A Grounded Theory Study of Multidisciplinary Staff Views on Participating in Team Formulation

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Abstract

Background: The use of psychological formulation within teams is steadily growing in popularity, although research surrounding its use is limited. This study aimed to explore the experience of multidisciplinary professionals outside of psychology in participating in team formulation sessions.

Method: Constructivist Grounded Theory was used to analyse semi-structured interviews conducted with ten members of staff from a variety of professional backgrounds working within two adult mental health teams, one within community settings and the other inpatient. Interviews were transcribed and then subjected to line-by-line coding, from which categories were derived.

Results: The emerging model of team formulation comprised of four core categories: 'The 'right' facilitator', 'Co-Creating safety', 'A unique meeting' and 'Changes for staff'. The values held by the facilitator and their position within the team were paramount in ensuring that formulation was perceived as a 'safe' environment for staff to voice their opinions. These were perceived to be the key ingredients in staff positioning team formulation as 'different' to other multi-profession meetings. This was seen to relate to an absence of professional hierarchy and an acceptance of ambiguity when contributing information or ideas. These factors facilitated changes in relationships within the team, increased staff confidence and a new understanding of service users.

Conclusion: This study indicated an underlying mechanism to explain the process of creating change as an outcome of team formulation. The results are discussed with reference to existing literature and the implications for clinical practice and research are outlined.

Keywords: Team formulation, Multidisciplinary Staff, Adult Mental Health, Constructivist Grounded Theory

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CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

1.1.1 Overview of thesis

Psychological formulation is an embedded competency of clinical psychology as a core component of clinical practice (British Psychological Society, 2010; Health and Care Professions Council, 2012; Kinderman and Tai, 2007). A formulation, when used within mental health context, aims to enable the practitioner to develop hypotheses regarding the cause and maintaining components of an individuals' psychological presentation. Traditionally this process has taken place between individuals or small systems, such as within systemic family therapy (Johnstone and Dallos, 2006). However in more recent years formulation is being used within teams as a mechanism for multidisciplinary colleagues to contribute towards the formulation process, which is referred to as 'team formulation' (Johnstone, 2013).

The current study explored the experiences and views of multidisciplinary staff regarding the use of team formulation. A qualitative methodology was adopted for the purpose of the study, as this was considered as the most appropriate method through which to explore staffs' understanding and experience of participating in team formulation meetings and to ensure that the resulting theory was immersed within clinical practice. It is intended that the study will contribute to a wider understanding of how professionals who do not come from a psychology training background perceive team formulation and understand the outcomes of team formulation.

This thesis comprises of four chapters. In the first chapter (Introduction) an appraisal of relevant literature surrounding formulation to date is provided so as to orientate the reader to background information surrounding the thesis topic. A systematic

review of research to relevant literature surrounding psychological formulation is also presented. Chapter two (Methodology) provides a rationale for the research design adopted for the current study, including the use of Constructivist Grounded Theory as the method of data collection and analysis. Methods used to identify and recruit participants is considered and participant demographics are provided. The penultimate chapter (Results) presents the findings of the data analysis, and in keeping with the methodology a theory is delivered to explain the experience of the participants' involvement in team formulation. The final chapter (Discussion) provides a key summary of the research findings whilst also outlining limitations of the study. Implications for future clinical practice and research are explored.

1.1.2 Overview of current chapter

This chapter provides a comprehensive background of literature surrounding formulation and research surrounding the increasingly popular use of team formulation. Historical perspectives of psychological distress culminating in the development of psychological formulation will be considered. A background of the context within which this study was set is considered; namely multidisciplinary working within an adult mental health setting. A systematic review of research pertinent to the utility of formulation is provided and the aims of the current study outlined.

1.1.3 Overview of terms used

In writing this thesis it has to be recognised that the concept of 'mental health or illness' and the people who receive services in support of difficulties are referred to in literature by many terms. As stated within the researcher's position statement (Chapter 2, section 2.2.3) they do not subscribe to the idea of 'mental illness', however it is recognised that this is not the perspective held by all. Therefore throughout the thesis the terms 'mental health difficulties', 'psychological distress', 'diagnosis' and 'disorder' will be used as reported within original sources to account

for an individual's difficulty or problem which leads them to seek psychological or psychiatric services.

This is also relevant for the use of the term 'service user', 'patient', 'client' to describe those who seek and use a service, where these terms are given within the original source.

1.2 PSYCHOLOGICAL FORMULATION

In order to contextualise the clinical use of formulation the historical perspective of psychological distress is briefly explored, followed by a definition of formulation and review of the literature to date.

1.2.1 Perception of psychological distress leading to formulation

The term 'mental health' is defined by the World Health Organisation (2014) as "*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*". Conversely, an inability to meet these criteria has led to the concept of 'mental illness', which underpins the psychiatric model of treatment for those experiencing emotional difficulties.

Formulation was developed during the emergence of the scientist-practitioner model in the 1950s (Kennedy & Llewelyn, 2001). The term *formulation* was first publicised within regulations for the profession of clinical psychology in 1969 (Crellin, 1998). It is believed that contributions from many influential clinicians including Eysenck, Meyer and Shapiro developed individualised alternatives to psychiatric diagnosis, based on operant learning theory (Division of Clinical Psychology, 2001). This was the basis of modern day psychological formulation.

1.2.2.1 Defining Formulation

Current definitions within existing literature centre on the concept of formulation as using information from a variety of sources to develop hypotheses surrounding a problem, as opposed to finding one 'fixed truth'. For the purpose of this thesis the definition provided by the Division of Clinical Psychology (2010) was deemed most appropriate:

> *"Formulation is the summation and integration of the knowledge acquired by the assessment process... This will draw on psychological theory and data to provide a framework for describing a problem, how it developed and is being maintained". (p.5-6)*

This definition was preferred, in part due to the encompassment of describing the process underlying formulation including the need for this to be informed by psychological theory. The majority of alternative definitions within existing literature are written from a psychiatric perspective (such as Eells, 1997; Weeraskera, 1996). These definitions lack any consideration of psychological theory as contributing towards resultant hypotheses surrounding the problem. However as noted by Johnstone & Dallos (2006), definitions to date neglect to include the role of the client in providing the information used to develop the formulation. This reflects a current uncertainty in clinical practice as to whether formulations are always constructed with a client, as opposed to formulation being a process that is 'done to' the client.

This broad definition of formulation recognises that the structure and even the content of formulation can vary, depending on the therapeutic framework used. For example in psychoanalysis the process of formulating is termed *interpretation* (Winnicott *et al*, 1989).

1.2.3 Aim of formulation

In a broad context, the Division of Clinical Psychology (2010) advocates the use of formulation to reinforce the core values and aims of clinical psychology as a profession; which namely include the promotion of psychologically-informed ways of thinking, to value cultural, social and racial influences at an individual and societal level and perhaps most relevant to formulation: To enable individuals to have the skills and abilities necessary to enhance emotional well-being and respond to difficulties. The use of formulation also promotes the linking of theory to practice for psychologists (Butler, 2006).

The mechanism underpinning psychological formulation requires the practitioner to generate hypotheses to summarise a client's difficulties and to provide links between these to demonstrate how the difficulties may have been caused and how they are presently maintained (Johnstone & Dallos, 2006). The incorporation of psychological theory and knowledge to develop hypotheses is paramount. Within the therapeutic relationship formulation should be used as a process of 'ongoing collaboration and sense-making', with the therapist seeking to utilise psychological theory in order to explain the development and maintenance of difficulties (Harper & Moss, 2003. p8).

The aims of formulation transcend beyond providing possible explanations. They may also be used to develop interventions that are tailored to the individual needs of the service user, and regularly reviewed (evaluated) and re-formulated if need be (Johnstone & Dallos, 2006). In this way, formulation informs and interacts with other three stages of the clinical cycle: Assessment, Intervention and Evaluation.

The aim of formulation holds different meanings to other professionals involved in mental health care. Psychiatry trainees, for example, are required to utilise formulation to hypothesise about client's difficulties but within the framework of the biological model, resulting in the perceived use of formulation being to support psychiatric diagnosis (Division of Clinical Psychology, 2011).

1.2.4 Benefits of formulation

The literature to date indicates a number of positive outcomes from the use of psychological formulation to understand an individual and their difficulties, although the research base for formulation overall is limited. Benefits are described as being not purely limited to the outcome for the service user, but also to the wider support system around them. However it is important to note that the majority of research to date has focussed on staff responses to formulation, leaving a distinct lack of research involving service users (Johnstone, 2006).

Although the main purpose of a formulation is arguably to identify the best way forward and inform interventions (Division of Clinical Psychology, 2011), there are additional benefits to using formulation, as suggested via practice-based reports. These include clarifying hypotheses and questions (from both therapist and service user), enhancing the ability to predict future difficulties, helping the service user to feel listened to and understood and increasing the service user's sense of agency, meaning and hope (Butler *et al*, 1998; Corrie & Lane, 2010; Johnstone & Dallos, 2006). Although The Division of Clinical Psychology (DCP, 2011) uses these studies to justify formulation as being beneficial the interpretations made by the DCP should be considered with caution. In the majority of these studies the researcher was either a trainee clinical psychologist or a clinical psychologist, which may have led participants to provide socially desirable responses.

Historically, comparisons between individually tailored case conception and manualised approaches have tended to favour the outcomes of manualised therapies. However recent research is beginning to establish an evidence base for the use of individualised therapy over manualised approaches. Ghaderi (2006) adopted a randomised control trial design utilising a sample of 50 patients with a diagnosis of bulimia nervosa, with half allocated to manualised therapy and the others given individualised therapy which utilised formulation as part of the process, in this case cognitive behaviour therapy. There was no significant different between the improvements displayed within both conditions, however within the 20% of

participants who showed no improvement following intervention, 80% of these were in the manualised approach condition. This may indicate interventions and approaches being tailored to the individual may impact on the likelihood of improvement being demonstrated.

1.2.5 Criticisms of formulation

Psychological formulation is not without controversy and has attracted criticisms regarding validity ('usefulness') and whether the process of sharing the formulation actually holds negative consequences for the client (Chadwick *et al,* 2003; Johnstone & Dallos, 2006). As recognised previously there is limited research to date that has attempted to explore the impact of formulation from the service user's perspective. However the existing literature in this field suggests that for service users formulation can be a negative experience, even going so far as to suggest that service users find formulation a shaming experience that emphasises personal deficits (Boyle, 2001; Gilbert, 1998). This appears in direct contrast to the growing base of staff research purporting formulation as a positive experience.

Leeming, Boyle & MacDonald (2009) conducted semi-structured interviews with 22 clients of mental health services in order to explore the clients' experiences of formulation. The study adopted thematic analysis to derive themes from the data. Despite implying that several themes were established only two are considered within the paper: *Difficulties with using psychosocial explanations* and *Diagnosis as both Damnation and Salvation.* Many participants reported having a psychosocial understanding of their difficulties following formulation, but found it easier to understand when integrating this with their psychiatric diagnosis.

Castillo (2000) provides an account of one client who experienced formulation as a therapist-driven process, reporting that parts of their personal history that they placed importance on were overlooked and the resulting formulation was merely a reflection of the therapist's perspective. Not only does this highlight the need for formulations to be a shared process in order to have meaning for both client and therapist, but it also emphasises that the usefulness of a formulation is in part

dependent on the meaning that it holds for the client. Similarly, Chadwick, Williams & Mackenzie (2003) found that half of the participants interviewed regarding the process of receiving a formulation reported negative emotions. These included finding the formulation complicated to understand and clients feeling less optimistic about their ability to change (due to not realising the longstanding nature of difficulties). This study also found no significant impact of formulation on symptoms of anxiety or depression.

There remains a paucity in studies to date that examine the benefits of formulation from the perspective of the service user (Chadwick *et al*, 2003; Emmelkamp *et al,* 1994; Leeming *et al,* 2009; Schulte *et* al, 1992). None of these studies were able to demonstrate any significant impact of formulation on treatment outcomes when formulation-based interventions are compared with standardised (non-formulation) interventions or no intervention.

Very few studies have reported negative reactions from staff to formulation, which poses an interesting line of enquiry as to why there appears to be this apparent divide between professionals and service users in the evaluation of formulation. Mohtashemi *et al* (2016) found when discussing formulation in teams with psychiatrists that some participants viewed the integration of formulation into teams a direct threat to their own profession from psychology. However other participant within the same study felt that formulation provided a bridge between the two professions, indicating that opinion was divided as the whether formulation was beneficial in this context. These findings touch upon the underlying views held by some professionals that psychological formulation could challenge the traditional view of distress as being a 'psychiatric illness'.

1.2.6 Formulation as an alternative to psychiatric diagnosis

The debate as to whether formulation can truly be considered a viable alternative to psychiatric diagnosis is ongoing within the field of mental health. Firstly it is

important to consider the potential overlap between the professions of psychiatry and psychology in relation to explaining a service user's difficulties. Formulation is a core component of training for psychiatrists (Royal College of Psychiatrists, 2010), even incorporating psychotherapeutic models such as psychodynamic formulation (Mace & Binyon, 2005). However whilst both seek to explain an individual's difficulties, a core difference between a psychological and psychiatric formulation is the role of diagnosis within the formulation and the resultant importance placed on diagnosis.

It is a requirement of psychiatric formulation to include 'appropriate differential diagnoses' (Royal College of Psychiatry, 2010. p25). In contrast a psychological formulation does not require diagnosis to be featured, which alludes to the underpinning philosophy that a psychiatric diagnosis does not provide adequate explanation regarding the cause or maintenance of a person's distress. This has led to a movement within the profession of clinical psychology for psychological formulation to be considered as an alternative to psychiatric diagnosis.

Arguably the best summary of proposed differences between psychiatric formulation and psychological formulation is provided by Johnstone (2013). Figure 1.1 below presents a comparison of diagnosis and formulation in order to demonstrate how the use of psychological formulation may counteract the arguable limitations of psychiatric diagnosis.

Figure 1.1 Comparison of Diagnosis vs. Formulation, Johnstone (2013).

Psychiatric Diagnosis	Psychological Formulation
Removes meaning	Creates meaning
Removes agency ('sick role')	Promotes agency
Removes social contexts	Can include social contexts
Individualises	Includes relationships
Keeps relationships stuck	Looks at relationship change
Expert-derived	Collaborative
Stigmatising	Normalising
Culture-blind	Culture-sensitive
Deficit-based	Includes strengths and achievements
Medical consequences	Non-medical
Social consequences	No social consequences

Within clinical practice psychologists have expanded their use of formulation from individual use to facilitating formulations within a team setting.

1.2.7 Team Formulation

The Division of Clinical Psychology (2011) states that clinical psychology should position itself as leading on the development of formulations within teams. Christofides, Johnstone & Musa (2011) found from interviewing clinical psychologists that there were a number of ways in which participants encouraged the integration of psychological formulation within their everyday practice in teams. The main feature was that psychologists used informal methods such as away days or allocated team training time to subtly implement psychological ideas within the team over time, which led to some multidisciplinary team members using the term 'formulation' to describe the process of coming together and sharing hypotheses. Johnstone (2014) summarises the various attempts to formally define term 'team formulation' as being broadly divided into: Co-constructing a team formulation in response to a particular request (when a team feels 'stuck' in working with a

particular service user), regular formulation meetings for the whole team (for various needs such as service user engagement, assessing risk or planning care following discharge) and Integrating formulation into the work of the team and service at every level. Johnstone notes that whilst this is likely to be universal goal of clinical psychologists, it is ambitious and has to date only been reported as achieved by Dexter-Smith (2010), working within older adult settings.

1.2.7.1 Additional benefits of team formulation

The Division of Clinical Psychology (2011) guidelines for the use of formulation consider additional benefits of using formulation with teams compared to use by psychologists alone. These include the following benefits in relation to team working: Promoting and facilitating collaboration, providing support amongst staff, aiding risk management, improving staff perspectives of service users, generating new information and ways of thinking and recognising the expertise of other professions (and utilising this to devise interventions).

There has been limited research on team formulation to date to validate the benefits that professionals report anecdotally, such as Hewitt (2008) who reported that following team formulation staff expressed feeling validated and involved in collaboratively devising interventions by drawing on staff expertise. To the knowledge of the author four studies exist to date that specifically explored the benefits of team formulation, all but one of which adopted a qualitative methodology to explore staff experiences. The three qualitative studies are summarised and critiqued within the systematic review (Chapter 1.5), however the remaining study (Hollingworth & Johnstone, 2014) was not published in a peer reviewed journal and was therefore excluded from being included in the review.

Hollingworth & Johnstone (2014) carried out a brief quantitative study of staff attitudes towards team formulation after they had completed a formulation workshop. All of the participants reported finding that the meetings had helped to

develop a shared team understanding of a client's problems, strengths and difficulties, generate new ideas about working with the client, draw on the knowledge and skills from different professional backgrounds, develop an intervention plan and improve risk management. Whilst taking the potential of demand characteristics into account, this provides a hopeful account of the benefits of team formulation none the less.

Research has suggested that delivering staff training in team formulation can act as a vehicle for culture-change within multidisciplinary teams and encourage psychological ways of thinking (Dexter-Smith, Hopper & Sharpe, 2015). There is also evidence through qualitative research that staff (described as 'non clinical psychologists') found team formulation as providing staff cohesion, creating new ways of thinking, improving staff relationships with service users and each other and holding an increased understanding of service users (Hood, Johnstone and Christofides, 2013).

1.2.7.2 Barriers to implementing team formulation

Although there are proposed attractive benefits to using team formulation there are barriers to implementing it as part of routine team practice such as time constraints (Mohtashemi *et al*, 2016), which suggested that team formulation relies on the co-operation and availability of the wider team.

Previous research has considered formulation as being one of the 'most complex skills' used within therapy (Kuyken *et al*, 2008). This is also supported by Zivor *et* al (2013), who advocate that professionals facilitating formulation require specialist training due to the complex nature of incorporating psychological theory with individual experiences. Given that clinical psychology holds formulation as a core competency it is perhaps not surprising that the majority of team formulations to date are facilitated in teams purely by psychologists. Whilst this ensures that the facilitator is competent in the skills of formulation it also limits the number of professionals in a team that feel able to hold team formulations.

There are also practical barriers to facilitating team formulation on a regular basis. Johnstone (2014) states that core components of effective team formulation should include availability of specifically allocated time alongside the presence and contribution of all multidisciplinary professionals. This highlights the challenge within the fast pace that mental health services must work to in finding a protected time that enables all relevant staff to the service user to attend formulation meetings. A further difficulty once professionals are gathered is ensuring that staff are best enabled to feel that they can contribute information and ideas.

1.2.7.3 Limited research base to date

Despite the emerging policy and guideline base for team formulation there is still a degree of inconsistency and uncertainty surrounding the use of formulation within mental health settings, both individually and within teams namely due to confusion over the definition of team formulation and identifying key elements (Mellsop & Clapham Howard, 2012). Dudley, Kuyken & Padesky (2011) also recognise that although psychology views formulation as an essential component of effective therapy, it has proven difficult to demonstrate that formulation has had a direct clinical impact within a multidisciplinary setting.

Team formulation is challenging to evidence via research as in addition to the outlined issues above there are still the existing complications that hinder research into individual formulations, i.e. the complex and individual nature of each formulation which does not lend well to a randomised control trial design. This is compounded by the awareness that the formulation is but one piece of the 'treatment outcome puzzle', with external factors such as client support and motivation holding the key to positive outcome within therapy. This could be seen as an argument for the use of practice-based evidence as opposed to purely evidence-based practice within clinical psychology.

1.3 MULTIDISCIPLINARY WORKING WITHIN MENTAL HEALTH

Legislation within the UK has long emphasised the importance of multidisciplinary team working to provide mental health services (Department of Health, 1997; 1998). Guidance states that teams should incorporate a range of knowledge and skills from varied disciplines in reflection of the complex nature of problems presented by mental health service users. Collaborative working via a multidisciplinary team is supported in order to achieve the best use of clinical time and resources, resulting in consistent standards and higher levels of service user satisfaction. Within these teams in NHS settings the role of clinical psychology is defined as therapist, supervisor, consultant and trainer via the application of specialist knowledge and skills (Lavender and Paxton, 2004). In addition to this clinical psychologists have a responsibility to promote individual and group therapies and to utilise psychological formulation to provide a better understanding of service user difficulties (Mace, 2007). Other professions have started to incorporate the use of formulation within practice, including therapists, social workers and mental health nurses (Crowe and Carlyle, 2008).

