subsequently there were many changes of staff and for a long time they operated with a lot of locum staff. Which meant that there wasn't good consistency of care for the patients um and there was a lot of practice that was bordering on quite risky because patients weren't being seen enough. And their risk wasn't being thought about carefully enough. Um and there was a lot of fire-fighting, people had very heavy caseloads'
		Freddie	'um it feels that in trying to help kind of like certain people you need people from more than one profession you need that there, you need that in terms of managing risk I think so yeah that in terms of a professional sense I think is vital for safe and like effective practice... there being less teamwork I think it's more risky I think if I'm honest because the vast majority of big enquiries in to all sorts of failings of services always repeat the same thing a kind of lack of communication'
		Grace	'The risk management's always a challenge in MDTs when you don't have enough staff and it's not 24 hours and you know there are strict criteria for crisis team involvement. But you can get people who are really quite risky who are not suitable for the crisis team and you know I find that really challenging as a part-timer knowing I'm going off and it's quite a bit of time before I'm back. Um that's something that I think all CMHTs struggle with'
		Hazel	

Overarching Narrative	Stories	Participants	Quotes
Colleagues	'Corridor conferen	Alice	'is almost a bit of a sort of virtual team and a lot of the people who actually work in it aren't always based in this

cing and kettle conversations'		building they're based elsewhere, so you get the kind of long irate conversations going on over e-mail, nobody sits down together, whereas certainly in my old team...if you wanted to talk about something, you just went next door with a cup of tea and you had that conversation'
	Bethan	'it wasn't a daily thing but in a, in a light touch corridor conferencing kind of kettle conversation there was always space to have those conversations not for hours but certainly while the kettle boiled and because things didn't build up that was enough'
	Charlotte	'I haven't got the time to actually sit and talk and drink tea with the team and so that stops me connecting to the team'
	Danielle	'I suppose it's a kind of transference isn't it? When you sit in a team, in the team meeting room, you feel all their emotions, whereas when you sit outside of it, and just go to the team meeting, umm, it's contained differently or it's expressed differently maybe, I don't know...You can come in to a work place where someone will make you a cup of tea...that's a very different environment to go in to than turn the computer on, make your own cup of tea'
	Ellie	'I've got a very good working relationship with the team manager, she's very accessible and in fact I think we're all very accessible so we're all nearby to each other in our offices... Um I have a lot of informal conversations just waiting for the kettle to boil ...and again that was different in the last team, psychiatrists were over in the psychiatric unit with their PAs and I was somewhere else and the rest of the team were in a third place. So we were all very disparate and didn't have lots of those informal conversations.'
	Freddie	'with the consultant psychiatrist it was always more formal, um, seen less of him I suppose as well...so if I'm kind of in the office and I say does anyone fancy a drink or come in the morning or say how's the weekend been, if someone's in a separate office on their own you get less of that sort of interaction so things felt kind of more formal I think with the consultant psychiatrist um but I suppose there was less contact'
	Grace	'Yeah so communication in general is tricky. Multi-site, lots of people working different part-time hours, getting hold of people is not easy. There's a lot of waiting emails to be

			responded to. There's a lot of popping to see people who are not there um that's quite frustrating so casual conversations about clients is a bit hard to do... to try and overcome that I will chat with people who are making a cup of tea at the same time as me'	
		Hazel	'Oh it's always a different team and always a different profession you don't generally get it for the people that you see and of course one of the problems with the new teams is there are people you just don't see so it's very easy then to you know... it's just somewhere to locate that upset feeling you might have yourself... doing things in lots of different ways so you know that you check in for an offer of the tea round'	
	'A very welcome space'		Alice	'I think the organisation has encouraged that really because there's become now a sort of, a culture from management that having two people working with a patient is not time-efficient, it's wasteful and why would you have two people doing an assessment when you could only have one ...there is a bit of a drive to have as little involvement for a patient as possible'
			Bethan	'I was really lucky from the first six months in when the ward manager changed to somebody who had been one of the senior nurses and who was really quite pro psychology as opposed to slightly baffled by it... that two of the three shift leaders were also quite reflective and thinky and, two different professions and it just made it a very welcome space to try things out'
			Charlotte	'I think there are times uh where it is and times where it's tougher to get in so'
			Danielle	'if I'd have gone into the [first team] and just been professional me, I wouldn't have got anywhere very fast at all. I wouldn't have got the respect of anybody, I don't think they would have talked to me about a lot of stuff, whereas I didn't need to do that in [current team], because it was like that position was scaffolded already for me so I