1.4 SETTING THE SCENE: ADULT MENTAL HEALTH SERVICES

1.4.1 Aims and set-up of Adult Mental Health services

Within the UK adult mental health (AMH) services aim of offer interventions to the population aged between 18-65 (Social Care Institute for Excellence, 2012). Nearly one in five adults experience the most common forms of mental health problem (Office for National Statistics, 2013), whilst a recent survey in Wales suggested that 12% of adults were receiving treatment for mental health difficulties (Welsh Health Survey, 2015). Estimates regarding the prevalence of mental health problems within the adult population vary, which is likely to reflect the discrepancy between the

prevalence of mental health difficulties occurring and the percentage who then seek intervention in relation to this.

1.4.2 Relevant legislation and policy

The framework under which AMH teams operate is guided by two key policies: the Care Programme Approach (CPA; 1990) and the NHS and Community Care Act (1990). The CPA suggested the need for four elements to ensure effective mental health care for individuals with severe mental health difficulties: A systematic arrangement for assessing mental health (including social needs), the formation of a care plan which identified key needs and labelled the providers required to meet these needs, the appointment of a key worker (whose role is to act as a co-ordinator between the individual and the care plan to ensure that progress towards meeting needs is fulfilled) and for the care plan to be reviewed regularly and altered if necessary. Given the context of the current research it is important to note that in Wales the CPA was replaced by the Mental Health Measure (MHM) in 2012, however the main elements of CPA are still incorporated under Part Two of the measure. Given that one of the main elements under the CPA is the need for collaborative working in mental health it could be seen as direct support for the use of formulation within teams to facilitate inter-disciplinary ways of working.

The NHS and Community Care Act (1990) states that it is the duty of local authorities to assess an individuals' need for health and social care within the community. The aim of the act has been to enable the tailoring of services to meet individual needs through specialist care provision and to ensure joint care planning occurs across services (Leathard, 2004). This arguably supports the use of multidisciplinary teams to inform care planning and delivery through the incorporation of specialist approaches and knowledge within each discipline.

Much of the purported benefits of psychological formulation (both within teams and individual practice) have been based on anecdotal accounts of its use within clinical

practice. Therefore it was considered appropriate for a systematic review to explore the current research base surrounding the impact of psychological formulation.

1.5 SYSTEMATIC REVIEW

1.5.1 Overview / Aims

The present study aims to examine the experiences of multidisciplinary staff within mental health who have participated in team formulation. A systematic review was adopted in order to assess the quality of existing literature within this area. Given that there is a limited research base for formulation in psychology; it was decided that a broad question for the systematic review was best placed to reflect this and also to highlight any relevant literature to team formulation research.

The systematic review question was:

"What do we know about the utility of psychological formulation, in relation to impact on patients and staff?"

1.5.1.1 Defining Utility

For the purpose of the systematic review it was necessary to consider how to define 'utility' in order to include and exclude papers based on relevance to the review question. The researcher drew inspiration from Hayes, Nelson and Jarrett (1987), who defined utility in relation to psychological assessment as being "the degree to which assessment is shown to contribute to a beneficial (treatment) outcome" (p.963). In clinical practice formulation forms a "recursive relationship within the assessment process" (Division of Clinical Psychology (DCP), 2011).

Through discussion with the research supervisor it was agreed that the term utility should focus on quality, specifically in relation to the 'usefulness' of formulation. This included the impact of formulation for staff, service users and the wider team. Impact encapsulates the experience of formulation from both staff and service user perspective as well as outcomes of formulation on either treatment or 'symptom reduction'.

1.5.1.2 Defining formulation

The definition of psychological formulation adopted for the purpose of the systematic review follows the definition by the Division of Clinical Psychology (2001) provided in section 1.2.2.1.

1.5.2 Search Strategy

1.5.2.1 Databases

In order to identify all relevant papers initial searches were conducted via a selection of databases on 7th March 2016. In trying to stay true to the underpinning philosophy of Grounded Theory (to be discussed in Chapter Two) the majority of data was collected and initial analysis had been completed prior to conducting literature searches for the systematic review. The databases searched are listed below:

- Ovid (including Medline, PsycINFO, and PsyArticles)
- Web of Science

These databases were chosen to reflect that clinical formulation is rooted within the field of psychology and not used in the same manner by other professions, therefore it was decided that the search needed to be contained within this field.

1.5.2.1.2 Search terms

Two search terms were used, in combination with Boolean operators to identify all relevant papers:

Psycholog AND formulation*
Case AND formulation

These search terms were developed through both discussions with the academic supervisor and initial "dummy-run" searches of various databases. As psychological formulation can also be referred to as 'case formulation' within the literature this was included in the search terms. Using the term 'clinical formulation' in dummy-runs yielded medical formulations, therefore this term was not included in the final searches. Given that the literature base is broad and thin it was felt that adopting broad search terms to gain maximum yield during the initial sifting process would be beneficial.

1.5.2.2 Inclusion of qualitative and quantitative papers

In order to consider wider literature both quantitative and qualitative methodologies were included in the systematic review. Whilst this holds additional considerations for the purpose of quality assessment and synthesising results, given the limited research base on psychological formulation to date it was necessary to not limit studies based on methodology. This decision was also supported though the fundamental aim of a systemic review being to bring together all existing knowledge surrounding a particular theme or phenomenon. By including both quantitative and qualitative methodology the researcher was able to consider the current evidence base for formulation from a comprehensive perspective. Including multiple methodologies to gain greater understanding of topics within systematic reviews is supported through prior literature and has been advocated as providing the greatest

possible benefit to inform future policies and practice (Harden, 2010; Joanna Briggs Institute, 2014).

1.5.2.2.1 Developing inclusion and exclusion criteria

Initial criteria for the inclusion and exclusion criteria were co-devised between the researcher and their research supervisor. Meline (2006) advocates the liberal use of eligibility criteria during initial stages so as to ensure that they are sufficiently broad to yield relevant articles and ensure that no relevant studies are excluded. Therefore the criteria were adapted by the researcher to enable a more stringent process following the results of the preliminary dummy run of search terms.

1.5.2.2.1.1 Inclusion criteria

Inclusion criteria were:

- Must contain primary data
- Published in a peer-reviewed journal
- Publication date after 1990
- Qualitative or quantitative methodology
- English language
- Must be relevant to the definition of psychological formulation as defined by DCP (2010).

1.5.2.2.1.2 Exclusion criteria

Exclusion criteria were:

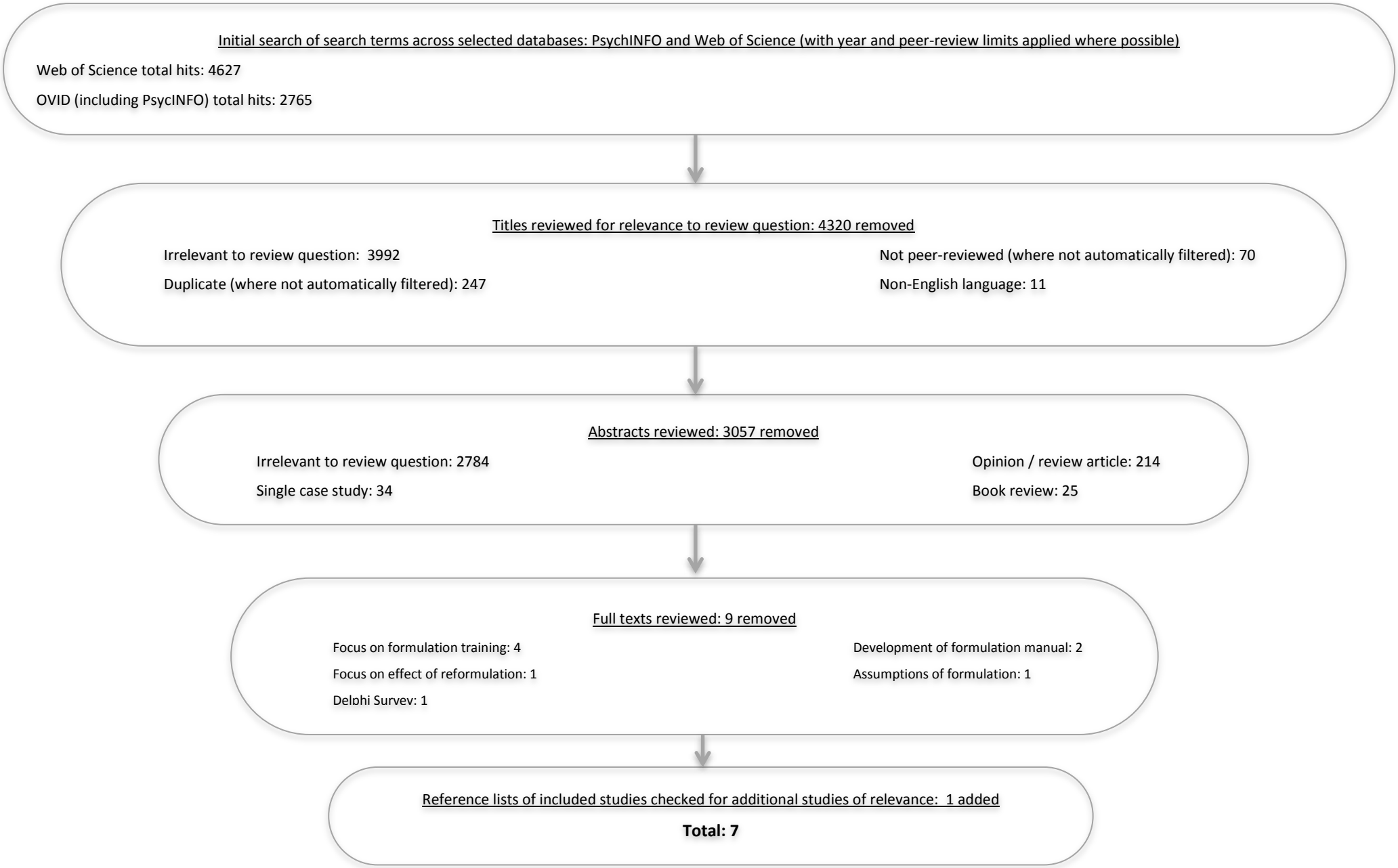
- Any study based exclusively on staff assumptions of formulation (as opposed to lived-experience of participating in formulation)

- Studies based on the quality, validity or reliability of formulation training programmes
- Studies that compared formulation and re-formulation only
- Single case studies
- Discursive articles and reviews, policy documents

1.5.2.3 Search process

The initial search of the two databases retrieved a total of 7392 results. Figure 1.1 below demonstrates the process by which the search results were narrowed in order to obtain the seven studies carried through to the systematic review.

Figure 1.2: Diagrammatic summary of systematic review process



1.5.3 Systematic review papers

Seven studies were included in the systematic review: Four adopted a quantitative methodology and 3 adopted a qualitative methodology. A full summary of all studies is shown in table 1.1 below. Studies are arranged by methodology used (quantitative, then qualitative), and within this studies are ordered by assessed quality of studies.

Table 1.3 Summary of Included Studies

No.	Authors	Aim(s)	Participants	Method (design, data, collection and analysis)	Findings	Comments	Quality Rating
1	Berry, Barrowclough and Wearden (2008) UK – England	1) To create individualised formulations for service users with staff teams 2) To explore the effects of developing a formulation on staff appraisals of service users	N = 30 15 female, 15 male. 16 participants were mental health nurses, 14 were mental health support workers. All worked within psychiatric rehabilitation settings.	**Design** Single group pre/post measure descriptive design **Method** Participants attended a formulation meeting lasting between 90 – 120 minutes. Pre and post measures were taken just prior to the meeting and then at the end of the shift. Staff perceptions were measured through Likert scales (based on the Brief Illness Perception Questionnaire; Broadbent *et al* (2006) and the Illness Perception Questionnaire for Schizophrenia (Loban, Barrowclough and Jones, (2005)). **Analysis** Changes in staff appraisal were assessed using repeated measures T-tests.	Significant changes in attitudes post-formulation included: • Increased belief that the service user has control over their mental health problems (p=0.004) • Increased belief that staff have control over the service user's mental health problems (p=<0.001) • Reduced blame for the mental health difficulty on the service user (p=<0.001)	Small sample size. Pre and post measure times were close together (1-6 hours), therefore participants were arguably more likely to display demand characteristics. Measure was created for the study by selecting certain questions from two measures, but no consideration is given to the effect of tailoring one measure to this study. Repeated analysis increased the probability of Type 1 Errors occurring, although Bonferonni analysis was undertaken in an attempt to reduce this. Future studies need to be completed to confirm the findings of this pilot study due to the limitations outlined above.	**73%**

2	Chadwick, Williams and Mackenzie (2003) UK – England	1) To assess the impact of formulation on the perception of therapeutic relationship and level of distress (within a population of individuals experiencing psychosis). (Experiment 1) 2) To assess the impact of formulation on the strength of 'delusional, self-evaluative' beliefs and distress within the same population. (Experiment 2)	<u>Experiment 1:</u> N = 13 Service Users 6 female, 7 male. N = 2 therapists All were service users had met DSM-IV criteria for one of the following diagnoses: Paranoid schizophrenia, schizo-affective disorder or delusional disorder. <u>Experiment 2</u> N= 4 Gender not reported as details were changed for the purpose of anonymity. All participants were experiencing 'distressing auditory hallucinations and secondary paranoid delusions'	<u>Experiment 1:</u> **Design** Within-subject, repeated design. **Method** Baseline phase: Participants met for sessions with no challenging of beliefs or discussion of formulation. Case Formulation phase: Two sessions devoted purely to formulating with the therapist. Hospital Anxiety and Depression Scale (HADS) and Helping Alliance Questionnaire for patients (HAq-P) data was collected for the two session preceding the formulation (T1&2) and the two formulation sessions (T3&4). Therapists completed the therapist version of the alliance measure (Haq-T) Semi-structured interview: Participants asked about their experience of the formulation. **Analysis** A Friedman 2-Way ANOVA was used to analyse variance in HADS and HAq-P scores between baseline and formulation.	<u>Experiment 1:</u> • Significant increase in alliance ratings on the HAq-P between T1 and T3, and T1 and T4 (p=0.05). However this in keeping with general improvement, and therefore cannot be attributed to formulation. • Significant increase in alliance ratings by therapists between times 1 and 3 (p= <0.05), 2 and 3 (p= 0.013) and 2 and 4 (p=<0.05). Suggests that formulation had a significant impact for therapists. • No significant effect on HADS scores. • Nine participants found formulation helpful in terms of understanding their problems, six participants reported positive emotions including feeling reassured and optimistic. • Six participants reported negative experiences, finding formulation upsetting and worrying as a process. However four of these participants also reported positive responses. • Two participants found their formulations complicated to understand.	<u>Experiment 1:</u> Neither hypothesis was supported for this study (that formulation would reduce distress and increase therapeutic alliance from the participant perspective). The fact the therapists demonstrated significant increase in their perceived alliance with the participant may indicate that the faith therapists place in formulation may be a direct reflection of the impact it has for them. In clinical practice formulation is not purely confined to two sessions, rather introduced gradually over time, therefore the clinical relevance of the procedure used in this study is questionable. Two sessions may also be insufficient time to examine the impact of formulation (hence why in experiment 2 this was increased to four sessions). <u>Experiment 2:</u> Due to multiple baseline design any effect seen during the challenging phase has to be jointly attributed to cognitive restructuring and formulation.	**71%**

	Chadwick, Williams and Mackenzie (2003) Continued			Pair-wise comparisons were made using the Wilcoxon Signed Ranks Test. Semi-structured interviews are summarised. <u>Experiment 2:</u> **Design** Multiple baseline design adopted **Method** Delusional and self-evaluative beliefs were identified. Participants rated their conviction in these beliefs via a Visual Analogue Line. Interventions - Case Formulation, Cognitive Restructuring of Beliefs and Cognitive Restructuring of Delusions. Measures used: HADS, HAq and the Psychotic Symptoms Rating Scale (PSYRATS) after each session and at a one-month follow up. **Analysis** Only able to conduct ANOVA analysis by combining HADS scores from experiment 1 and 2. (N = 17).	• Three participants felt there was no emotional impact of having a formulation, positive or negative. <u>Experiment 2:</u> • No significant impact of formulation on either strength of delusions or negative self-evaluation, however both sets of beliefs weakened during the subsequent challenging phase. Suggestion made that formulation alone does not impact on beliefs. • No significant effect of formulation on distress.	Chadwick *et al* conclude that research surrounding the impact of formulation is both limited and conflicting.	

3	Nattrass *et al* (2015) UK – England	To investigate: 1) The content, timing and quality of case formulations for patients with obsessive compulsive disorder. 2) The impact of formulation on symptoms, distress and therapeutic alliance. 3) The relationship between formulation quality and treatment outcomes.	N = 29 16 female, 13 male (Original sample = 37). All participants met diagnostic criteria for Obsessive Compulsive Disorder (OCD). Therapy was delivered by 8 therapists. All therapists were British Association for Behavioural and Cognitive Psychotherapy (BABCP) accredited. Therapists received specific training for formulation in OCD as well as on-going supervision.	**Design** Within-participant design based on archived data of CBT sessions. Session-by-session outcomes measures were recorded during therapy. **Method** Audiotapes of therapy were assessed using a validation coding manual in order to ascertain formulation content and quality. These were then evaluated against treatment outcomes at various stages of therapy. Measures completed by participants during therapy included the Yale-Brown Obsessive Compulsive Scale (YBOCS, Goodman, 1989); The Clinical Outcomes in Routine Evaluation – Short Form (CORE-SF, Evans *et al* 2002) and the Agnew Davies Relationship Measure (ARM-12, Cahill *et al*, 2012). **Analysis** Analysis of Variance (ANOVA)	• 31% experienced a reliable and clinically significant reduction in symptoms based on the YBOCS, 20% experienced clinically significant change based on the CORE-SF. However, post-hoc comparisons (Bonferroni) indicated no-significant difference between phase pairs. • Quality of formulations was assessed as follows: Rudimentary (4), Adequate (11), Good (9) and Excellent (5). Elaboration achieved the highest mean quality score, followed by complexity, coherence and precision of language, systematic process and comprehensiveness. • Psychological distress post-formulation was significantly lower than during assessment and the formulation phase ($p=<0.01$). • Therapeutic alliance post-formulation was significantly higher than during assessment ($p=<0.05$). • Formulation quality did not correlate with treatment outcome at any of the stages. • No significant effect of therapist on treatment outcome.	Formulations were less likely to contain patient strengths / resilience factors, despite research suggesting the value of these factors in treatment for OCD. Less than half of formulation fell into good or excellent rating, despite all receiving training. Simple formulations may however be appropriate or even beneficial if chosen so as not to overwhelm service users in early sessions, which brings into query the manual used to rate formulation quality. Conclusion: Case Formulation may be valuable in reducing attrition due to the timing of its use in therapy during earlier sessions. However more research is needed to identify the most important component of formulation. Disorder-specific theoretically sound measures for evaluating formulation are needed.	**70%**

4	Dudley *et al* (2015) UK - England	To investigate whether case formulation guides the endorsement of appropriate treatment strategies; and the impact of training / expertise on effective treatment decisions.	<u>Study One:</u> N = 43 Split by expertise into two groups based on their experience of using Cognitive Behavioural Therapy (CBT): *Novice:* N = 23 17 female, *Experienced* N = 20 11 female <u>Study Two:</u> Same splitting as study one: *Novice* N = 30 30 female *Experienced* N = 16 16 female * For study two in order to qualify as Experienced	**Design** Between-within subject design. (Within subjects = formulation based on 2 levels: sociotropy or autonomy); between subject = expertise based on 2 levels; novice and experienced. **Method** <u>Study One:</u> Participants were presented with two prepared case formulation vignettes followed by multiple-choice options of potential CBT treatments. Participants made judgements as to which treatment planning options were the best fit for the presented case formulations. Treatment planning questions were taken from CBT manuals and included problem list development, goal setting, behavioural experiments, use of thought records, activity scheduling, role plays, continuum method, relapse prevention planning and identification of potential therapeutic barriers/ problems. <u>Study Two:</u> The assessment and	<u>Study One:</u> • Significant effect for response type (p=<0.001), suggesting that the content of the formulation aided therapists in selecting formulation-matched interventions as opposed to less pertinent or mismatched interventions. • No significant effect of therapist experience. • No significant effect of vignette type on quality of formulation. • No significant interaction effect between experience and response type. <u>Study Two:</u> • Formulation Quality- Experts produced formulations that were significantly more internally consistent and coherent than novices (p=<0.001). • Experts made significantly fewer changes to their formulations (p=<0.005) and fewer errors. (Novices made 35 errors, experts 2). • Treatment planning - Experts rated the irrelevant planning questions and	The nature of the experimental task, involving ratings of suitability of possible treatment options suggested for the case, limits the interpretation that formulation directs the development or generation of the clinician's treatment plan. In study two the task may still have limited the capacity to demonstrate further differences between expert and novice therapists. Study one - the inclusion criteria used to distinguish between the novice and experienced groups may not have been sufficient to distinguish the two. The tasks used in the research may have been too simple to differentiate between groups.	**68%**

	Dudley *et al* (2015) Continued		participants needed to have been practising CBT for at least 10 years	formulation materials developed in study one were utilised within study two. However participants were not provided with the provisional or final completed formulation, instead they were asked to generate their own which was recorded on to a blank formulation template. They then used this to answer the treatment planning questions. **Analysis** Results from both studies were analysed using mixed ANOVA.	mismatch planning questions as a lower fit to the formulation than novices (p=<0.001)		
5	Christofides, Johnstone and Musa (2012) UK – England and Wales	To investigate clinical psychologists' accounts of their use of psychological case formulation in multidisciplinary teamwork.	N = 10 6 female, 4 male. All qualified clinical psychologists, with a mean of 5 years post-qualification.	**Design** Thematic analysis (as outlined by Braun and Clarke, 2006). **Method** Semi-structured interviews. **Analysis** Interviews were transcribed and then underwent thematic analysis. (Coding which was then organised into preliminary and sub themes).	**Themes:** 1) The need for a space to help make sense of clients' difficulties together. 2) 'Chipping in' with psychological ideas as an ongoing process: i) Defining the role of the psychologist. ii) Team culture and the acceptance of alternative perspectives. iii) Acknowledging the experience of staff and not taking the expert position.	Limitations as staff self-selected to participate and therefore were likely to advocate the use of formulation; no input from either service users or multidisciplinary staff. All participants worked in adult mental health and therefore findings are not generalisable to other areas.	**82%**

6	Mohtashemi *et al (2016)* UK – England

	Continued				4) **Making a Frankenstein monster** – The consequences of not using formulation resulted in a perceived lack of reflection. This led to over-reliance on a medical understanding of distress. The 'monster' was created through a combination of overreliance on medication, a lack of integrated understanding of the patient and lack of resources.	Further research is needed surrounding the outcome of formulating in teams.	
7	Summers (2006)	To explore the benefits and limitations of psychological formulation for patients with severe mental illness	N = 25 No gender demographics provided. Sample consisted of 9 nurses, 11 support workers, 2 doctors, 1 occupational therapist, 1 social worker and 1 drama therapist.	**Design** Qualitative design using semi-structured individual interviews **Method** All staff participated in semi-structured interviews, each lasting a maximum of 20 minutes. **Analysis** Grounded theory (Miles and Huberman, 1994).	Categories: Overall Impact – Both positive and negative views of impact. Dimensions of benefit – (4 subcategories): Management, Better staff-patient relationships, Individual staff satisfaction, Improved team working. Mechanisms of benefit – (3 subcategories): Bringing together people's ideas, Helping staff knowledge and understanding of patients, A Space to think creatively. Convictions competing or shared uncertainty – (2 subcategories): Formulation as statement of fact, (vs). Formulation as hypotheses.	Interviews all lasted under 20 minutes, which brings into question whether the information gathered was shallow as opposed to the researcher truly immersing themselves in the participants' experience. Also not acknowledged by the researcher is that 11 of the 25 participants had very little, if any experience of formulation. Only six of those 11 had even attended a formulation meeting. Participants attributed the inability to make positive comments of formulation to not having the knowledge to comment.	**56%**

1.5.4. Quality of included papers

1.5.4.1 Quality Assessment Framework

The Specialist Unit for Review Evidence (SURE) quality frameworks were chosen for the purpose of evaluating included papers. The researcher considered several frameworks which could be utilised for both qualitative and quantitative, including the Critical Appraisal Skills Programme (CASP, 2014). SURE was felt to be most appropriate framework as it builds on the structure already held by the CASP and provides a more comprehensive tool for the purpose of evaluating quality. The inclusion of additional prompters within each subsection in comparison to the CASP suggested that it would allow for a more rigorous appraisal. The quantitative papers were evaluated using the checklist for 'Randomised Control Trials and Other Experimental Studies' (SURE, 2013a); whereas the remaining qualitative papers were evaluated using the checklist for 'Qualitative Studies' (SURE, 2013b). The checklists both required rating to be based on answers of 'yes', 'no' or 'can't tell'. As neither of the two checklists provides numerical scoring the following values were agreed by the researcher and their supervisor:

2 = Good ('Yes' Answer)
1 = Unclear
0 = Unreported / Poor evidence ('No' or 'Can't tell' answer)

Whilst selecting an appraisal tool for the quantitative papers it became clear that some of the criteria would not apply across studies which were quantitative in nature but had not adopted a randomised control trial design. It was therefore decided that in the event of criteria not being applicable to a study that this would be removed from the overall maximum score obtainable.

For the full ratings and justification for each study rating please view the full SURE quality framework in relation to the four quantitative papers in Appendix 1 and the three qualitative studies in Appendix 2.

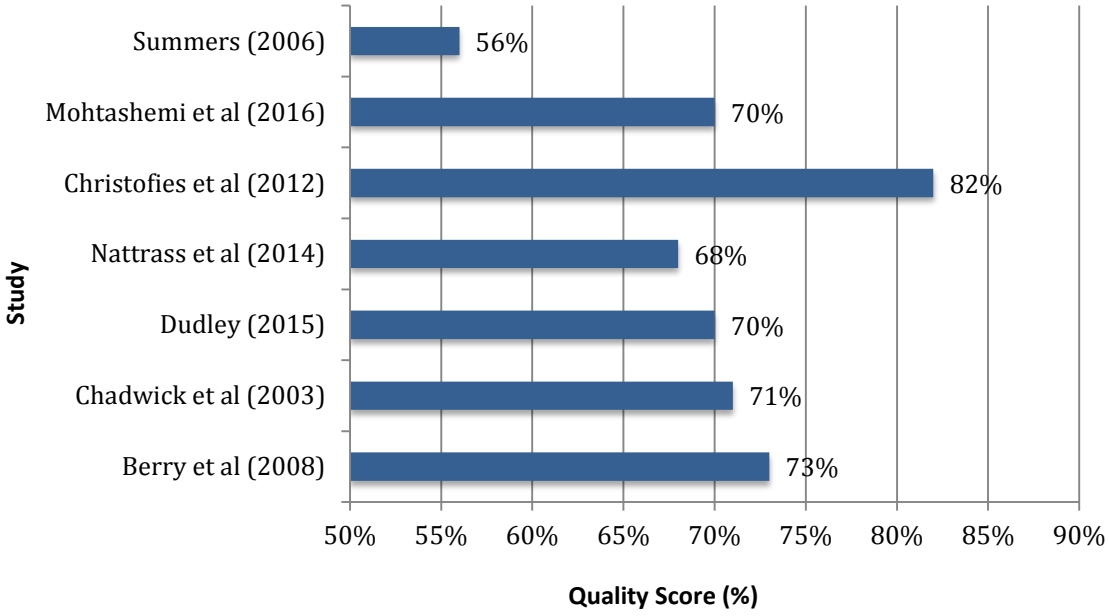
1.5.5 Synthesis of systematic review papers

A narrative synthesis of the seven studies included within the systematic review is provided below, with consideration of research findings, methodological issues clinical and research implications and limitations of the review.

1.5.5.1 Quality of included studies

Only one study achieved a quality rating score of over 75% on the respective rating score (Christofides et al, 2012). The average rating across studies was 70%, with the lowest rated being Summers (2006) with the considerably low outcome of 56%. For the purpose of this review studies scoring above 80% were considered 'high' quality, those between 61-80% were deemed to be 'medium-high' quality and between 50%-60% 'medium' quality. Prior to scoring it was decided that an overall percentage score of less than 50% would warrant studies being removed from the review. Following quality review the researcher was satisfied that the quality of all seven studies were of sufficient nature to remain in the review, therefore none were excluded. Figure 1.3 below demonstrates the spread of rated quality across studies.

Figure 1.3 Attained Quality Scores Across Included Studies



The majority of studies were deemed to be medium-high quality (n=5), whilst one was high quality and one medium. Taking this into consideration, the findings of studies with a higher quality rating are considered to be relatively credible. However in recognition that three of the included studies adopted a qualitative methodology any attempts to generalise findings of this review should be made with caution.

1.5.5.2 Results

The included studies will now be systematically considered in relation to study findings (themes which occurred across studies) and methodological considerations, including quality of sampling, data collection and interpretations made by each study.

1.5.5.3 Recurring themes

1.5.5.3.1 Formulation changing relationships

The findings across studies suggested formulation as being key to building positive relationships. Berry *et al* (2008) reported significant shifts in staff attitudes post formulation. Following a formulation meeting staff were significantly less likely to blame the service user for their mental health difficulties, had greater understanding of the service user's problems and held fewer negative feelings towards service user. An unexpected finding was that staff also reported a significantly increased belief that both service users and staff had an ability to control the service user's mental health difficulties. This finding is also substantiated by Christofides *et al* (2012), who also found that staff used formulation to gain greater understanding of service users as to see them as 'people' rather than patients. The positive effect of formulation on relationships may hold further benefits over a prolonged period for areas such as treatment outcome and reducing attrition rates in therapy.

Chadwick *et al* (2003) reported findings that therapists experienced a significant increase in therapeutic alliance following formulation for service users with diagnoses of either paranoid schizophrenia or delusional disorder. This suggests that the process of formulating has a significant positive impact for the therapist, although this was not supported in full from the service user perspective. Although not achieving significance, six of the 13 service use participants reported formulation as being a positive experience through providing them with hope, reassurance and optimism regarding their mental health difficulty.

Change in relationships was also observed at a team level, indicating that formulation meetings promote interdisciplinary working relationships (Christofides *et al*, 2012; Mohtashemi *et al,* 2016). The overarching mechanism for the changes described at both staff and team levels appears to stem from formulation changing attitudes and beliefs, as evidenced by Berry *et al* (2008). This can lead to all involved 'singing from the same hymn sheet' (Mohtashemi *et al,* 2016). These findings

indicate that formulation has the potential for widespread impact at multiple levels within the therapeutic relationship.

These limited research findings currently suggest that staff working with service users may perceive reliably greater benefits of formulation compared to service users, however there is a clear need for further research to consider the impact of formulation on relationships from a service user perspective and from a wider range of clinical presentations.

1.5.5.3.2 Impact of formulation on treatment outcomes

To date there has been limited evidence for formulation impacting on the outcome of treatment. Chadwick *et al* (2003) found no significant impact on self-rated mood following either two or four formulation sessions. There was no evidence of significant improvement in symptoms experienced, which included delusion thoughts and negative self-perception. However, it is difficult to distinguish whether these results are a valid representation as there is no firm evidence to suggest how many sessions the process of formulation typically lasts within clinical settings. Nattrass *et* al (2015) considered symptom reduction, comparing outcomes during the assessment, formulation and intervention stages of cognitive therapy for individuals with a diagnosis of Obsessive Compulsive Disorder (OCD). Following formulation sessions there was a significant reduction in service user reports of psychological distress and for 31% of participants a significant reduction in symptoms. It is important to consider that this study did not utilise a control group, which makes it impossible to determine whether clinical changes over time are attributable to formulation alone or in line with expected changes as therapy progressed. Again, studies investigating treatment outcome have all been based on the use of cognitive behavioural approaches, which therefore limits the ability to generalise findings to other therapeutic approaches, given that the modality of therapy used and its fit with the individual is likely to impact on treatment outcome.

1.5.5.3.3 Quality of formulation

Two of the included studies considered quality of formulation (Dudley *et al,* 2015; Nattrass *et al*, 2015) in relation to the interaction between clinician skill or experience. Dudley *et al* (2015) found in their second study that clinicians with more experience produced formulations that were significantly more internally consistent than novices and also made fewer changes to their formulation upon review. However this study was criticised for using relatively weak criteria to distinguish participants as being either 'novice' or 'expert'. The vignette task from which participants derived formulations was also criticised as being too simple. Both of these considerations reduce the extent to which these findings can be interpreted as having ecological validity. Dudley *et al* (2015) found a significant correlation between clinician experience and formulation skill.

Nattrass *et al* (2015) considered the impact of formulation quality on treatment outcome, however there was no significant correlation between quality and symptom reduction within the sample of service users with a diagnosis of OCD. This indicates that there may be multiple factors that contribute towards positive treatment outcome for the patient beyond formulation quality. This study did not take additional factors into consideration, such as service user motivation to engage in therapy or strength of beliefs, which is a prominent feature within this client group.

One limitation across the studies is an ability to provide a consistent definition of 'quality' within a formulation context. Nattrass *et al* (2015) define a good formulation as relieving patient distress and effectively guiding therapy to improve process and outcome for the patient. There is not definition of quality provided by the other studies (Dudley *et* al, 2015). The inconsistency of findings between studies indicates that formulation quality is a relatively complex and abstract concept to quantify through research.

1.5.5.3.4 Negative impact of formulation

Whilst the majority of findings across studies highlighted benefits of formulation, negative experiences were reported from the perspective of the service user (Chadwick *et al*, 2003) and from professionals (Mohtashemi *et al*, 2016; Summers, 2006). Chadwick *et al*, (2003) reported that six of the eleven service user participants reported via semi-structured interview that the process of creating a formulation had been a saddening and worrying experience. Some attributed this to formulation highlighting the longstanding nature of their difficulties, which in turn reduced their optimism towards treatment being effective. However, four of these participants also made positive statements regarding formulation. The variation of both positive and negative experiences being expressed within the same study may reflect the person-centred nature of formulation, and suggest that there is no one 'true' formulation framework that will be appropriate for all. These findings should be interpreted with caution however, given the small sample size and lack of further research exploring service user experience of formulation, particularly from frameworks outside of the cognitive structure adopted by Chadwick *et al* (2003).

Professionals involved in formulation meetings viewed formulation as a threat, partly due to role of psychology in facilitating formulation and the perception of formulation being a competing concept for psychiatric diagnosis (Mohtashemi *et al*, 2016). However these findings must be viewed within the context of the sampling chosen for the study. All of the participants in this study were psychiatrists. In the context of psychiatry training, which advocates the view of mental health under the medical model it is perhaps not surprising that some professionals within this field would perceive formulation as conflicting with this stance.

Summers (2006) used a sample of multidisciplinary staff, which did not include psychologists or psychiatrists. Some participants felt that formulation provided too much information regarding service users and that this could cloud professional judgement leading to inappropriate conclusions. Staff also felt that formulation

provided service users with an 'excuse' for current behaviour. This finding appears to conflict the aforementioned findings by Berry *et al* (2008) of staff experiencing reduced blame for service users in addition to greater perceived control of service users in their ability to manage their difficulties. However these findings should be interpreted with caution given that Summers (2006) was as noticeably lower quality than the other studies included in the review. The sample included participants who had no experience of formulation, which was not justified by the authors, although they recognised that participants who did not have experience of formulation were less likely to make positive statements regarding formulation and that this was attributed to lack of experience and knowledge.

1.5.5.4 Methodological Issues

1.5.5.4.1 Sample size and characteristics

The quality of sampling was low across studies, with none of the quantitative studies citing sample size as a relative strength. Given the small sample size across studies it is less likely that results or findings from any of the papers included in this review could be reliably generalised to other settings.

Ascertaining appropriateness of sample size in qualitative work is more of a challenge. Mason (2010) argues that research which relies on interviews for data collection should consider saturation to be the guiding principle for when to cease data collection. Similarly, Marshall and Rossman (2010) suggest that any sample that answers the research question should be considered adequate in qualitative research. Only one of the three studies, Christofides *et al* (2012) reports achieving saturation. Mohtashemi *et al* (2016) clarified that due to time constraints the researcher did not seek saturation and instead opted to cease collecting data when theoretical sufficiency was achieved. In contrast to the concept of saturation, which suggests that new insights should always be followed with further interviews in order to inform the emerging theory, theory sufficiency was considered to be

reached when emerging categories did not require revision in light of fresh data. This implies that two of the studies within this review had adequate sample size. Summer (2006) however did not report achieving saturation or provide any indication of how the researcher knew to cease data collection, which brings into question whether the sample size of 25 was adequate. Although this is a reasonably high participant number compared to other grounded theory studies, the richness of the data is questionable given that the maximum interview length was 20 minutes and no minimum is disclosed.

Assessing the sample characteristics across the seven studies included is also challenging, given that few provided demographics beyond age and gender. Only two studies sought service users for their sample; Chadwick *et al* (2003) and Nattrass *et al* (2015). There appears to be a gap in the literature to date of considering the impact of formulation from the service user perspective.

1.5.5.4.2 Recruitment and data collection

None of the included studies identified sampling as strength. However it is worth noting that all studies utilised participants from real world settings, such as NHS staff or service users, therefore this is arguably a strength across all studies. However there is a distinct lack of information regarding how participants were recruited across all of the quantitative studies. None of the quantitative studies indicate a response rate. Nattrass *et al* (2015) used data from archived therapy sessions, reporting that 78% of the archive sample was used. It is notable that none of these studies account for any non-responses or decision to not include data. This denies the opportunity for the reader to consider how significant or representative the sample of participants is.

All three of the qualitative studies used purposive sampling. Selecting participants in this manner may be beneficial in terms of obtaining the most relevant and

productive sample to answer the research question whilst also reducing the likelihood of collecting irrelevant responses. However participant sample of was recognised as a limitation by all three papers due to participants self-selecting. This indicates that participants were likely to have strong views regarding the use of formulation, which may result in individuals with less extreme views being overlooked by comparison. This therefore reduces the ability to generalise the findings across professions. Mohtashemi *et al* (2016) and Christofides *et al* (2012) also recognised that as interviews were co-constructed with the researcher that participants might have displayed bias in their responses in order to conform to the researcher's stance on formulation. Summers (2006) neglects to consider the impact of their values and views on the data collected, despite adopting a grounded theory approach which advocates open awareness of the pre-conceptions and values of the researcher throughout the data gathering process. It is unclear from the studies included whether the researcher was known to participants prior to the research taking place. There is also a lack of information surrounding non-respondent rates; for example 78 psychologists (Christofides *et al,* 2012) and 'all ward staff' (Summers, 2006) were invited to participate, yet neither study identifies how the end sample was reached. Mohtashemi *et al* (2016) merely reports the number of participants, not how the sample was selected or how many were originally invited to participate.

Summers (2006) included participants in the sample who had not been to formulation meetings or ever read a written formulation, which given that the study aim was to explore staff experiences of formulations seems questionable. No justification is provided as to why these participants were included or whether there were any exclusion criteria for participating. Hartley *et al* (2015) also indicate that the lack of significant results in their study could be apportioned to sample choice as many participants were not from a psychology background and had no training or experience of formulation. This highlights the need for future studies to place importance on ensuring that stringent inclusion and exclusion criteria are adopted so as to not to impact on the validity of results.