			could just walk in and do a little less of the hearts and minds stuff and they would still seek me out for consultation or listen to what I had to say'
		Ellie	'So they're very respectful of psychology as a resource, they are very respectful of me, I'm used very well in the team so I've got a much more diverse role than I feel I was allowed to have in the previous team... and I have a regular slot on the team meeting agenda to update about all my cases'
		Freddie	'it was a new team manager who um, who the previous team he had worked with had a good relationship with the psychologist and it was clear to me that he wanted a good relationship with psychology in this new team as well...So I kind of like saw it as an opportunity for potentially psychology to take more of a lead on certain things'
		Grace	'in general I'd say psychology is valued. People want, they want their clients to access psychology, they're not disparaging of it'
		Hazel	'there are people who have very little time, faith or respect for therapists and I do, it really does have an effect because it really influences then how you then try and relate to so things that would get communicated don't get communicated um it's really hard to make yourself keep doing it when that's difficult so it has a massive impact'
	'It came down so much to individual personalities'	Alice	'I mean there was one particular person I'm thinking of in my old team who I was very fond of but who couldn't stop talking in meetings and it was quite a problem. This person took over all the air space. There isn't a character like that so much here. That's just a quirk of who you get in the team I guess...it was very much a personality quirk'
		Bethan	'I think that I think every team is different, every team room is different, we sit in four different rooms at the moment and the, the feeling in terms of how it is to sit there, is like a different mini team in each of them. Not with animosity or anything but I think similar people drifted together to kind

		of have the working relationship with the working environment that they found most comfortable... The relationships I've had with other professionals are, I think, as individual as each of the other professionals'
	Charlotte	'I have to really think about the way I deliver stuff and the personal circumstances of the staff and you know, shall I say x oh no she's tied up in all that stuff alright so I'll wait to ask x in a day or two's time. I guess it sounds almost narcissistic but I do think of my, the team as my clients and I have like a small formulation of them'
	Danielle	'and then the psychiatrists in [current team], have been totally different, much more psychologically minded, quite respectful of psychologists, not easily threatened, umm, quite happy for the medical model and the psychological models to sit next to each other and that would be fine, helping me guard my waiting list umm made for a much easier, much closer working relationship'
	Ellie	'A few years ago there were some ructions as one or two people didn't get on with each other and it was a bit of kind of a naughty school child stuff so people would move desks to different rooms and so on'
	Freddie	'by the time I left I felt kind of fairly connected I think um certainly definitely wasn't any divide in terms of like professionals it's more kind of like individuals if that makes sense um there were certain individuals within the team that I felt connected with and certain ones I didn't, I don't think that was reflected in terms of their professional centres or way of working'
	Grace	'it was fabulous when it worked but it didn't work all the time and then it was hideous because it came down so much to individual personalities ...So I think it's definitely you know. Yeah your personality just comes in with you doesn't it'
	Hazel	'whole sense of um you know what constitutes need, attitudes towards need, attitudes towards um hope all sorts of things like that can change quite a lot between two