1.5.5.4.3 Research aims and design

One strength across all seven of the studies included within the review was the clarity of research aims and objectives. All of the studies provided a clear setting and target participant group to meet defined aims. Tracy (2010) argues that the signature of good quality research is that which is timely, relevant and interesting.

All seven of the studies recognised the limited research within this field to date, particularly in relation to the impact of formulation (Chadwick *et al,* 2003), understanding of formulation (Mohtashemi *et al*, 2016) and as an evidence base for the use of formulation (Dudley *et al,* 2015*).* Nattrass *et al* (2015) critically evaluated previous research in terms of study weaknesses and considered this when designing their study. The range of aims across studies is broad, which in part reflects the broad scope of the review question.

Study designs were broadly justified across the majority of studies, however a weakness amongst the quantitative studies was a reliance on manufactured hypothetical case vignettes as opposed to 'real-life' examples.

The only therapeutic modality named within the studies as providing a framework for formulating was cognitive behavioural therapy (Chadwick *et al*, *2003;* Dudley *et al,* 2015; Nattrass *et al,* 2015). Whilst CBT arguably provides the most 'research-friendly' framework due to the consistent structure of formulations this also limits the generalisability of findings to formulations from other perspectives, such as psychodynamic or systemic. Other studies did not specify from which framework formulations were constructed. Given the variation between formulations under different modalities it would be prudent for future research to consider alternative models, as this would potentially support the findings of existing studies to a more comprehensive understanding of formulation. Given that neither Chadwick *et al* (2003) or Nattrass *et al* (2015) were able to obtain significant indications of formulation positively affecting treatment outcomes it would be of particular

interest to investigate whether this changes when a different therapeutic stance is used to create and deliver the formulation.

It is of interest that four of the included studies chose hypothesis-driven designs. Given the comparative lack of exploratory studies surrounding formulation, the reader was left questioning whether more qualitative research would be beneficial to develop an underlying understanding of formulation before specific hypotheses are drawn regarding other aspects such as reliability or validity.

1.5.5.4.4 Data analysis

There was considerable variation in quality of data analysis, particularly between the three qualitative studies. Summers (2006) was noticeably weaker in terms of describing and justifying the analysis chosen. The form of grounded theory used was not disclosed and very little detail provided regarding how the core principles of this methodology were followed beyond generating codes and seeking exceptions. Interviews used to collect data in this study were short in length (maximum length reported was 20 minutes) across 25 participants. Interviews were not recorded or transcribed completely verbatim, which leaves the reader to question whether this was sufficient time for the researcher to immerse themselves in the world of participants and to accurately represent their views during analysis. Saturation is not reported as being achieved. Mohtashemi *et al* (2016) provides a more comprehensive perspective of using grounded theory and justifies where principles such as reaching saturation had to be altered.

Overall quantitative analysis in the remaining six studies was stronger, as reflected in by quality assessment framework. Descriptive and inferential statistics were both described and justified within studies. Providing detailed descriptions of analysis increases the 'usefulness' of data and allows for wider generalisation of results.

1.5.5.4.5 Ethical issues

It is of note that despite the Committee on Publication Ethics (COPE, 2011) stating that all human studies should provide confirmation of ethical approval, six of the seven studies reported ethical approval as being considered and granted. There was an overall weakness in confidentiality considerations, with none of the seven studies demonstrating explicit consideration of how to maintain confidentiality. This was a particular weakness within the qualitative studies. Christofides *et al* (2012) used participant numbers when providing direct quotes, however there is no evidence of whether steps were taken to ensure confidentiality. Summers (2006) offers no consideration of confidentiality and also does not attribute any quotes to specific participants. Only Mohtashemi *et al* (2016) openly consider confidentiality, although participants in this case chose their own pseudonym, which is arguably less stringent than being externally assigned a pseudonym.

1.5.5.4.6 Reflexivity

Charmaz (2012) highlights reflexivity as being vital to maintain quality within qualitative research and specifically those that adopt a grounded theory methodology. This refers to the transparency and honesty with which researchers position themselves in relation to the research, such as preconceptions, values or beliefs surrounding the chosen area of focus. It is recognised under this concept that the stance of the researcher is likely to impact on the analysis and subsequent interpretation of data. Two of the three qualitative studies openly acknowledge the need for reflexivity. Christofides *et al* (2012) provide a position statement, which allows the reader to consider the lens through which the researchers viewed the data. Mohtashemi *et al* (2016) describes using reflection in supervision and triangulation of perspectives whilst analysis data in order to maintain an open awareness of their position and to identify gaps in analysis. Summers (2006) provides very little to recognise the need for reflexivity beyond stating that the

researcher held a prior interest in formulation. However Summers (2006) justifies why they believe this position had no bearing on the emergent theory, which is arguably not in keeping with reflexivity.

1.5.5.5 Implications

Consideration of clinical implications was provided across the range of included studies and in the majority of studies direction for future research was considered. Examples include that formulation may be valuable in reducing attrition rates in therapy due to the early position of formulation within the therapeutic relationship. (Nattrass *et al*, 2015) and the need for clinical psychologists to receive explicit training surrounding the use of formulation in order to feel confident to use this skill within team working (Christofides *et al,* 2012*).* However several studies did not yield significant results, including Chadwick *et al* (2003) who had conflicting responses between participants when discussing formulation as both a positive and negative experience. Research into the impact of formulation is both limited and conflicting, which reduces the ability to draw clinical implications from the research to date that are sufficiently robust enough to generalise implications beyond the context of the studies.

1.5.5.5 Summary

Overall methodological strengths of the studies included in the review include clear and concise study aims, alongside an open recognition across all studies that there remain many gaps in current knowledge of formulation to be filled by future research.

Whilst there is limited research surrounding formulation overall, it is apparent from the study aims and designs that there is very little research to date considering formulation from the service user perspective, both in terms of experience and impact on psychological distress. There has also been very limited research on team formulation, and none to date that goes beyond exploratory methodologies. A comment across all studies was that the limited research base for formulation does not reflect the level of use in clinical settings. Further research to better establish effects of formulation on outcomes for patients and staff would be welcomed in the future.

1.5.5.6 Limitations of the Review

A challenge presented by adopting such broad search terms was an exceedingly high retrieval incidence of irrelevant papers. However this enabled the researcher to continue to develop inclusion and exclusion criteria and apply this to reviewed papers. The researcher recognises that this method placed a considerable demand and increased workload during the process of the review, however it was decided that through adopting this method the likelihood of omitting papers of relevance to the review has been reduced. With this in mind the researcher recognises that due to human error there will always be the possibility of papers being unintentionally omitted.

The scores allocated by the researcher were checked by two peers, in order to check reliability of the scores allocated. However due to the subjective nature of self-scoring it is recognised that another reviewer may hold different interpretations of quality and therefore derive a different score.

1.6 RATIONALE AND AIMS OF CURRENT STUDY

1.6.1 Rationale

Despite formulation being a recognised core component of clinical psychology there is a distinct lack of research within this area, as recognised by the majority of current literature and research. Formulations by their very nature are individual and therefore not generalisable. This, in combination with the variety of theoretical frameworks which can be utilised in order to create a formulation and the concept that a formulation is but one component of therapy which may effect treatment outcomes present a real challenge to examine the process within the structured confines of a research environment. This may, in part, account for the overall lack of research to date. The sheer complexity and number of variables involved with team formulation will continue to make the effectiveness of team formulation a 'significant challenge' to evaluate (Ingham, 2015).

Qualitative studies have started to investigate the experience of formulating in teams, such as Christofides *et al* (2011)'s account from psychologists facilitating team formulation and Summers (2006). At the time of the current research commencing there was a distinct lack of quality research that has explored multidisciplinary experience of team formulation, although the researcher notes the recently published study by Mohtashemi *et al* (2016), which specifically explored psychiatry perspectives. The past studies have all demonstrated benefits of using formulation within teams, alongside potential barriers to facilitating effective formulation. However none of the previous research has sought the views of multidisciplinary members who all had experience of team formulation, or offered an account of the mechanism that underpins these benefits. An increased understanding of such mechanisms would enable future formulations in teams to be tailored more in order to maximise the opportunity for the best possible outcomes for both the client and the wider team.

1.6.2 Aims

The current research aims to explore the experience of multidisciplinary staff of participating in team formulation in order to expand the current literature and research base. A grounded theory methodology will be utilised in order to provide a theory derived from the data, which aims to offer an understanding of team formulation within the current context of lacking understanding. It is hoped that this research will increase understanding of whether team formulation has a perceived impact on multidisciplinary working.

CHAPTER TWO: METHODOLOGY

2.1 OVERVIEW OF CHAPTER

In keeping with previous research surrounding staff views of using team formulation a qualitative methodology was utilised via constructivist grounded theory as described by Charmaz (2012). This method was chosen so as to explore and generate an understanding of professionals' experience of participating in team formulation. Data was collected via semi-structured interviews with ten multidisciplinary professionals who were working within two mental health teams in South Wales. This chapter aims to outline the methodology used and the rationale for this, the study design, a description of the participants. The chapter will also consider ethical issues and the process undertaken to maintain quality during the research.

2.2 DESIGN

The aim of this study was to provide an exploratory account of multidisciplinary staffs' experience of participating in team formulation. Qualitative research aims to develop an understanding of human experience and make meaning (Silverman, 2000). This underpinning philosophy has led to the increasing popularity of qualitative approaches within the field of psychology. Flick (2009) suggests that the central ideas guiding qualitative methods that distinguish such methodology from quantitative research are: The correct choice of appropriate methods and theories; the recognition and analysis of different perspectives; the researchers' reflections on their research as a component of knowledge production; and the variety of approaches and methods utilised. Smith (2003) states that qualitative methods are best suited to research where the aim is to explore concepts on a personal, phenomenological and experiential level. Fossey *et al* (2002) support the use of qualitative methodology in cases where there is a limited research evidence and theory base, which is apt when considering the limited research currently

ascertained regarding both team formulation and psychological formulation in general terms. It was therefore deemed that qualitative methodology would be appropriate for the current research. The decision was made to utilise constructivist grounded theory as a methodological approach (see Charmaz, 2006).

2.2.1 Grounded Theory

Grounded theory is widely acknowledged as being developed by sociologists Glaser and Strauss (see Glaser and Strauss, 1967). Their theory was regarded as ground-breaking by many in the field of qualitative research, given their avocation of deriving theory from *within* the research data as opposed to previously held approaches which relied on deducing hypotheses from pre-existing theory. Grounded theory has gained much popularity in new areas of research, given the ability to generate theory without the need for underlying hypotheses (Willig, 2008). Grounded theory has the potential to expand into the realm of formal theory, which Kearney (1998) attributes to the ability to generate abstract concepts and identify relationships between them.

In developing Grounded Theory Glaser and Strauss successfully converged the two opposing traditions of sociological research, Positivism and Pragmatism, which alongside an increased in quantitative research dominated research in the 1960s. Positivism in research terms can be defined as the relationship between the world we exist within and the understanding that we hold of that world. Underpinning positivism is the stance that research exists in order to uncover a universal truth (Willig, 2008). The role of the researcher within this is to remain removed and unbiased, in order to obtain a 'definite' truth. As cited by Willig (2008), an obvious criticism of this approach is that any research undertaken using these assumptions is likely to ignore crucial influences on interpretation such as cultural factors.

The term 'pragmatism' within sociological research dates back to Pierce (1878; as cited in Willig, 2008), who founded the philosophy of thoughts serving as a tool for

prediction and problem solving, rather than holding the function of mirroring reality. It recognises the world as being in a state of constant change, therefore rejecting the concept of one 'universal truth'.

Glaser & Strauss (1967) state that the core components of grounded theory are simultaneous involvement in collection of data and analysis; deriving codes and concepts from within data as opposed to preconceived and logically-deduced hypotheses; constantly comparing data throughout the process of analysis; continually developing the theory during each stage of the data collection and subsequent analysis; and maintaining a record of memos in order to identify gaps in data, elaborate and specify categories whilst also considering the relationship between categories.

2.2.1.2 Constructivist Grounded Theory

Grounded theory in its original form has been historically criticised for implying that a particular truth exists within data through the language of themes 'emerging'.
The theoretical underpinnings of classic grounded theory dictate that the emerging theory is strictly external to the researcher and their position, i.e. that it emerges purely from the data collected. However, Charmaz (1990) argued that themes and resulting theories are *co-constructed* between the researcher and the data. This flies in direct contention with the more classical strands of grounded theory, which maintain the researcher in a position of objectivity. Instead, within constructivist grounded theory framework the researcher is held as being at the core of interpretation, as it is through the position of the researcher that all themes are drawn together.

2.2.1.3 Rationale for using grounded theory

This research aimed to develop a deep and rich understanding of process surrounding a shared group experience. This therefore rendered grounded theory a preferred methodology as opposed to Interpretative Phenomenological Analysis (IPA), which seeks to provide an arguably more descriptive account of an individual experience.

As previously stated, grounded theory has become a popular methodology for areas of research that surround relatively new or under-researched phenomena, due to the ability to generate preliminary theories without pre-existing hypotheses (Strauss & Corbin, 1998). The majority of the research base regarding team formulation to date is exploratory and descriptive as opposed to explanatory. Given the limited research regarding formulation (both in an individual and team context), grounded theory was considered to be suitable for the current research.

The choice to adopt constructivist grounded theory was based on the recognition of team formulation as a shared experience. In an environment where an MDT inhabits the same space to create a formulation as part of a shared process, the formulation itself is arguably a socially constructed process, with each member viewing the 'problem' (the focus of the formulation) through their own lens and 'chipping in' to create a shared understanding of the problem. (Christofides et al, 2012).

A final consideration made by Willig (2008), is the importance of considering the methodology adopted to ensure that it reflects a good 'fit' between the position of the researcher and the epistemological assumptions held by the methodology. As stated in the position statement of the researcher (see 2.2.3), social constructionist views were valued prior to the current research. The researcher also related to Charmaz's (1990) approach as mirroring the reality of clinical work, in that any 'truths' within a therapeutic context are co-constructed between therapist and

client; which in turn informs the formulations created jointly within this context.

2.2.2 Research Context

The research was conducted within two multidisciplinary teams within the same health board in South Wales. Both serve individuals of the adult population (between 18-65 years) who experience severe mental health difficulties. Team One was a community-based team who hold weekly team formulation meetings. These meetings are primarily requested by staff who feel 'stuck' whilst working with a service user. The narrative held here is that formulation meetings are for people who are complex and cause staff members to feel 'stuck'. Team two was based on a locked inpatient unit. The team uses four different varieties of team formulation: 'Engagement formulation', which all inpatients receive within the first six weeks of being admitted; 'Stuck formulation' which serves a similar purpose to the formulations used in team one; 'Risk formulation' meetings are held when the team have to make decisions surrounding risk and lastly 'Move-On formulations' are completed for every inpatient when they are due to leave the unit, either to return to community settings or to transfer to another service. This formulation aims to facilitate a smooth transition from one service to another by considering individual care needs.

2.2.3 Researcher's position

In keeping with the guidelines set by Elliot *et al* (1999), it is important for the researcher to provide a statement of their values in relation to the present study. This allows the researcher to 'own their perspective' whilst also giving the reader the opportunity to consider how the values and experience that the researcher brings to the research may affect their interpretation of the data.

2.2.3.1 Position Statement

The researcher is writing from the perspective of a 27 year old, white, engaged female. The researcher grew up in southern England but now works and lives in South Wales. Whilst this research was taking place, the researcher was employed as a trainee clinical psychologist, and worked within a variety of mental health settings across the lifespan. Prior to interviews taking place, the researcher had not met any of the staff who participated.

From her journey in psychology beginning as an assistant psychologist in 2009 to the present day the researcher has come to develop an understanding of 'mental health' as being socially-constructed, as opposed to biologically-determined. She therefore holds the view that there is not one 'universal truth' as to the cause of mental health difficulties. She tries not to be drawn to the attraction of dichotomy- because the world we live in is not renowned for simplicity; however she perceives formulation from a theoretical basis to be the antithesis of psychiatric diagnosis in mental health. She adopts the stance that such diagnoses convey unhelpful messages to individuals in terms of understanding their situation as being evidence of 'abnormality'. She much prefers the holistic explanation offered by psychological formulation. In recognition that some individuals report positive experiences of receiving a mental health diagnosis (and equally negative experiences of formulation), the researcher aims to maintain a person-centred view in her clinical work and is led by how the individual chooses to construct and understand their difficulties.

As a psychologist it is perhaps not surprising that the researcher sees great value in formulation for both professionals and the individuals for whom formulations are utilised. She is of the opinion that our health service should be offering a choice for individuals to understand their difficulties via formulation as opposed to being purely diagnostically-driven. In the researcher's view this is a choice that is sadly denied to many. It is her hope that further research into formulation, including team formulation will support its continued and expanded use within health settings.

2.3. MAINTAINING QUALITY IN QUALITATIVE RESEARCH

Using qualitative methodology in research has long attracted criticism. Mays and Pope (1995) offer the criticism that qualitative research lacks scientific rigour through the reliance of anecdotal evidence to draw conclusions. It has been argued that relying on interviews as a method of data collection can lead to participants displaying demand characteristics when answering questions, 'saying one thing and whilst doing another' (Dean & White, 1958). Qualitative researchers have since developed quality frameworks for use by researchers in order to meet some of these criticisms, such as Elliot *et al* (1999) below.

2.3.1 Elliot et al's framework of quality within qualitative research

In order to defend the use of qualitative methods in research various professionals from within the field have developed guidance and frameworks by which to conduct qualitative research. Elliot *et al* (1999) published a comprehensive set of guidelines to ensure that quality is maintained throughout the research process. The researcher of the current study adopted this guidance. The following section introduces each of the guidelines and provides evidence as to how each point was addressed during the research.

2.3.1.1 Owning one's own perspective

The first stipulation made by Eliot *et al* (1999) is that the researcher must specify their own underlying assumptions and theoretical orientations, as this provides a lens with which readers can understand how the researcher may have influenced analysis. This is particularly pertinent for constructivist grounded theory given that the researcher's position is openly acknowledged as contributing to the analysis and interpretation of data. For the purpose of the current study the researcher has published their position statement in section 2.2.3.1. The process of keeping a reflective journal throughout the research process and making memos (See

Appendix H) during data collection has encouraged the researcher to maintain self-awareness.

2.3.1.2 Situating the sample

Participants should be described in sufficient detail that it allows the reader to gain an impression of the range of participants involved and thus the situations to which any generated theory may be applicable. Participant demographics are provided in Table 4. The research context is also outlined in section 2.2.2 above.

2.3.1.3 Grounding in examples

There should be sufficient examples provided that that reader is able to appraise the fit between raw data, coding, concepts and theory generated via the research. Full illustrations of categories and sub-categories are provided in the results section (Chapter Three), alongside illustrative quotes to support the category.

2.3.1.4 Providing credibility checks

Researchers should aim to triangulate data with other sources in order to check the credibility of data. Coded transcripts were reviewed by other trainee clinical psychologists with an interest and/or experience in using grounded theory. Transcripts and codes were also discussed with the academic and clinical supervisors, who both have extensive experience of team formulation and grounded theory. Triangulating the data with others facilitated changes within the coding of the data, such as the development of categories.

2.3.1.5 Coherence

Data, analysis and study findings should be presented in a consistent and integrated manner, through the use of diagrammatic maps and frameworks alongside a coherent narrative account. The results section and discussion (Chapter Four) provide a narrative of results, alongside an interpretation of the data and diagrammatic representation of the generated theory.

2.3.1.6 Accomplishing general vs. specific research tasks

Limitations of findings pertaining to the applicability beyond the original context of the data should be clearly addressed. The researcher should provide a clear account as to whether the research aims to create a generalisable theory or understanding of the given phenomenon, or whether the aim is to provide an in-depth comprehensive insight into an individual event. The current study is representative of a sample of multidisciplinary staff members working with an adult population of service users who experience complex mental health difficulties in South Wales. Any findings from this study are not considered to be generalisable to any other group. Participant demographics including number of team formulations previously attended have still been provided so that readers may make an informed decision as to how applicable it would be to generalise findings to other research settings. The limitations of this study are outlined and duly considered in Chapter Four.

2.3.1.7 Resonating with readers

Any emergent theory and all related research material should actively clarify and increase the reader's understanding of the study area. All presented material should make sense to the reader. Within the current study, draft and final versions of the theory were shown to the academic supervisor in order to verify that this standard was met. In addition to this, a comprehensive review of relevant literature concerning theoretical and clinical issues is provided in Chapter One. The categories, sub-categories, core categories and themes are presented in Chapter Three, which allows readers to make an assessment as to what extent the theory resonates with the data.

2.3.2 Validity within grounded theory

As outlined above, a series of constructs were used to ensure that the aim of this research of exploring the experiences of multidisciplinary team workers who

participate in team formulation meetings. Validity within grounded theory is defined as the usefulness of the theory generated from the data. Glaser (1978) states that the quality of grounded theory should be based on four criteria: *Fit* refers to the emergence of conceptual codes and categories as coming from the data as opposed to preconceived codes or categories. *Workability* refers to the ability of the theory to explain and interpret behaviours in a substantive area so as to predict future behaviour. *Relevance* refers to a focus of the research on a core area or process. Core areas must come be conceptually grounded within the data as this confirms the significance and relevance of the core area and ensures its relevance. Finally *Modifiability* refers to the ability for the theory to be adapted and continually modified as future data produces new categories and dimensions of the theory. Thulesius (2013) advocates that all grounded theory research should be evaluated against Glaser's criteria.

2.4 ETHICAL ISSUES

2.4.1 Ethical approval and Research and Development Department Permissions

The study proposal was reviewed and approved via the School of Psychology Research Ethics Committee hosted by Cardiff University in December 2015. Given that all participants were NHS staff and not service users ethical approval via the NHS was deemed not necessary. Please see Appendix C for University approval. Permission for the research to take place within the NHS came from the Health Board within which the two teams used for this study were situated geographically. Please see Appendix D for anonymised permissions.

2.4.2 Informed Consent

Consent to participate was gained in writing from each participant prior to each interview taking place. In order to ensure that providing consent was an informed decision all participants were given an information sheet regarding the study (Appendix E). Details on the information sheet included the aim of the study, the procedure that all participants would be required to complete, how the data would be stored and analysed and a clear statement that participants had the right to withdraw from participation at any stage without needing to give a reason.

2.4.3 Confidentiality and Anonymity

In order to maintain confidentiality and anonymity of participants the procedure met with standards outlined by both the Data Protection Act (1998) and the Healthcare Professionals Council (HCPC) Code of Conduct (2012). All participants were assigned a unique participant number once recruited, which was stored on a separate database to signed consent forms which contained participant names (Appendix F). All interviews were recorded and stored on an encrypted USB device and deleted by the researcher after transcription. For interviews that were transcribed by an external agency the researcher was provided with written assurance that the company would also abide by the legislation of the Data Protection Act (1998) in terms of maintaining confidentiality during the transcription process, storing data on a secure server and then deleting all audio data once transcription was complete.

In keeping with the British Psychological Society (BPS) Code of Ethics and Conduct (2009) all participants were informed of the need for the researcher to break confidentiality should they disclose any information that presented a risk to either inpatients/service users or staff during the interview. This was discussed both informally and stated on the consent form before any interviews took place.

All participants were informed that as interviews were being recorded it was likely that direct quotes from their interview would be used in the final write-up. Participants were reassured that the researcher would assign pseudonyms to any quotes so as to maintain confidentiality and anonymity in their participation.

2.5 PARTICIPANTS

2.5.1. Sampling

The two identified teams for participation contained approximately 80 members of staff between them who worked in a range of MH roles excluding psychology. It is acknowledged that both teams are considered as Adult Mental Health Teams. It was decided that the teams used for the purpose of this research would be purely adult mental health, in part as this represents the client group that team formulation is currently thought to be mostly utilised for, and also in order to create an in-depth theory given that team formulation is well established within both teams. There is also evidence of team formulation being used within other settings, such as Older Adults (Craven-Staines, Dexter-Smith & Li, 2010), which would be of interest for future research to consider.

In order to be eligible to participate it was agreed between the researcher and their supervisor that all participants must be NHS staff who worked in a role that was not defined as a psychologist, and who had also attended a minimum of two team formulation meetings in the past 12 months.

2.5.1.1 Sample Contexts

The first team to be identified for participation was an adult mental health community team. Team formulation had been established within the team by a clinical psychologist. Team formulation was typically utilised for when staff within

the multidisciplinary team felt 'stuck' with certain service users. It was possible for any member of staff to request a team formulation. Multiple professions were invited to attend formulations from different agencies, such as health and social services. Typically attendees would consist of a clinical psychologist, support workers, an occupational therapist, a social worker (if involved) and a psychiatrist.

The second participating team (set within inpatient settings) had an established pathway for team formulation to ensure that all service users had team formulations during their stay. All members of the MDT were invited to attend team formulations, including the care-co-ordinator. Typical attendees included the ward manager, deputy ward manager, support staff workers, nursing, specialty doctors, occupational therapist and an activities co-ordinator. There were four types of team formulation utilised, each with a different function. 'Engagement' formulations were scheduled within the first six weeks of a service user's admission to the ward. This formulation aimed to consider factors that had contributed to the service user being admitted, previous history of service engagement patterns and to collaboratively develop a plan to promote positive engagement and interaction during the service user's current admission.

During admission the service users could also receive a 'Risk' formulation, which aimed to adopt a shared approach to risk management and promote positive risk taking within the team, or a 'Stuck' formulation, which took the same function as team formulations within the community team. As service users headed towards being discharged they had a 'Move-on' formulation. Additional attendees to these meetings included any relevant staff who were about to become involved after discharge, e.g. community staff or staff from alternative inpatient facilities. This formulation acted as an opportunity to hand over to future services and additionally as a space for staff to reflect on what had worked well with the service user during their stay and to consider progress and changes from the staffs' perspective.

2.5.2 Recruitment

Following ethical approval being gained and permission from the Health Board Research and Development department, link psychologists in both of the two identified teams of interest were contacted. They adopted the role of raising staff awareness of the study within the teams and passed on the researcher's contact details to any staff who expressed an interest in participating. After receiving contact and ensuring that potential participants met the inclusion criteria the researcher arranged a date and time for the interviews to take place. This proved particularly challenging with staff working in inpatient settings due to the unpredictable nature of shift patterns and the potential for staff to be called away from interviews at short notice.

2.5.3 Participants

Following obtaining informed consent, all participants were asked some basic demographic information: Gender, age, job role, number of years in service and the number of team formulation meetings attended over the past 12 months. The sample consisted of 80% female. The mean age of the sample was 41.5 years; with a range between 27 and 59 years. The mean number of team formulations attended over the past 12 months was 9.4; with a range between 3 and 36. Table 4 below summarises relevant details of the ten participants who were interviewed. All participants have been given a pseudonym to preserve anonymity.

Table 2.1 Summary of participant demographics

Participant	Gender	Number of team formulations attended in past 12 months	Team
Lisa	Female	15	Adult mental health (Community)
Gethin	Male	3	Adult mental health (Inpatient)
Eloise	Female	5	Adult mental health (Inpatient)
Sarah	Female	4	Adult mental health (Inpatient)
Rachel	Female	3	Adult mental health (Community)
Kara	Female	5	Adult mental health (Community)
Hannah	Female	6	Adult mental health (Community)
Sasha	Female	36	Adult mental health (Inpatient)
Tim	Male	5	Adult mental health (Inpatient)
Lucy	Female	12	Adult mental health (Inpatient)

In order to preserve participant anonymity job titles have not been included in the individual demographic table. The combined total sample consisted of three staff members from an Independent Living Support Service, two occupational therapists, two staff nurses, one ward manager, one deputy ward manager and an activities co-ordinator. Due to grounded theory being the chosen methodology there was no set number of participants to recruit; instead the aim was to continue to interview until a point of saturation was reached. Riley (1996) suggests that the majority of studies will achieve saturation between eight and 24 interviews, with variation depending on the subject being studied. Following reflection after interviews in combination with the analysis it was decided that after 10 interviews a point of saturation had been reached.

2.6 INTERVIEW PROCEDURE

The interviews were all conducted face-to-face at the participants' work base. Length of interviews varied, with a range of 28 to 56 minutes. A USB-enabled Dictaphone was used to capture interviews, which participants were made aware of. After introductions the researcher went through the participant information sheet and consent form with participants and allowed time for any questions to be asked. The purpose of the interview was outlined as being to investigate how members of the multidisciplinary team who were not from a psychology background experienced being involved in team formulation meetings.

When conducting interviews under constructivist grounded theory framework, interviewers should seek to balance the explicit content within the interview alongside the relationship between the researcher and participant and the construction of silences and stories told (Charmaz, 2009). The use of semi-structured interviews to achieve this is supported by Field and Morse (1985), who suggest that adopting a flexible approach to data collection marries well with the philosophy of grounded theory. With this in mind, an initial interview schedule was constructed between the researcher and the two research supervisors. This included open and general questions in order to generate a curious stance and facilitate flexible lines of enquiry as the interview progressed. This schedule was used merely to guide the interview, not as a finite structure. Many additional questions were asked in the spirit of following the participants' responses, which allowed them to lead in conversation.

2.7 DATA ANALYSIS

2.7.1 Data analysis pathway

In keeping with constructivist grounded theory methodology the process used to analyse data follows that outlined by Hood (2007). Figure 2.1 demonstrates the relationship between the data, coding and theory generation.

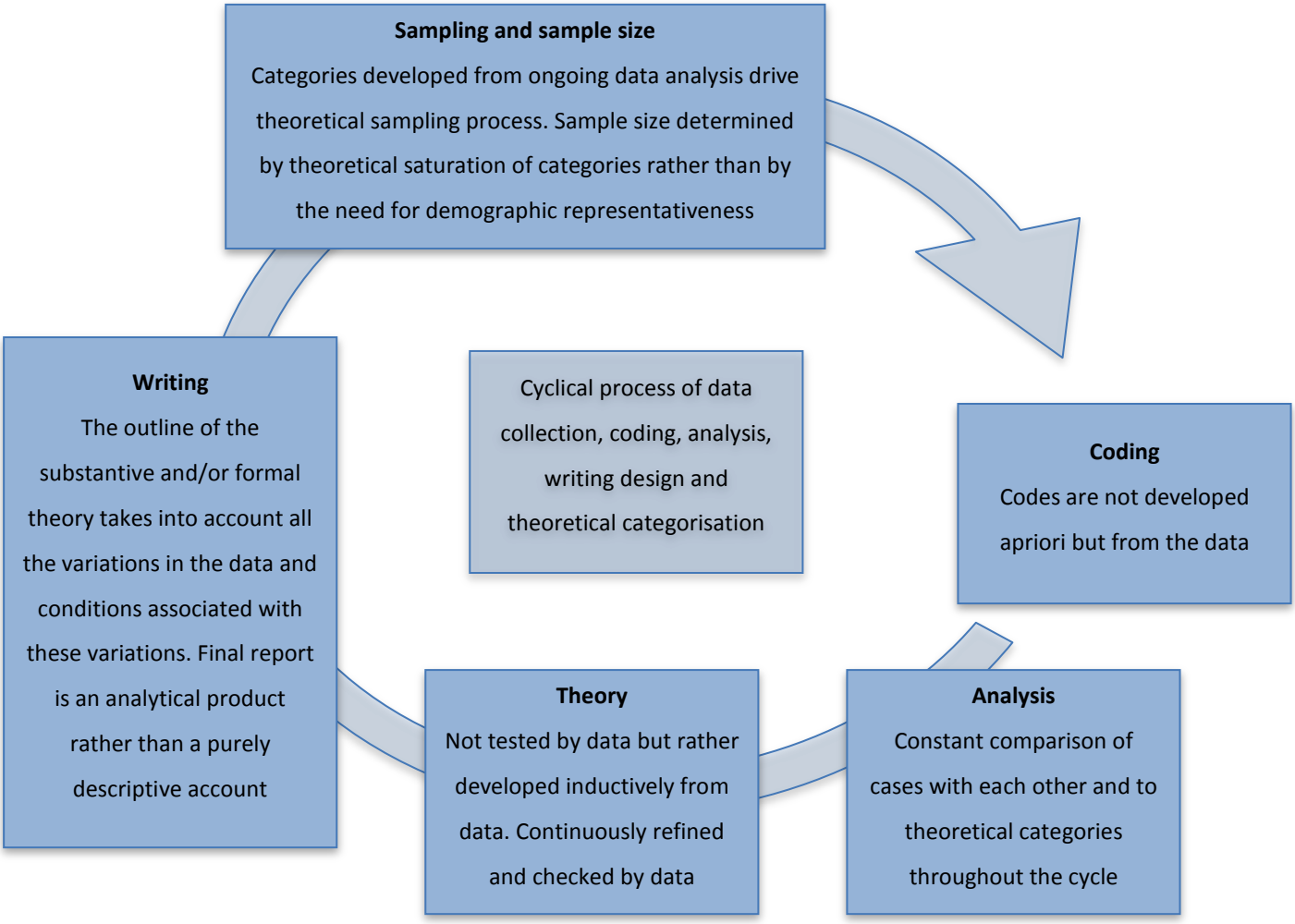


Figure 2.1 Hood (2007) conceptualisation of grounded theory process

2.7.1.1 Transcribing the data

The researcher aimed to transcribe interviews within two days of the interview taking place. However due to time constraints and the labour-intensive nature of audio transcribing it was not possible for the researcher to transcribe all 10 interviews, therefore an external transcription agency was used for seven transcriptions. The researcher listened to every interview recordings following the interviews and again before coding, so as to try and reduce the potential sense of being less immersed in the data than if they had transcribed each interview. Each interview transcribed by the researcher took between six – eight hours, depending on the length and richness of data. All 10 interviews were transcribed verbatim and included non-word utterances.

2.7.2 Coding

All transcripts were coded using computer software NVivo (Version 11.1). The use of computerised approaches to data analysis has been historically criticised for potentially removing the context of the data (Coffey & Atkinson 1996). However the same authors also note that this method can allow for more comprehensive extraction and analysis of coded segments. It was therefore felt that the advantages of using software justified the use of NVivo within this project.

Initially each transcript was examined using a line-by-line coding approach to capture specific words or phrases of interest. Participants' language was used to label codes when possible. This generated a large base of codes which allowed for comparison across interviews, leading to the development of concepts as outlined by Evans (2013). An extract of initial coding can be viewed in appendix G.

2.7.2.1 Concepts

The ongoing comparison of initial coding across interviews facilitated the development of 'concepts'. The process of developing such concepts relies on the researcher observing similarities between codes, which gives concepts the status of being both higher level and less descriptive (Evans, 2013).

2.7.2.2 Categories

Following the generation of concepts the researcher then considered hypotheses regarding the relationship between concepts; which generates the next level of analysis, categories. Once categories were established this allowed the researcher to code later data in relation to these existing categories. Identifying difference within each category generated sub-categories.

2.7.2.3 Reflective Journal and Memo Writing

The importance of keeping memos as a researcher adopting grounded theory is crucial to the process of analysis (Glaser, 2012). Keeping such memos and document allow the researcher to defining categories and codes whilst also identifying gaps within the analysis in concordance with the function of keeping researcher notes (Charmaz, 2003). Throughout the data collection and analysis process the researcher kept a reflective journal alongside written memos. Extracts from the written memos are provided in appendix H.

2.7.3 Theory Generation

Once all categories and sub-categories had been identified a theory was generated in order to bring all of the substantial categories together, thus offering an explanation of the core theme of participants' experience. At this stage the priority

was not to present the theory as factual, rather that the final theory is conceptualised through the relationships between the researcher, participants and the data. The resulting theory of this research is described in detail in Chapter Three.

2.7.3.1 Theory Sensitivity

Theoretical sensitivity relates to the method in which the researcher engages with the data based on their own previous experience, knowledge and assumptions pertaining to the examined phenomena. In relation to the current research the researcher has professional experience of formulation within a variety of client groups and has engaged in several team formulations to date, all of which enhances theoretical sensitivity. This experience provided the researcher with a knowledge base regarding formulation, which was utilised during interviews. However there is a balance to be consciously maintained as a researcher between recognising and utilising ones own experience and not being drawn into making assumptions that others will interpret similar experiences in the same manner. Keeping a reflective diary enabled the researcher to own their thought and feelings and facilitated self-awareness into maintaining this balance as the research progressed.

CHAPTER THREE: RESULTS

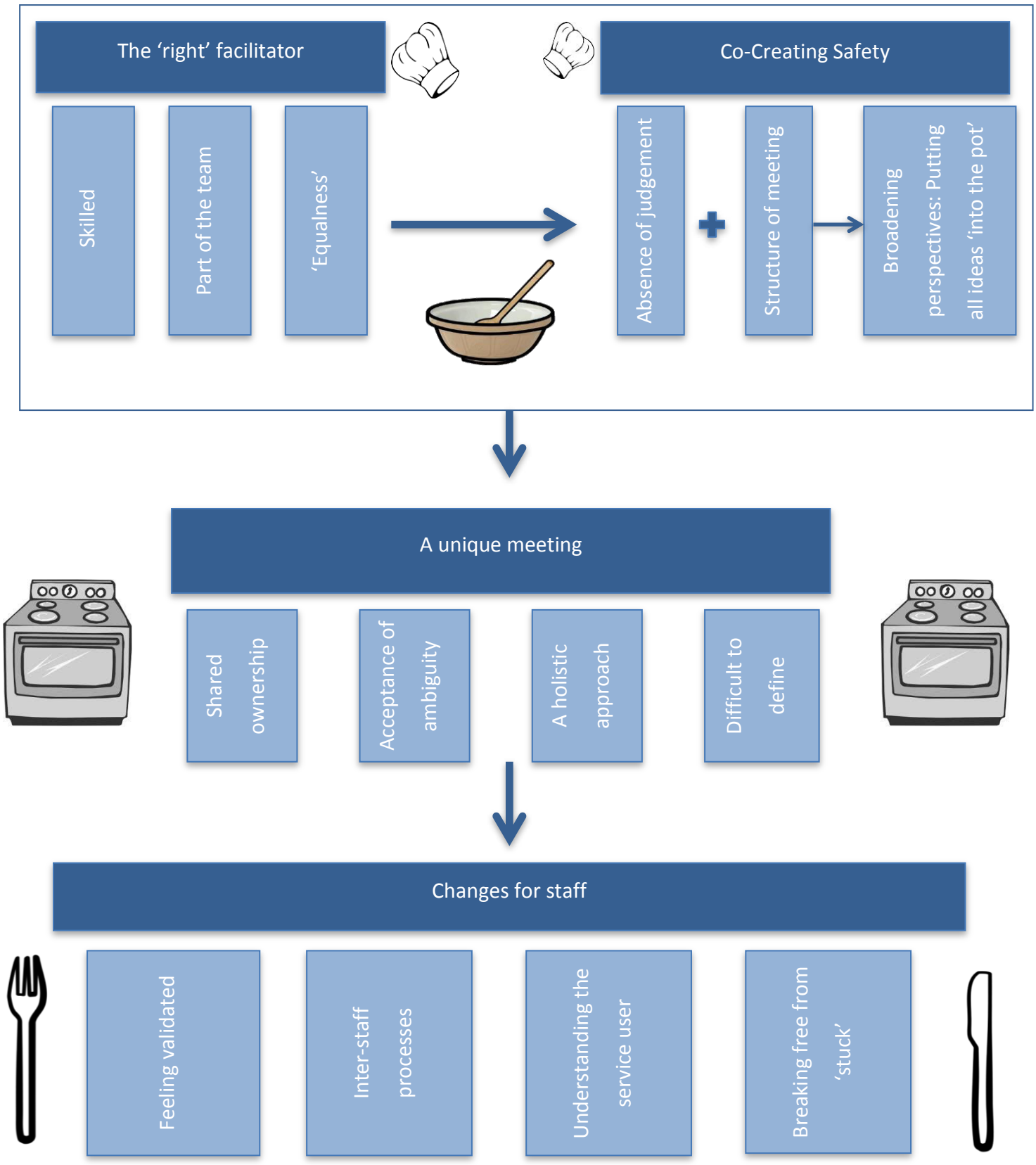
3.1 OVERVIEW

This chapter presents the constructivist grounded theory arising from analysis of the data obtained via 10 individual interviews. Following a series of analyses of the codes generated from the interviews and memos, the resulting final theory features four core categories, 14 categories and 17 sub-categories.