			different places um but there's a huge difference in the teams, the bodies in them look the same but their attitudes, beliefs and their understandings...you get as many different sorts as there are people'
	'It doesn't happen overnight'	Alice	'I think that you just can't create those kinds of working relationships overnight. They only kind of evolve over a period of a long period of time and going through a lot together you know, you have the happy times together, where you have a laugh, or you might have something really unpleasant, like a suicide, or something that you will have to come together over... yes, takes a long time to get to that level of intimacy with people'
		Bethan	'I think it's not impacting too much on it because we've got existing working relationships and because we've known each other a long time'
		Charlotte	'I think it could be time, you know, with this team, and also I think perhaps I've seen some erm tricky customers and so I've almost, got more respect as often the psychiatrist says oh I saw so-and-so and they were positive about your work together'
		Danielle	'the idea that I could have contained them at 27 to their 50 whatever, would have just been a source of absolute hysteria I suspect, although over time, I think that did actually, maybe I'm over-crediting myself, something that did emerge I think because mainly because I was outspoken and bolshie and they could relate to that side of me, umm, so, yes'
		Ellie	'of course the longer I was there the more of an embedded presence I was. So I think that, I think probably that made the most difference. ...it felt to me like what was important was just slowly building a reputation and trusting that I would, that I do a good job and that that would eventually be recognised. And it was'

	Freddie	‘so a lot of it at the beginning seemed to be kind of reassuring people so I think people were reluctant to discuss about cases as though I was going to say oh you’re doing all these things wrong you should be doing this instead...and it was quite nice because it took a while but people started to like warm to the idea and found me a bit more approachable’	
	Grace	‘I think there’s still some people around in the team who have known one another for quite a long time and have worked together and have probably worked together in easier times so know that that person is good, know that that person is hard working, know that that person is good with clients and therefore they respect and trust them’	
	Hazel	‘I’ve always thought that getting in and getting my hands dirty is very important so you know you’re not going to get anyone’s respect by just standing there and stamping your feet and demanding it and I’ve never seen that go well but I think that by that shared work that’s the bit about working very collaboratively together you begin to get more of that’	

Overarching Narrative	Stories	Participants	Quotes
System	‘The teams are all changing ,	Alice	‘perfectly pleasant people but they’ll be here today, gone tomorrow...I mean the number of of staff who are agency, there are yes, large numbers of staff who are not permanent staff here. That doesn’t help...the way that we work isn't set up for joint team working anymore’
		Bethan	‘but for the new colleagues whom I’ll be working with and I’ll be in a team for whom many of the colleagues I’ll be working with are strangers. It will be about renegotiating those relationships... But in our room bad things have happened to colleagues too in the sense of having been disregarded for their specialist skill so it, it’s kind of taken that away already that feeling of safety’

		Charlotte	
		Danielle	<p>'and the teams are all changing. Its been on the horizon so we can't ignore that back drop of, yes, I've been part of this team for 18 months, but from that time, it's just been change upon change and we've all known that, at some point, we're going to be disbanded and reformed in to different kinds of teams'</p>
		Ellie	<p>'There was a lot of change going on but there always is. So at the time it felt like this was an unusual thing because I was newly qualified but actually it's continued to be all change all of the time. So I think I had felt that at some point everything would settle, um but it never and it never does in teams anyway because the staff were always changing, if nothing else...So we had some fairly big organisational changes, we had location changes, we had team manager changes'</p>
		Freddie	<p>'it almost seemed like everyone was in mourning because of the people that had gone...and why people are reluctant to maybe share when they are struggling is I don't know maybe it's often a bit of atmosphere of um almost like divide and conquer almost that sense of, maybe this seems overly negative but, every one kind of looking after themselves, making sure that they're ok... it's all very individual focused, and wanting to make sure they can keep their job'</p>
		Grace	<p>'And they were a bit in disarray, they were having all kinds of changes, that's an absolute common theme. CMHTs just endlessly appear to be undergoing some kind of restructuring that the team itself does not want, um where it's sold as something in the benefit of teams and clients but everybody knows it's about money'</p>
		Hazel	<p>'well it doesn't go fast uh yeah um it's little things isn't it, I mean it's very easy for people to get very dispirited and particularly when you've got such shifting sands as we have with the current teams where as I say we've got lots of agency. I think it's probably across the NHS but there's a lot</p>

			of agency staff so you might not create huge change instantly'
	'An element of hierarchy'	Alice	'he was a consultant psychiatrist so I think that perhaps there is something that goes with the role that they feel under pressure to be leaders and set examples and you know guide the rest of the team... I think it leads to sort of you know tensions and sometimes people pulling rank on other people and trying to make them do things'
		Bethan	'all that separateness so that's been an element of hierarchy and some people being horrible to people they perceive as lower in the hierarchy than they are or feeling that they can make more demands of people lower in the hierarchy, um and just assuming as opposed to asking nicely which I think is rude because asking nicely doesn't cost me anything but that's my personal philosophy and again it's not one that I have the right to stamp on anyone else'
		Charlotte	'but I am aware of a strong power divide where it's the psychiatrists, not on top and I'm at the bottom, so like as in like powerful to powerless and so I guess at the start I would stay in the powerless position but now I'm much more assertive and I try to be in an equal and sort of try to bring him or her down to here'
		Danielle	'The [first team] psychiatrist umm was extremely hierarchical, believed very much in an authoritarian kind of leadership, where she had the expectation that what she said should go and it's not in the custom of being challenged in any way and found it deeply offensive on a personal affront if you did... so that became part of my role as the psychologist, to counterbalance that'
		Ellie	'we didn't have very good leadership which meant from the team manager's side of things which meant that the psychiatrist became very powerful. Um there were a couple of nurses in the team who were very old school nurses and I think that then supported the powers that psychiatrists have because those particular nurses were used to deferring to the doctors.'
		Freddie	'it was just different I think in that context and maybe it felt, well it was interesting really there's maybe something,

			it felt I was talking with the consultant psychiatrist whereas when it was the support worker it felt like I was speaking to x or I was speaking to x and maybe that kind of sums it up'
		Grace	'Psychiatrists are um, uh well, they, being absolutely honest they think they're more important which in a sense they are, in terms of um legal, the kind of legal framework. Um so I think they're just more used to being listened to when they want to be listened to and therefore if they want to speak to a psychologist they'll speak to a psychologist'
		Hazel	'she just said 'it was so different having you here' even though there are other therapists around it was something about that authority and I think being there then allowed her to say something she wouldn't of at other times so they have um, they find it much harder to influence when you're a small number um and that's why it's important to kind of get together and work together'
	'Maybe it's more to do with the structure'	Alice	'the multi-disciplinary bit isn't the biggest part of it if you've got, you know, people are people, and I think if you set organisations up such that a team culture can flourish, the fact that you come at things from different points of view, umm, ought to be something that you can thrash out, so you can come to an understanding over'
		Bethan	'will be replaced by the new standard of possibly more separate, more compartmentalised, more target-driven environments...my perception of what it can be like affects my or feeds into my degree of disgruntlement about what it can no longer be like due to all sorts of external factors that are outside of, well possibly the NHS' control'
		Charlotte	'I think it's hard because you know the trust want us to stay, no to be, more part of um teams but I'm scared that if I stay a part of a team I can't do all the statistics, then I can't see four people a day and do all this this this so it feels ever so privileged to be as part of a team but I'm anxious I'll be told to climb out and see six people a day'
		Danielle	'the team's autonomy has been really eroded by a lot of these changes that are happening, so they've brought in a team that um like triages all the referrals, so some unknown people in the ether screen all the referrals...but it means that, when it comes into the team meeting, we don't