Firstly, a diagrammatic representation of the overall theory and accompanying narrative will be presented. Each core category will then be considered in turn, including categories belonging within the core category. Selected quotes will be incorporated throughout in order ground the theory within the data and to provide illustrative examples of the codes. Where it has been necessary to include words to enhance the meaning of quotes or to remove identifies such as team bases or where a professional has been named these will be displayed in (brackets).

3.1.1 Diagrammatic summary

Figure 3.1 'The recipe for change': The process of using team formulation to facilitate change for staff.



3.1.2 Narrative Summary

The grounded theory that was constructed from the data focussed on staff's perceptions of how team formulation was able to facilitate change, through recognising formulation meetings as being different to other meetings that occur under the same context, such as weekly multidisciplinary meetings or professionals-only meetings. During the interviews the researcher observed that staff appeared to be describing the optimum conditions for team formulation to occur, which was most likely to culminate in a positive team experience. Within the memos the researcher began to interpret the interview data as contributing towards a 'recipe' for team formulation.

Firstly, it was fundamental to have the right chefs. In this case, the facilitator of team formulation acted as the head chef and the team acted in a sous-chef capacity. Much like a head chef, the facilitator needed to have the right skills for the role of facilitating a meeting. They were seen as being responsible for the team of staff (sous-chefs) feeling valued and therefore able to bring their ideas (ingredients) into the formulation meeting. Through the relationship between the facilitator and the team, formulation was able to become a 'safe space' to experiment and share different ideas, resulting in a wide range of ideas being thrown 'into the pot'. As with a professional kitchen, without the right chefs, the right range of ingredients and the right mixing bowl to place these (the 'safe space'), the result could be unpalatable, or unhelpful in relation to team formulation.

The resulting meeting was reported to be a unique environment. Staff felt that formulation meetings were noticeably different to other meetings, in terms of a shared meeting space, where the output was not viewed as being fixed (as with any recipe, the outcomes of team formulation were flexible to change in the future if need be). This 'unique environment' was akin to an oven set to the perfect temperature to enable the best result. Other meetings may have been too high or too low in temperature, meaning that the same professionals could sit within

another multidisciplinary meeting for service users and the outcome would be very different. As a result of the cooking process being 'right' from the start, outcomes were enjoyed by the team through discussing changes that staff perceived within the team and as individuals following team formulation meetings.

3.2 PRESENTATION OF RESULTS: 'THE RECIPE FOR CHANGE': THE PROCESS OF USING TEAM FORMULATION TO FACILITATE CHANGE FOR STAFF.

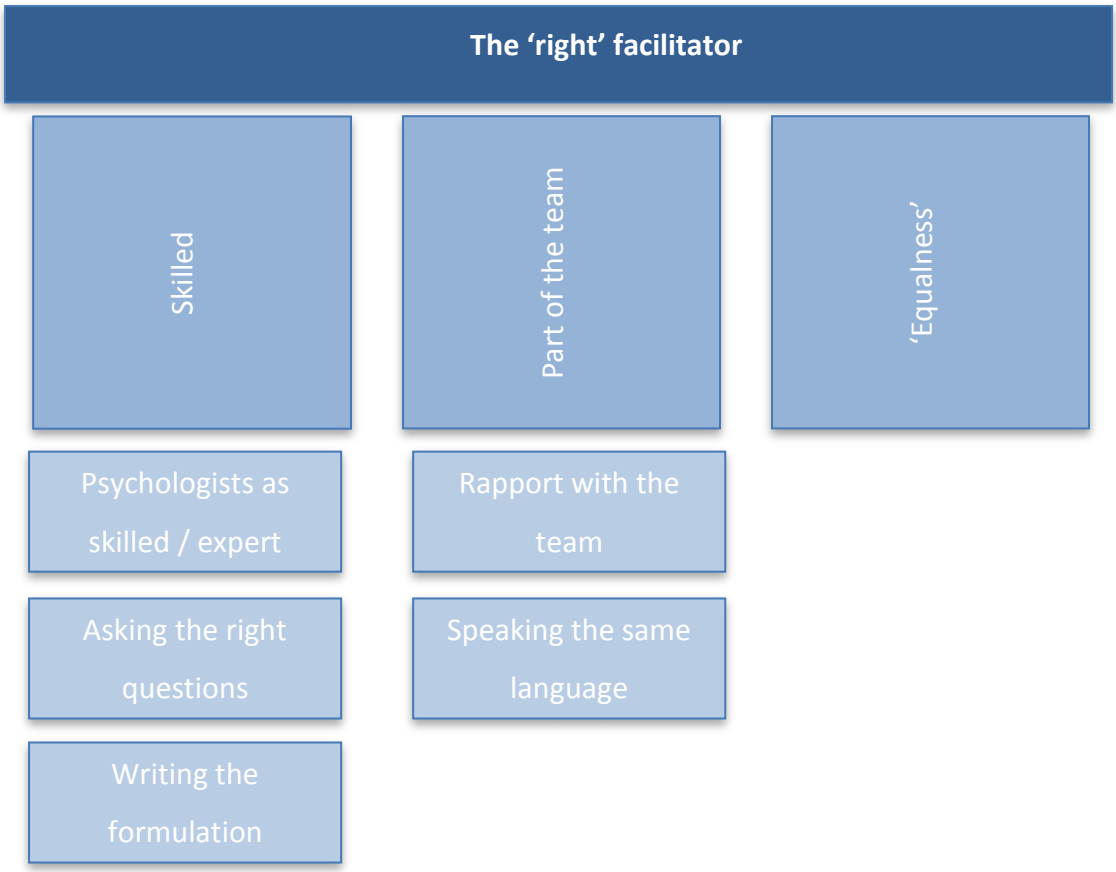
3.2.1 Core Category One: The 'right' facilitator

Participants identified the facilitator as playing a core role within the process of team formulation. It was clear that being a facilitator meant more than just 'running' the meeting. Participants reported that it was a role that required specialist skills in order to ensure that the meeting was successful. It was clear that having the 'right' facilitator played a central role in creating an environment for the meetings where staff felt safe.

> *"For me the main thing in (team) formulation is about having a good facilitator that makes it work, because I think it can very easily be unproductive if not" – Kara*

Staff talked about the features that they felt were needed to have the 'right' facilitator to fulfil the role and result in the meeting feeling productive, including specialist skills, being a part of the team and creating a platform upon which all attendees to formulation meetings felt equal and valued. Figure 3.2 summaries the core category, including all categories and sub-categories.

Figure 3.2 Summary of Core Category One: The 'right' facilitator



3.2.1.1 Skilled

Staff identified the role of facilitator as being skilled in asking questions and composing the written formulation after the meeting. This was sometimes explicitly in reference to the strengths of the facilitator that they had experienced, and sometimes implicitly through talking about the barriers that they would perceive to facilitating a meeting themselves.

3.2.1.1.1 Psychologists as skilled / experts

Staff believed that psychologists were the most appropriate profession to facilitate team formulation meetings.

> *"I personally think (feeling relaxed in formulation meetings) has a lot to do with it being facilitated, or chaired if you like, by psychology". - Sasha*

Viewing psychologists as best placed to facilitate was often attributed to the skills held by psychologists in terms of leading and encouraging multiple perspectives. Some participants also felt that psychologists were naturally more confident in using formulation and in producing written formulations.

> *"From experience I would say that our specific psychologist is very experienced in creating an environment where we all feel comfortable and confident to speak about different things. And yeah, that is a very, you know, she's a very skilled individual." – Sasha*

As well as creating a safe environment the clinical psychologist was also seen as particularly skilled in problems solving and facilitating change.

> *"It's (the facilitator's) problem solving skills... It's generally psychologists I've seen doing this, so I suspect it's in their training, it's where they're coming from that they have that ability to be able to perhaps listen to all of these different viewpoints and then decide how they can encourage a change somewhere, or facilitate a change." – Rachel*

Perceiving psychologists as holding specialist skills enabled staff to have more confidence in the formulation meeting the need of the team.

> *"In a sense it makes me feel more comfortable knowing that a psychologist is in charge of it if that makes sense; because they almost seem sort of good at what's needed– you know, they will value everyone involved". – Lucy*

3.2.1.1.2 Asking the right questions

The facilitator's role was seen as guiding, but not steering the content of the meeting, through the use of questions to increase the shared knowledge of the team in relation to a service user's history.

"Sometimes we just need somebody to bring us back in and rein us in on the right path I suppose or just ask: have we tried... has anybody tried this? Or has anybody tried X, Y, or Z or just does anybody know anything about the (service user's) child, or is there any trauma? Or does anybody know if the partner is still involved?" – Hannah

Through the facilitator posing questions about staff interventions to date, staff were encouraged to adopt a more critical stance of the input, which led to them questioning their practice.

"When she asks you about your work so far you are thinking, 'well am I missing something? Is this very subjective? How objective am I being here?', and that all helps." – Sarah

3.2.1.1.3 Writing the formulation

Producing a written formulation was perceived as a more challenging component of team formulation to complete; the ability of the facilitator to produce a written formulation this was held as a core skill. For some, having a written formulation was one of the most valuable outcomes of the formulation process.

"For me one of the most useful, helpful outcomes of the formulation is to have a user-friendly written formulation" - Lisa

The written formulation was seen as being specifically important for disseminating the formulation amongst the team as well as structuring future intervention.

"*If we've have a formulation and we come up with some kind of plan, you know, if we just talk about the plan then people are going to forget people are not going to cascade that information to everybody else. If it's in black and white in writing ... if anybody's getting queries they can just go to the (formulation) and they know exactly what to do." – Gethin*

The written formulation was viewed as being different from other pieces of written information within the team. It was also recognised that were the formulation was

unique to that particular facilitator; a formulation written by any other person would be different. However the main function of the formulation was perceived to be offering a balanced account of the formulation whilst being 'patient-centred'.

> "The formulation reads very differently from other bits of information because it's all – because it's so patient-centred. I think when you read it again that could come down to who had written... who has written that piece of work because everyone has got different writing styles I suppose. It's a balanced view of things."- Sasha

Writing the formulation was identified as a challenge that made staff from other professions feel hesitant to take on the role of facilitator, and provided further support from the staffs' perspective that psychology should continue to facilitate formulations.

> *"I wouldn't do as good a job (facilitating) as a psychologist. Writing it up I would struggle with. It feels like there's a format and a structure to doing that, but…. You know, when we've got some really good psychologists here, when I look at theirs… I would be shamed!" – Lisa*

Staff perceived the ability to write and communicate the formulation as requiring training to be able to achieve competently. This led to the belief that facilitating was not a role that was open to all team members.

> *"I would be much less confident to write it up with the same articulate kind of package that the psychologist comes up with at the end. And I think it's not something that you can just do ... I think how you interpret it and send it out feels like it sits in a more senior role than perhaps nursing staff. " – Kara*

In addition to perceiving psychologists as holding specialist skills which lent them to be the best facilitator, staff also reported that the facilitator needed to be part of the team.

3.2.1.2 Part of the team

Some participants had experienced formulation sessions held by different facilitators. This enabled participants to draw comparisons between formulation meetings held by their 'regular' facilitator and the impact of formulation being led by someone new. Staff voiced that there were noticeable differences in the meetings between facilitators that were a part of the regular team versus an external facilitator.

> *"Having had a formulation experience with somebody who isn't part of our day-to-day team, it felt very stilted. It felt very forced and there wasn't a natural flow to them like they are with (the team psychologist)." – Kara*

Participants outlined the benefits of utilising an internal facilitator, which included the rapport held by the facilitator with the team, the ability to share the team's language and the promotion of equality within the meeting.

3.2.1.2.1 Rapport with the team

Staff felt that it was of great importance that the facilitator was embedded within the team and had established positive relationships with other colleagues prior to facilitating a formulation. Having rapport was seen as enabling staff to feel more relaxed and aiding in creating an environment where staff felt safe to float ideas within the meeting.

> *"There's a lot of skill to facilitating the formulation definitely. And I would say that's no reflection on the other facilitator, but I think it's – what it could be is maybe a reflection on the rapport within the team. We've gelled together really well as a team and I suppose if you've got a different person facilitating there's not going to be that... I wouldn't feel as comfortable and confident then maybe to sort of put (an idea) out there to see what everyone else thought about it". – Sasha*

For some members of staff the rapport with the facilitator outside of the context of formulation further developed a sense of being valued by the facilitator within the meeting.

> *"(The facilitator) was so highly regarded within our team, and particularly by my manager, because like we've felt from day one she's been such a big part of the team... We got on so well. And (she) just made us feel so much part of that formulation meeting and what we had to say as well". – Hannah*

3.2.1.2.2 Speaking the team's language

Alongside the importance of having good rapport within the team there was also a sense that having an internal facilitator ensured that needs were met and that a pre-existing shared language between the team and the facilitator enabled staff to feel heard.

> *"The facilitator that we've got here is very much part of our clinical team ... so she's not coming in from outside and having to work out what we're trying to say. I think she knows it intrinsically because she's there every day and she has got a very good rapport with the staff. She's already got a good rapport with the patients, so she's not second-guessing what we're trying to say or what we're trying to achieve." – Kara*

The facilitator having knowledge of service users within the team was seen to be advantageous in terms of sharing in the team's experience and understanding their experiences. This knowledge was felt to be a result of the facilitator being a member of the clinical team, as they were present in other regular meetings within the team where service users may be discussed.

> *"(The psychologist) knows all the current patients here, even if she hasn't worked with them one-to-one... you know, we talk about the patients in MDT too so she'll always have heard of them and heard us talk about them. And that's good, you know... because she knows how we've found it working with them so she understands." - Tim*

It was also important to the team that the facilitator provided a sense of all staff as being of equal value within the formulation meeting.

3.2.1.3 'Equalness'

The facilitator was seen as key to ensuring that all staff felt valued, on an equal level and able to voice ideas, regardless of professional label or previous training and qualifications. Participants spoke of this through describing the values held by the facilitator and how these were communicated to the team.

> *"It's all about the equal – well I think it's about the equality, the equalness of everybody that's in the situation regardless of your role or whatever. You go in there as equals, that sense of 'equalness'." – Sarah*

The facilitator was seen as the communicator of equality and setting the tone for the meeting.

> *"It's made clear that when everyone is sitting round that table everyone is absolutely equal and everyone's opinion is discussed". – Eloise*

One regard in which staff felt equality was achieved came from the belief that the facilitator was interested in hearing different perspectives, regardless of which profession provided those perspectives.

> *"That's what I feel here as well when we have our psychologist do the sessions – everybody is valued and everybody is encouraged to contribute- regardless of what your job title is, it could be HCA, it could be staff nurse, psychiatrist... everybody is valued". – Gethin*

From speaking with a range of professionals, the feeling that their opinion was valued and of equal importance was of highest importance to professionals in lower banded positions within the team.

> *"You wouldn't speak to anyone in our team who doesn't really love (the facilitator) and misses her greatly because she really... she really was positive*

about the role of ILS (Independent Living Support)... (the facilitator) really I think saw our role out there and how important it was and really how important we were" - Hannah

Positioning all staff as equal led to staff feeling that the traditional professions-based hierarchy within the team was removed, which staff observed still prevailed within other contexts.

"I think everyone is on an equal footing but I think again that is a lot to do with (the facilitator) because she is very much, 'look it doesn't matter if you have a qualification or not' – because our team, you don't need to be qualified to work in our team – it didn't matter because you were as important as everyone else's point of view to her". - Hannah

"The difference for us was (the psychologist) and just her attitude and the way she conducted it- because, you know, she doesn't enforce the hierarchy as such does she? That's just not her style and I think everyone is aware of that so there's no hierarchy if you know what I mean. Everyone is just like... whereas in some professional meetings, you know, there's... yeah, it's different". - Sarah

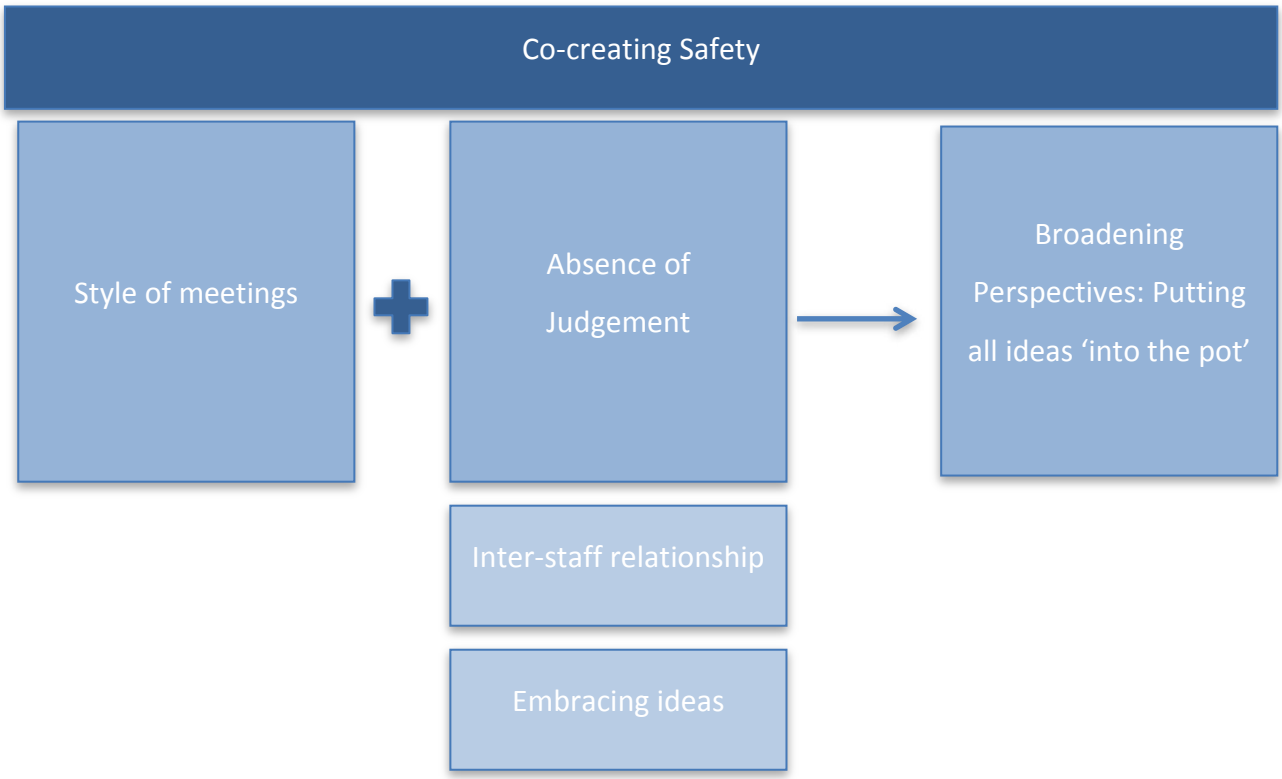
As well as talking about the need for the right person to facilitate the meeting, staff also talked about the facilitation of the meeting as feeling 'safe' and how this was critical to encouraging participants to verbalise ideas and knowledge about the client.