			have any agency at all now to accept or reject referrals. We have to accept everything that comes through most of which are inappropriate, so it's a massively disempowering environment'
		Ellie	'I don't feel that the Trust as a whole has gone seeking to get the very best team leaders for the teams and I think if they did it would be a whole lot easier in that team.. and I think also um the level above the team managers and perhaps also above that have not taken it seriously enough...I think it left people feeling quite a powerless position'
		Freddie	'I uh probably think that kind of like the current political climate being very much around internal markets in the NHS and kind of like with it being privatised I have the feeling that what that will mean is that there will be less team work... but because of some of the changes in the trust it means that psychology runs in a different way to how it was previously and I think that's causing some conflict'
		Grace	'do get quite uh quite you know pissed off, pardon my French for delays or people being declined or um and that's worse now that we are being much more tight on ...I would say like to be able to offer people more um and I think it helps you articulate why and what what's really quite distressing quite a lot of the time about how little we can offer... and I can offer them twenty sessions and like it's not even going to touch the sides or whatever'
		Hazel	'it's been a massive difference, we do notice we got a lot of positive response about how much more involved we are. But it's definitely the opposite from the psychiatrists. I don't mean to say, I don't think that's to do with the individuals so much, it's that, maybe it's more to do with the structure'
	'A lot of pressure to get things done'	Alice	'It's just that nobody quite knows what to do with it because it feels too big for one individual to resolve umm and, as I say, nobody has the time or the inclination to take on any other kind of project given that everyone's you know everyone's going flat out'

		Bethan	'I don't feel that psychologists are particularly listened to because we're not a large profession in the trust and it's a little bit like um standing on a hill and shouting into the wilderness sometimes because under pressure everybody reverts to what they know understandably'
		Charlotte	'that stops me connecting to the team but also when the team is stressed and they have a lot of pressure to get things done they stop taking time to talk and to think as they're doing other stuff, you know, like paperwork or stuff'
		Danielle	'No, its pretty much been constant throughout and could be a facet of them being boundaried and everyone being so busy that you just don't have time for the chats and it could be a response to me being much more unapologetically clinical about certain stuff and clearly busy so it's hard to know'
		Ellie	'the most tension seemed to be in the admin room with the admin staff...these people in difficult situation, you know, other staff members come in and yak on about their cases while they're trying to type a letter and answer the telephone and deal with the psychiatrist coming in and saying where are my case files, I can't find them. So it's a very stressful environment for them and they sometimes rub each other up the wrong way so it can be a bit of a hot bed in that room'
		Freddie	'and I think you can want things done sometimes as well so yeah I think there's those sorts of sides of it...so I was very much in an office on my own away from the team and to be honest having that time was quite nice because I used to get a lot of paperwork done'
		Grace	'I think sometimes they end up just being seen by psychology and there is no sense of the rest of the team being interested or involved ... They think what can I do for them...and uh really want to disengage from them. Um and have you, you have it now, you have this client. And that is a challenge, that's just everybody struggles with that stuff. No-one wants to be left holding someone they can't help,

			who feels risky. It's not a pleasant sensation is it really?'
		Hazel	'everything improves but it doesn't take much for that to reignite and come back again, it's never really dealt with because actually the reality the problem of it as I see it, being fuelled by those professions being overworked so it fuels it and fuels it and fuels it... so there's lots of talk about how busy we are which in turn is basically indirectly saying 'and are you really that busy''
	'There needs to be permission'	Alice	'but I think the organisation has encouraged that really because there's become now a sort of / a culture from management that having two people working with a patient is not time-efficient, it's wasteful and why would you have two people doing an assessment when you could only have one or if you are seeing this patient does that person really need to be involved and I think, in the interests of everything being efficient, which is obviously the buzz word of the moment, umm, there is a bit of a drive to have as little involvement for a patient as possible'
		Bethan	'Um but people have let me do that'
		Charlotte	
		Danielle	'I felt like in order to fit in, there was definitely / I had to sacrifice something of my psychological self sometimes (hmm) and that can be a bit unnerving and you don't have to do that so much if you're in an environment where there's lots of psychologists or there's just the clearly reflective sort of milieu umm / it's easier to get lost I suspect when you are the only psychologist in MDT team (hmm) where they're less / where they are more medically minded or there is much more of a black and white sort of idea of how things are.'
		Ellie	'I think generally psychological therapies are, have always been well regarded in the Trust. So even though there was conflict between psychiatry and psychology service, I don't think any of the psychiatrists would have said that they didn't want psychologists around. I think they just, they were frustrated that they didn't have enough and they were taking it out on psychologists rather than trying to deal with it differently. Um yeah so I, I don't think I've ever encountered anybody that I felt was really very against psychological therapies. Um and it would be quite difficult now anyway because I mean there's been so much publicity and Government initiative around psychological therapies that, and the patients are talking about all the time, it's on the