3.2.2 Core Category Two: Creating safety

Staff consistently spoke of formulation meetings as being a safe place to share ideas and questions about a service user and the input of the team. Having the right facilitator (core category one) was paramount in creating an environment where staff felt safe, however there were additional factors a 'judgement free' environment and the co-created structure of meetings. These additional factors were seen as being jointly controlled (mediated) by staff as well as the facilitator, which led to a co-constructed environment of 'safety'. When staff felt that they

would not be judged and experienced the style of formulation meetings as relaxed this then enabled staff to voice opinions and ideas to contribute within formulation meetings. Figure 3.3 below summarises core category two.

Figure 3.3 Summary of Core Category Two: Creating Safety



3.2.2.1 Style of meetings

It was important that formulation meetings felt relaxed and informal. Staff commented that in other environments where formality was present or expected that this was likely to lead to staff feeling 'introverted' or "go into their shell". From the perspective of some, formality resulted in more confident or outspoken members of the team dominating the meeting.

"Yeah and you know, you get people with stronger personalities than others so, you know, if it's very formal, people are going to go into their shell a bit, especially professionals that aren't as confident as others... but if it's a relaxed atmosphere everybody is encouraged to contribute. Then people are going to contribute then." – Gethin

For some staff communicating the informal sense of the meeting was achieved by likening it to an informal discussion.

"(Team formulation) is an opportunity to bring a team together and say "help, I'm stuck ... um.... can we have a chat about this as a team?" - Lisa

Other participants framed the style of formulation meetings as 'relaxed'. This empowered staff to speak in front of colleagues and feel supported by the team to do so.

"It's a very relaxed environment where you feel comfortable to put ideas and views out in front of the team and to sort of gather back their opinions then on whatever thoughts or views you have. I've never felt silly in a formulation then sort of voicing a concern or an opinion that I have." - Hannah

"I think because it's more laid back, I think people are more willing to say anything as opposed to thinking, oh, I'm going to seem so stupid or I need to say it in a much more professional way". – Eloise

Perceiving the meeting as informal in nature resulted in staff feeling more readily-able to contribute their ideas, however it was also important to staff that once those ideas were 'in the room' that they would not feel judged for their input.

3.2.2.2 Absence of Judgement

Team formulation meetings were seen as being 'free from judgement'. Staff talked about feeling able to voice ideas that they may not feel confident as being 'right', but trusted their colleagues to listen to ideas and to value their input. The atmosphere

being non-judgmental was framed both in terms of the facilitator and other colleagues as co-creating a sense of supportiveness.

3.2.2.1.1 Inter-staff relationship

Staff felt that the professional relationship between staff members contributed towards being able to voice their ideas without feeling judged for doing so. This was framed as an unspoken sense of trust within the team. Staff felt comfortable amongst other attendees of formulation meetings, which they considered when weighing up the decision whether to voice an idea. Formulation meetings were viewed by some as 'the place' to bounce ideas around.

> *"Everybody is feeling so comfortable with each other they'll put it out there like. (Now) I'm like, 'shall I say this? Is this the right thing to say? I'll just say it anyway because, you know, in a meeting if it's anywhere to be said it's in (formulation meetings) I guess isn't it?'"- Tim*

Some found the ability to feel comfortable was the most important part of the formulation meeting. There was acknowledgement that the same information could be shared outside of a formulation meeting but be received differently.

> *"That openness is the most important part of formulation – to feel comfortable enough to speak about things that in other situations you would feel perhaps you would need to be more guarded. The openness to be able to say things without feeling that it has, I don't know, reflected badly on you outside of that formulation". – Sarah*

Staff who identified as being 'non-professionals' talked about the inter-profession dynamics within their team being conducive to feeling respected by their colleagues. This was in addition to the facilitator placing their ideas as equally valid, as discussed in core category one. These staff felt supported by the wider team within formulation meetings, which was interesting as participants also reported the traditional hierarchy (where they did not perceive their ideas as being valued equally) was still present within other meetings.

"We know that the other people in that forum will listen to us and respect our views and try and help us as opposed to considering it as, 'oh the support workers can do this', or 'the support workers are not happy because of something'. So I think it's being on the – on the same playing field shall we say?" – Rachel

In addition to feeling comfortable around each other, staff also spoke about the importance of ideas being embraced within the meeting, whether by the facilitator, or by other staff members.

3.2.2.1.2 Embracing ideas

Ideas were felt as being acceptable to communicate within formulation meetings, regardless of how thorough the idea or whether the contributor themselves regarded the idea as 'possibly irrelevant'. Ideas being perceived as accepted within the meeting reinforced the likelihood of participants contributing further in the future.

"If you do make a comment about something that isn't particularly relevant, it isn't dismissed. Everything is kind of taken on board really and everybody feels valued I think. And that makes it informal to think it's okay to say anything and you never feel soft or judged in any way." Kara

There was a sense of staff feeling that they had permission to be creative in their ideas and able to express their true opinions without fearing negative repercussions. Staff were confident in asserting their right to voice opinions.

"I know I can go in and say... not say what I want but you know I can air my opinion and it wouldn't be judged or like frowned upon." – Tim

Being in a space that felt informal and gave staff the confidence to voice their ideas freely facilitated a broad range of ideas and perspectives coming forward within the meeting.

3.2.2.3 Broadening Perspectives: Putting all the ideas 'into the pot'

Staff emphasised the importance of speaking up and having a voice in relation to broadening the perspectives taken to meetings, which they perceived as being beneficial for the service user:

> *"The more opinions and views- that can only benefit the team and patient really... More experience in the room, the better the care plan is going to be". – Gethin*

> *"The more views you have and the more debate and problem-solving that's gone on, one would hope that you've achieved the best solution". – Rachel*

The responsibility of deciding which ideas were beneficial to the service user was attributed to the individual member of staff. When discussing some staff members were surprised at the thought that they might not voice any idea within a meeting that they felt was relevant.

> *"If I had a point, which I thought it could be beneficial to the patient then I'd 100% throw it into the mix in that meeting... because why not?" – Tim*

One participant made the link between the facilitator being approachable as facilitating the feeling that all ideas should be added into the meeting. It was felt that doing this brought the team together to question practice together through debating.

"(The psychologist) does (our formulations) and she makes us feel so... you know she is so approachable and makes it all approachable for everybody to put their own opinions across, it's just the fact that it feels good that everybody can. And then that's when the debate starts coming through and 'why they shouldn't be doing this, why they should be doing this?'" – Gethin

The ability to voice opinions and broaden the overall number of perspectives within the meeting was identified as being a result of staff perceiving the environment around them as non-judgmental and safe. This was particularly prevalent when staff

were attending 'stuck' formulations that were more likely to raise emotional responses from staff.

> *"Because it feels safe, it feels that it's made it feel ok to, to say "I'm stuck", and I think that's important and not feel "I should be able to sort this out myself". It's made it ok to say "I need the support of the team here" and that's been a really um, a really positive thing for me". – Lisa*

Other members of staff echoed this sentiment of feeling supported. There was a reciprocal relationship within the meetings; with staff feeling able to talk within stuck formulations, whilst also feeling heard and supported by their colleagues.

> *"It is a nice setting. I've never been in a formulation where I was uncomfortable, where I felt uncomfortable to talk, you feel listened to; your opinion is always sort of valued. So everyone sort of – you feel as if you can, sort of, in that situation say how you feel or what your concerns are". Lucy*

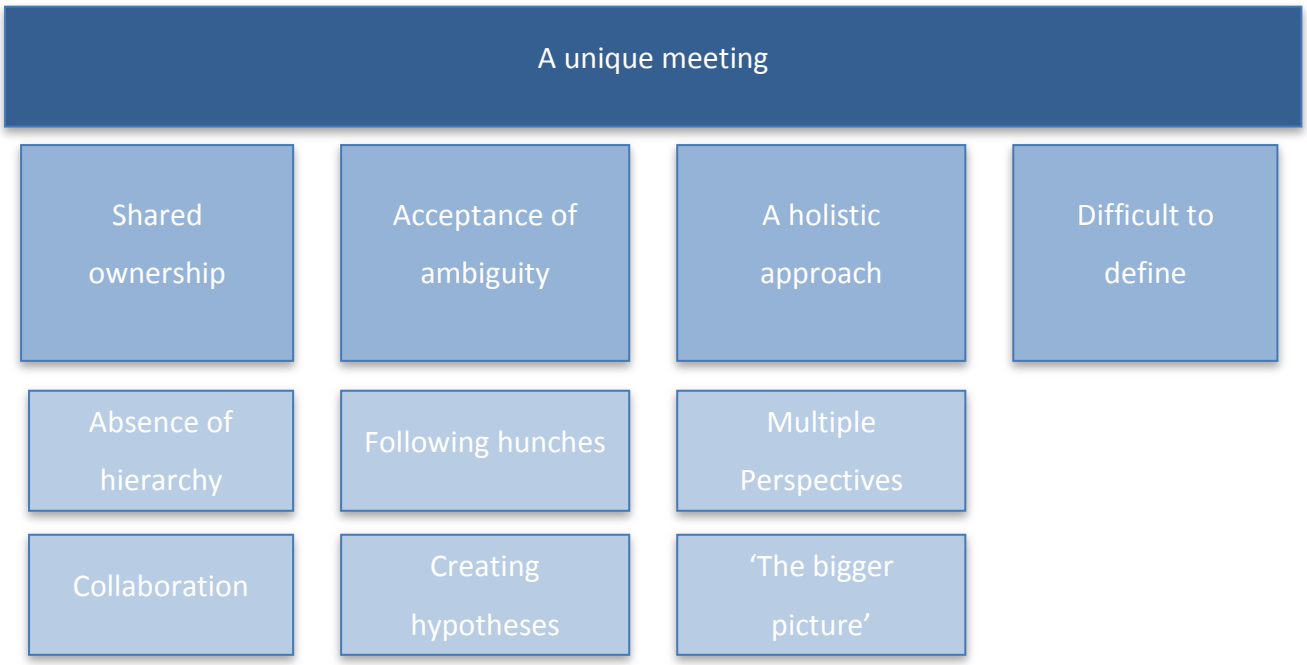
The role fulfilled by the right facilitator needed to be enacted in combination with the team sense of formulation as a 'safe space'. When combined, this facilitated a large number of perspectives and ideas to be suggested in relation to a service user. Staff reflected at length during the interviews how these led to a meeting that felt truly unique, distinctly separate from other multi-professional meetings that they attended on a regular basis.

3.2.3 Core Category Three: A unique meeting

Talking about the role of facilitator and the impact of formulations feeling safe often led to participants talking about formulation as a unique meeting. Participants described formulation meetings as feeling distinctly different to other meetings held within the team. The main comparisons made included multidisciplinary (MDT) meetings, professional-only meetings and discussing a case in supervision. At times it was difficult for participants to describe tangible differences beyond team formulation 'feeling different'. However key features of team formulation that were not perceived as being present in other meetings emerged at a service level and also

at a meeting level. Within the service level of difference the team discussed a shared ownership of team formulation meetings. At a meeting level staff considered the contents of the meeting, specifically in terms of formulation meetings accepting ambiguity and uncertainty during the formulation process and adopting a holistic approach within the meeting. Throughout these differences it was evident that the perceived safety of the meeting and the facilitator both played a role in creating this unique environment. Figure 3.4 below summarises the core category.

Figure 3.4 Summary of Core Category Three: A unique meeting



3.2.3.1 Shared ownership

Participants perceived other meetings within the team as being predominantly medically led. There was a sense that Consultant Psychiatrists who chaired other meetings had the ultimate control over both the content within meetings, such as the agenda, alongside the outcome of meetings. These meeting were also associated with a hierarchy being present within the team that placed medical staff above other

clinical staff groups. This stood juxtaposed with the perception of the facilitator in team formulation as promoting inclusiveness and equality within the team. Some members of staff saw formulation as being in opposition to the medical model.

> *"Formulations are different I suppose to the very definite medical model and, of course, that would probably be the sticking point, the fly in the ointment. Opposition to formulation depends I suppose how strong the medical model is within that system." - Sarah*

3.2.3.1.1 Absence of the hierarchy

Other meetings which several professions attended were seen as being 'owned' by the Consultant Psychiatrist within the team. Within this, the function of these meetings was viewed as being to meet the need of the consultant.

> *"An MDT (meeting) is to discuss the whole of the consultant's case load" – Sasha*

Owning the meeting translated to having control over what was discussed within the meeting, and also what the communicated outcome of the meeting was. Staff felt that the consultant held control over what was communicated within multidisciplinary meetings, however by contrast team formulation was deemed as being more useful due to the broader perspectives of the wider team included (as outlined within core category two).

> *"I think in an MDT meeting it's historically seen as the consultants' forum where <u>they</u> make decisions and <u>they</u> are in charge of documenting what's said, what's decided. You know it's kind of done in their words... So team formulation is much more useful." – Kara*

Staff reported that team formulations were unique in relation to the hierarchy of professionals not being present during formulations, despite the potential for the same professionals to sit within both the formulation and other 'medically-led' meetings.

"(In formulation meetings) you don't have the consultant or the medic- Well you might have, but it... if it was a professionals meeting, you would have the people involved and it may be the consultant or the doctor, CPNs, possible team leaders – the hierarchy there is I would say". – Rachel

For some, the absence of the hierarchy was understood in terms of feeling able to contribute to team formulation meetings and perceiving this input as welcomed regardless of the staff's job title. For one member of staff they also felt that all members of staff had come into the meeting with a shared purpose. This provided contrasted to the 'consultant-led' MDT meetings and communicated a sense of collaboration within the team formulation meetings.

"Everyone is there with one single purpose to share that information and it doesn't matter whether you are a consultant or a support worker, you get to have the opportunity to voice your opinion and that's valued just as much as anyone else is. I definitely think that it is that sort of opportunity that we've never had before." – Lucy

Another way in which participants described owning the meeting was through taking ownership in requesting a formulation meeting. Within the team there were underlying patterns, held almost as 'rules' that dictated which professions were able to request a team meeting of any kind. This had resulted in staff groups that perceived themselves to be at the lower end of the hierarchy feeling unable to communicate a need for meetings and instead organised these through other professions (viewed as being higher in the hierarchy).

"Obviously I could never call a professionals-only meeting because that isn't how it works ... (my role) couldn't do that." - Lucy

As above, staff reflected that they would never feel able to, or in some cases even consider, initiating a professionals-only meeting for the service users they work for. However across the range of professions who took part in the interviews all felt that they would be able to request a team formulation meeting, as many already had. This suggested a sense of shared ownership and responsibility within the meetings.

"That's the good thing with a formulation, you could request it; I guess you could probably go and speak to the social worker and request a professionals' meeting but that just isn't how it works. I don't know anyone who has ever done that. Whereas with formulation, we've asked, "Could we have a formulation for this person because I'm at a sticking point?" – Hannah

Following the formulation meeting participants felt strongly that the written formulation produced was true to the discussions within the meeting, and that this encouraged the view of formulations belonging to the team, not solely the facilitator, which again felt in contrast to participants' descriptions of other multi-profession meetings.

"Our psychologists are brilliant at writing up our formulations in a very cohesive and very understandable way that really encapsulate everything that's been said". – Lisa

Ensuring that staffs' ideas were accurately recorded made staff feel that they had been valued and had succeeded in their voices being heard. This led to an increased level on contribution within the meeting.

"Everything you say is getting written down and it is written down – you get your voice in there... People tend to get more involved with the formulations than they do with the professionals meetings and the after part of it – because you will all have the formulation written down, it's so much more information given in the formulation than ever is shared in a – sort of a professionals meeting I think definitely. So I find them much more useful than I have a professionals meeting." – Lucy

Maximising staff participation in team formulation meetings led to staff perceiving it as a collaborative approach.

3.2.3.1.2 Collaboration

Team formulation meetings were seen as providing a collaborative space, which aided the sense of shared ownership amongst the team. This was also described as being absent in other meetings.

> *"I think we'd like to think that collaboration happens in other meetings but I don't think it does. It's much more medically-led in an MDT (meeting)". – Kara*

Meetings felt collaborative when staff all entered the space with a shared objective and shared their ideas. It was interesting to note that the language staff used to describe going to other meetings tended to reflect that they "attended", whereas when talking about formulation staff spoke of "experiences". This may reflect formulation as being a more engaging and interactive process for staff.

> *"Everyone experiences it, we're all in it together. We've all got this same objective in our minds, you know, this is the next step and the next step..." – Sasha*

Experiencing formulation together was seen by some as strengthening the relationships within the team.

> *Definitely for team working, it strengthens the team, so there are a lot of advantages from being part of the formulation and working within the team. It strengthens the team and you feel more united I suppose and you sort of – what the patient is experiencing or whatever you are experiencing as a team, it's a shared experience." - Eloise*

Staff also identified team formulation as a unique meeting in which ambiguity was both accepted and actively encouraged by the team.

3.2.3.2 Acceptance of ambiguity

Participants viewed the contributions made in formulation meetings as being ideas, as opposed to definitive answers or solutions, which reflects the hypothesis-driven

nature of psychological formulation. Team formulation meetings were accepted by the team as an environment for sharing and bouncing ideas.

3.2.3.2.1 Following hunches

Participants felt able to be led by hunches or 'gut feelings' about how to move forward with service users. Staff described the formulation meeting as feeling safe, and reflected that this was crucial for enabling staff to communicate and explore hunches.

> *"It's an opportunity to be able to say your gut feeling as well – it's a very safe environment I find, a formulation. To be able to say something that you've just got a hunch about and to feel that you can say that in a safe environment. Definitely. – Lisa*

Staff acknowledged that voicing different ideas that might feel 'silly' would not feel appropriate within other meetings. Formulation was viewed as the appropriate environment where all ideas were welcome and thrown into the mix, which gave staff permission to share any thoughts that they possessed.

> *"You can say maybe the silliest, stupidest thing that you might not think- that you might not say in the professionals meeting, you can say (in formulations) because it's just all thrown in there". – Hannah.*

Conversely in other meetings it was felt that there was a need for a 'right' answer, and ambiguity was not tolerated. The language staff used when talking about formulation tended to be more hypothetical, such as staff 'wondering' about part of a service user's history. However within other contexts there was higher importance placed on knowledge rather than hypothesis, with staff feeling that certainty was expected within contributions.

> *"In the professionals meeting, you feel like you've got to be much more 'professional'. You have to know the answer." - Eloise*

Some staff felt that this resulted in internal pressure to say the 'right' thing in other forums, which in turn made them less likely to contribute within other meetings than in formulation meetings.

> *"I think everyone just feels happy to throw in anything (in formulation meetings) – whereas in professional meetings that doesn't happen. I don't see it happening. I mean in professional meetings I will tend to sit there very quietly unless I need to say something- it's not the place where people throw ideas in." - Hannah*

3.2.3.2.2 Creating hypotheses

Ambiguity was also accepted in relation to the outcome of formulation meetings. Resulting interventions or even the formulation itself were not viewed as a fixed or permanent 'solution', but as ideas to be tried. Participants recognised that there was scope to revisit ideas and adapt formulations in the future when needed, reflecting the nature of formulation as generating hypotheses.

> *"If something doesn't work we revisit it, because it's not set in stone". – Eloise*

Viewing outcomes with this lens was perceived as being beneficial for service users and staff.

> *"It may be an outcome for now but the person's problems have not gone away so we may have to re-visit, keep re-visiting to review and see where we're going, so that 's – that's beneficial for all I would think". – Rachel*

One member of staff felt very aware that the outcome of formulation did not always 'answer' questions or provide the final solution. However the formulation was still viewed as being a helpful process in terms of providing a hypothetical understanding of the reasons behind a service user presenting in a particular way to the team.

> *"I mean we don't always come up with the answers- that's for sure... you have even more information and you just have to say "well now I think I understand, they went through this trauma and I understand that they didn't have this love,*

and they were rejected, and this why they are…" and still not having all the solutions". – Lisa

In addition to the presence of ambiguity staff also felt that formulation as a whole offered a much more holistic approach in comparison to other meetings.

3.2.3.3 A holistic approach

Formulation was seen as being a holistic process. This was voiced in terms of both the range of professional perspectives that were considered within the team during a formulation in addition to the depth of information regarding the service user that was brought into the meeting.