			internet, what the NICE guidelines are about and people are asking for what they want now – patients’
		Freddie	“So I kind of like saw it as an opportunity for potentially psychology to take more of a lead on certain things, um, so yeah that’s the way I took it...Yeah um I think, my sense so far is it’s quite good as in terms of psychology, I think people are quite open, um to working in a psychologically-informed manner, um I think people have had more training here which helps and kind of like there’s a bigger emphasis on psychology but because of some of the changes in the trust it means that psychology runs in a different way to how it was previously and I think that’s causing some conflict’
		Grace	‘Uh and as said I mean in general I’d say psychology is valued. People want, they want their clients to access psychology, they’re not disparaging of it. Um if anything really too far at the other end they think psychology may...(fix everything) do magical things, fix stuff which you know which it just doesn’t. But um uh but it’s nice’
		Hazel	‘I think it makes a massive difference so where it’s not good and we’ve got some clients um people that we work with at the moment there are people who have very little time, faith or respect for therapists and I do, it really does have an effect because it really influences then how you then try and relate to so things that would get communicated don’t get communicated um it’s really hard to make yourself keep doing it when that’s difficult so it has a massive impact and that could have very practical outcomes for those clients, they might not get offered as much choice, they might not get offered therapies in fact by some of those people’
		Alice	‘Yes, there's not enough time for that any more either. I think we've had three newcomers into the psychological therapies team and certainly two of them have sort of complained fairly bitterly that there's nowhere to, there's no time to stop and think, there's no time for case discussions, umm, yes, there just isn't that. Everybody is so busy. You kind of frantically go from one thing to the next and there isn't any time for thinking any more’
		Bethan	‘not through ill will but through lack of capacity, lack of capacity, lack of space to think because space to think is something commissioners understandably don’t pay for ...there’s just too much stress in the system for there to be
	‘There isn’t any time for thinking’		

		any give, for people to have any thinking space and it feels a bit, no it feels very dangerous, I think people are going to die and I'm not looking forward to the prospect'
	Charlotte	'I haven't got the time to actually sit and talk and drink tea with the team and so that stops me connecting to the team but also when the team is stressed and they have a lot of pressure to get things done they stop taking time to talk and to think'
	Danielle	'I think another major challenge is there is so much more demand than our capacity to meet and wanting to give to the service users, to give to the staff, especially when you know that they're all maxed out and actually they need something from you and having to say to them, you know what, I cannot / this is my limit'
	Ellie	'so in a dysfunctional team you're much more likely to get patients presenting in crisis and so the focus then of everybody's energies is about managing the crisis stuff and that makes it difficult to kind of slow down the pace and think about what's going on in the team because it, all the energy goes to the reactive stuff'
	Freddie	'being separate from the team can sometimes mean I have more time to reflect, and things can be calmer'
	Grace	'at the same time it's difficult to hold onto that when it's impacting on you negatively in the immediate sense such as having a client you're worried about, needing to find someone to speak to, not being able to find someone to speak to, or when you find them they look annoyed because it's coming to the end of the day and they've got a million things to finish off'
	Hazel	'that's the reality and so that then makes a very good difference in the space that people have to think or do things'