3.2.3.3.1 Multiple perspectives

When talking about formulation as being different staff sometimes related the purpose that formulation aimed to address as being similar to taking a case to individual supervision for discussion. However in doing so staff felt that they were missing out on the wider perspectives outside of their own profession that could ultimately shift the feeling of being 'stuck'. Gaining multiple perspectives was perceived to be an advantage to team formulation.

"I think there's a difference because you've got more people – if you're just having a one-to-one interaction you've only got your views and opinions and the other person was listening or, you know, you are communicating with. Obviously when there's a team there's more ideas and you know, sort of – it allows for that forum really of everyone you can just sit down and share views and opinions". - Hannah

"With the formulation you're getting everyone's opinions; if you're bringing up a case in supervision you're only getting that one person's opinions on the care, and that's not to say that they're right. You know- our manager's really good, but you go to your supervision and you might bring up some frustrations but more or less you're always advised to bring it up in formulation meetings 'cos you're getting more opinions." – Gethin

Holding multiple perspectives in the room allowed staff to receive feedback on ideas and questions from a variety of professions. This led to staff questioning their routine practice and ways of delivering interventions. Staff felt that this, alongside considered explanations in addition to psychiatric diagnosis enabled the team to adopt a holistic approach to care.

> *"Normally there's nobody questioning you or challenging you is there? Team formulation absolutely does that". – Kara*

For one member of staff they felt that holding the perspectives of psychology and considering the impact of a difficulty (as opposed to solely considering the diagnosis) led to a holistic approach to care.

> *"I suppose you could argue and say 'well maybe these discussions could also happen in an MDT meeting' but it's very ... it's got a very psychological sort of feel throughout the whole meeting... even though we consider the impact of their illness and the risks associated with that, we're not focussed on diagnosis, we're focussed on the individual rather than the diagnosis... it just feels a lot more holistic." – Hannah*

3.2.3.3.2 'The bigger picture'

Information about the service user's past was held with much more importance within formulation meetings than within other meetings. Staff felt that formulation was therefore for the 'long-term'. Interestingly although both MDT meetings and 'stuck' formulations held a shared purpose when used in response to crises, formulations were still seen as a longer-term intervention than MDT meetings.

> *"The MDT is much more about the shorter-term planning and dealing with things as and when they arise, whereas the formulation is much more about the bigger picture really and having a look at what's gone before and what we can see kind of long term ahead". - Kara*

One member of staff considered the reason underpinning this difference, which was related to formulation being designed to facilitate in-depth discussions. By comparison other meetings that were held to discuss multiple service users were unable to facilitate discussions of any great length or depth.

> *"You get whole new depth to the discussion that can take place in a formulation in comparison to an MDT. And I suppose the logistics of the meeting – an MDT is to discuss the whole of the consultant's case load; so if you average it down to maybe a quarter of an hour or 20 minutes for each individual, whereas formulation could be 1.5 hours just on one person." - Sasha*

In considering 'the bigger picture' of a service user's life staff felt that this facilitated discussion around the cause of clients difficulties, which reflects the importance of utilising background information within psychological formulation. This also led to confidence in resulting interventions as being beneficial, which echoes the ethos of person-centred planning within mental health.

> *"Sometimes you can be reading through the reports and like again an MDT will discuss what's happened in the last fortnight but having an opportunity to really look back into that individual's life and thinking, 'well maybe that is generated from there and that's a lot to do with presentation that we see today' and just really discussing useful and beneficial interventions then for that person. - Sasha*

Sharing and considering background information was seen as having a fixed position within the order of formulation meetings, placed typically at the start of the formulation. Again it was noted that other meetings did not consider information relating to service user's personal lives or experiences.

> *"I think it's a process because everyone – they all start sort of, they always go through background information. They will ask people about relationships, about what their – all those sorts of things that you don't tend to have in other meetings here."– Lucy*

Whilst the interviews elicited responses regarding specific differences as outlined above, there was a selection of staff who found it particularly challenging to

articulate these differences, regardless of how many formulation meetings they had attended in the past.

3.2.3.4 Difficult to define

All ten participants felt that team formulation was different to other meetings that multiple professions attended, however it proved difficult for some participants to quantify the difference. Many spoke of a general sense that it was different or a 'feeling', which possibly reflects the feeling of safety being present but not explicitly spoken within meetings.

> *"I'm not saying that people are like, "You're not important," in a professionals meeting, but formulation has a different feel to it definitely. I was recently in a professionals meeting and it was funny, I was sitting there and I didn't have to say much in it, I wasn't involved really, and I was thinking how much – how it differs to a formulation meeting and how formulation meetings I think are much better." – Hannah*

> *"I think team formulation is a really good thing for all staff members from different teams, different opinions, even though that probably happens in all the other meetings ... I guess you are focussing on that one thing, whereas in those other meetings it could be something that just arose yesterday... But when you book a formulation you know what it's kind of going to be about, so you like structure it well- Like when (the facilitator) is there she will structure it really well and I'm sure they do in the other meetings too but I- do you know what I'm – what I'm trying to say? ... What <u>am</u> I trying to say?" – Tim*

> *"I'm trying to get to the nitty gritty now and I'm thinking – I think– I think – I suppose it must be – what must have an impact has been the amount of input that the facilitator has with the other professionals outside of formulation... perhaps that's possibly something" – Sarah.*

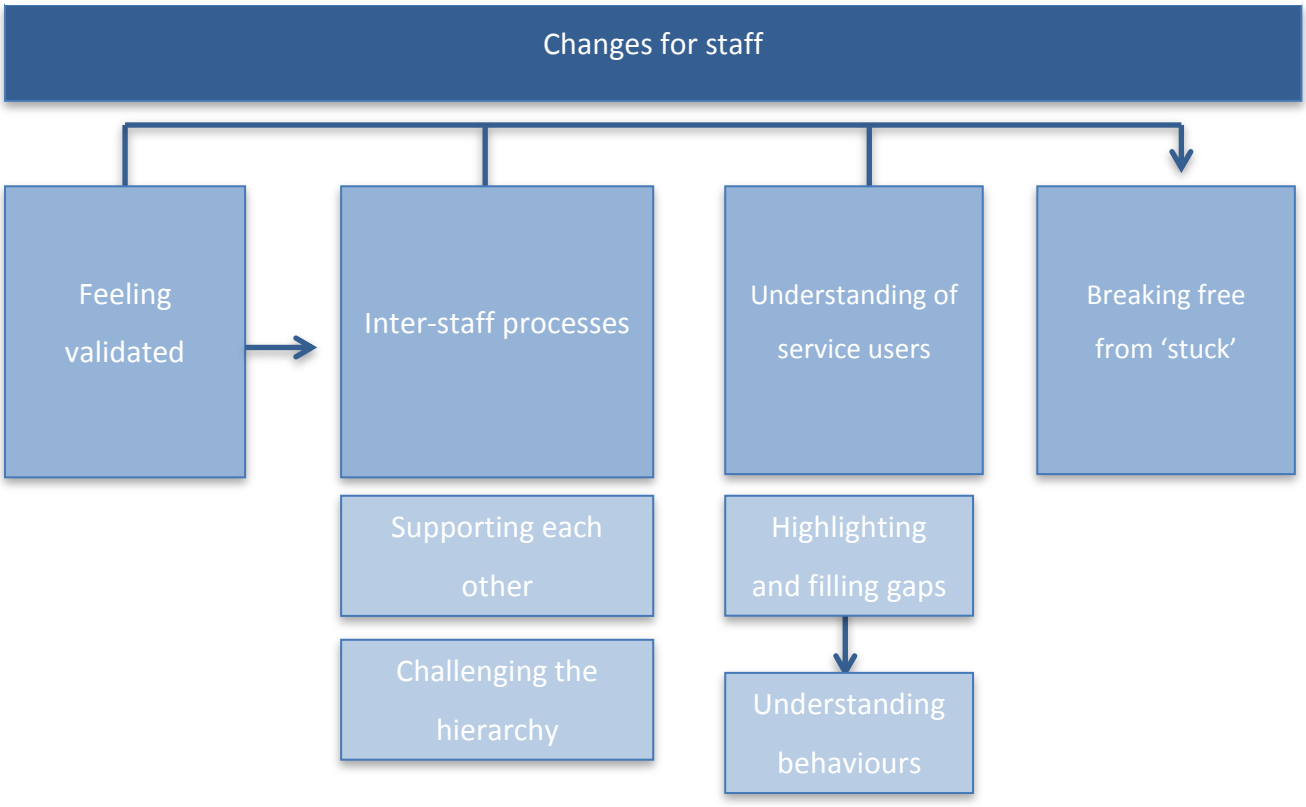
> *"It's all hard to put into words really isn't it? It is, it's very, very difficult because I know what I'm trying to put across but it's – yes. It is different." - Sasha*

The combination of the previous three core categories (having the right facilitator, creating a safe space and the uniqueness of team formulation meetings led to staff reporting changes in their relationship and clinical practice.

3.2.4 Core Category Four: Changes for staff

Staff experienced changes in their work, which they attributed to participating in team formulation. The scope of these changes ranged from an individual level, such as feeling validated, to changes between systems, such as relationships between professions and how certain professions were viewed by the wider team. Staff felt that they had gained a new understanding of service users. These individual and team changes led to staff breaking free from feeling 'stuck', in relation to working with specific service users. Figure 3.5 illustrates the core category.

Figure 3.5 Summary of Core Category 4: Changes for staff



3.2.4.1 Feeling validated

Staff felt that participating in team formulation led to increased confidence. This was achieved through the processes of staff receiving validation from other members of the meeting. This, in turn gave staff the confidence that they were 'doing the right thing'.

> *"It's given people more confidence that what they're doing is right". - Gethin*

For some members of staff receiving and giving validation within team formulation meetings encouraged staff to support each other.

> *"You know, sometimes it's just that reassurance from others to say, 'no we're doing the right thing and we just need to keep doing what we're doing' and, yeah, it's definitely given us an opportunity to support one another as a team". - Hannah*

There was additional value placed on receiving validation from different professionals compared to inter-disciplinary validation.

> *"For someone else to say, "Well no, actually what you are doing is fine and that's okay to continue as you are'... that does make a difference. ... You can get that from your manager. You can get it from your colleagues, but to get that from other professionals does make a difference, definitely and we didn't have that before and we have that now". - Lucy*

For some participants the confidence gained in formulation meetings had a wider effect, as this empowered them to provide more input in other team meetings. This was strengthened through having a stable environment of the same professionals across meetings, thus maintaining the feeling of safety, alongside the values upheld within formulation meetings of all participants having an equal voice.

> *"It's usually the same team that's in the formulation and the MDT and other people coming in, so each time that just gives you more and more confidence to be able to speak and you know what is said is listened to". – Eloise*

"I think it's given us the confidence to voice our opinions and to realise that it doesn't have to be done in a formulation". – Sasha

Having our voices heard and respected, I think that's valid and being able to share and give advice from whoever you are. We know now that you don't need a professional qualification to feel you have an understanding of somebody and to be able to give your view". – Hannah

For staff who had previously viewed their profession as being lower within the team's hierarchy it was a particularly important and positive experience to receive validation via team formulation.

"I think for us it's different because we haven't got this "professional" status... not- that doesn't mean that we feel undermined, because we don't... but sometimes we may- support staff may feel that they need validation from 'the professionals', shall we say, that what they're doing is right, what they're doing is helpful, yeah... um so, to them I think that's really important." - Rachel

Receiving validation improved staffs' confidence in their own ability, thus acting at an individual level. However, the process of validating others also facilitated wider changes to the way in which different professions related to each other and positioned themselves within the wider team. This change in relationship was conceptualised as an 'inter-staff process'.

3.2.4.2 Inter-staff processes

Staff felt that the validation they received in formulation meetings resulted in changes to the ways that different team members related to each other. Some of these changes had not occurred as the result of one meeting, rather over a prolonged period of engagement with the meetings, following them being introduced into routine practice.

3.2.4.2.1 Supporting each other

One more immediate effect of team formulation on relational processes amongst staff was feeling well supported by the surrounding team. This was different to the feeling of validation that staff had described, which tended to revolve around increasing staff confidence. Supporting each other was described as an emotional connection and response within the team. Within 'stuck' formulations in particular, staff were able to openly support each other and to share frustration and distress whilst finding working with a service user difficult. This allowed staff to feel that their distress was recognised and validated within the team. This acted to increase empathy and a sense of unity amongst staff. This was valued by all professions interviewed, but particularly those acting as lone professionals within the team.

> *"You've got that reassurance, the support and just opportunity I suppose to share things that may have been concerning us slightly as individuals, but then you've got that opportunity where you can share it amongst the team. And really I consider what communication is and discussion that goes on in formulations is extremely valuable for future practice". – Sasha*

Sharing the emotional impact of working with individuals created a united sense within the team, and allowed some members of staff to talk about their emotional reactions to working with individuals that they had not felt able to discuss outside of the meeting.

> *"You feel really supported then when you all sit down and they say, 'Oh well I was feeling like that too but I didn't like to say,' but you are all feeling the same way." – Hannah*

Providing the space for staff to openly talk about these emotions led to some staff framing the process of support as being given permission by each other to struggle when working with service users.

> *"At least you are not the one person saying, "Oh well no, actually I'm kind of stuck," but everyone is on that same consensus and saying, 'No, (you've) done everything you can, you've gone through everything and this literally is maybe not*

the right service for him at this point'. I think that does help because it gives you that sort of support then and that there's other professionals there who can say that they feel the same as you do. I think it's having someone say it's okay to be in that situation where you are sort of– stuck with someone" – Lucy

Support was also discussed in terms of reducing previous feelings of animosity within one of the teams and creating a collaborative way forward in relation to team approaches with service users.

"There's less animosity for one. People are not airing their personal opinions about everybody you know, they might recognise that they don't agree with something but as long as the MDT care plan has come... from the formulation meeting then they have support each other to follow it, so it has created less kind of animosity and tension in that respect". – Gethin

Staff also talked about changes between professions, in relation to subtle challenges to the team hierarchy.

3.2.4.2.2 Challenging the hierarchy

As previously discussed, within team formulation meeting there was a noted absence of the traditional team hierarchy, which set the meeting apart from other forums. However, following team formulations staff reported the hierarchy being challenged in a broad sense outside of the formulation meetings. For some staff this was on a subtle level, such as communication between different professionals and increased acknowledgement of the individuals within the team by those at the higher end of the hierarchy.

"Before, sort of nine years ago, I don't remember talking to consultants (psychiatrists) or them even knowing my name or anything like that, because to them you are just support working in the back office. But now because you're all – you know, we're much more involved, it's definitely helped in that regard". – Lucy

Team formulation was viewed as the mechanism by which to draw all professions in together, promoting involvement of those across the professional hierarchy whilst

simultaneously removing the hierarchy within the meeting space. For some of the support staff this had led to the wider team promoting their involvement beyond the formulation meetings.

> *"I think formulation has been an excellent way to bring teams together without the hierarchies. So for support staff to be – to be that involved shall we say and to be treated as equals is very, very good – very important I feel. Because in the past we have not been so, so involved- so strongly involved with the team and I think that's – that's increased overall as a consequence of the formulation meetings". – Rachel*

> *"Talking before – you could speak your opinions, you could say, but it was never in that sort of controlled way that everyone was there and you all had those opportunities sort of to feel like you weren't below or above; there was hierarchy, sort of. But then definitely formulation has changed that... It's only since formulation got brought here that we've sort of been involved and I think that's made a big difference. It's sort of given us – it's given us a little bit of a voice, like I say, that we can sort of be involved". – Lucy*

Additionally, team formulation provided staff with a new understanding of the service user, which enabled staff to use this framework to challenge other professionals' ways of viewing service users. Staff reported challenging the view of mental health in terms of an illness or psychiatric diagnosis and felt able to promote a holistic view of the service users' difficulties.

> *"Now, I think it is very much- very important in those cases to challenge and to say 'Look, this person might just be presenting in a way that might be seen as an illness or a diagnosis, but you have to be able to consider the social aspect of this, or the fact that, you know, there's so many other factors that could be influencing why this person is behaving in this way or why they are struggling, or why they're hearing the voices'." - Lisa*

3.2.4.3 Understanding of the service user

Through the process of formulation, staff experienced a new understanding of behaviour displayed by service users, in relation to both challenging behaviour and choices made by service users pre- and post- service engagement. It was important to staff to gain an understanding of why certain behaviours were likely to be used to

meet service users' needs. This ensured that interventions resulting from formulation were held as being tailored to the individual and in keeping with person-centred care.

> *"People can get really despondent can't they towards patients doing certain things and you don't understand why they are doing it. So the formulation then brings out all the history, like family history and things like that". – Eloise*

In order for staff to feel that they understood a service user it was important to share as much information as possible relating to the service user within the meeting. Having different professions and opinions within the room meant that staff often discovered new information about service users that they were unaware of prior to the meeting. Staff felt that one of the functions of team formulation was to collectively highlight and fill theses gaps in knowledge.

3.2.4.3.1 Highlighting and filling gaps

Sometimes formulation meetings highlighted gaps in knowledge within the team. This frequently related to gaps in knowledge around a service user's background history, or how the service user engaged with different professions. Staff reported learning more about the individual as being a common outcome in their experience of formulation.

> *"Every time it gives me more, well like I say, more knowledge of the patient." – Tim*

For some staff sharing information to create a timeline of the service user's experiences to date was a crucial step in increasing the team's collective understanding of the service user. Past events were viewed as being relevant to the current day presentation of service users.

"I think with the formulation, because you are going back through a lot of historical information as well you have a better understanding of why the person is who they are". - Eloise

Formulation was regarded as the environment most likely to highlight gaps in knowledge, however it was also perceived to be the best environment to fill these gaps.

"Most likely (in formulation meetings) we find that we work with people and we may not know this information or um, and that's actually quite surprising – but that's good! That's not a negative. We can fill the gaps then, so it's good for filling gaps." – Lucy

In order for staff to learn the optimum level of new information surrounding a service user it was important for staff to all contribute their ideas within the formulation meeting.

"You definitely learn something new. I think that there's a lot of coming together of information and I think, you know, I would bring five new things; somebody else would bring five new things – so already that doubles the knowledge that the team have got about that person." Kara

In some instances the knowledge was already in the team but had not been shared between professionals, in other cases staff were aware of missing information that no one had discovered about the service user. The nature of these gaps in knowledge sometimes came as a shock to staff, particularly for service users who may have spent a considerable amount of time within the service.

"Sometimes what a formulation is really good for is making us realise that we might have worked with somebody for a very, very long time and there's massive gaps in our knowledge, because whoever is leading the formulation will say 'Do we know about this part of their family, or upbringing?' and everyone looks around and says 'No', and we think 'Ok, they've been in service for twenty years, what's going wrong here?'" – Lisa

In some cases new information informed ways of interacting with service users, which staff found particularly helpful. In this sense formulation was received as a

systemic account for behaviour, interweaving contributions from multiple perspectives to shape perception of the service user by the professional team. Using information from multiple sources allowed staff to hypothesise the reasons behind the service user presenting to mental health services, which was a powerful experience for staff.

> *"I think I went to one formulation, I'm not working with the lady now and people were saying and one of the consultants was there who wasn't currently working with her and there was a whole host of information that came out of that that I had no clue to because it wasn't in her referral... It was almost like a bit of an epiphany for me thinking, 'okay, that's why she's like this' or 'that's why'". – Hannah*

Outside of the recorded interview taking place one member of staff expressed that they felt that background history, such as family genograms, was often seen as 'basic' information and not necessarily relevant or important to the service user being seen by the mental health team. This led to the possibility of professionals overlooking such information in favour or information that supported a psychiatric diagnosis as opposed to considering past traumatic events or childhood experiences. Gaining a more holistic understanding of an individual's history enabled staff to feel empathic towards service users. As a result staff found it easier to continue to work with service users who were perceived as more 'challenging'.

> *"I've sat in formulations and heard things about clients that I've worked with, and their histories.... it happened the other week, and I just did not know what this woman had been through... and it was upsetting for me... but I hadn't been fully aware of what she'd been through and it was horrifying. And it... it made it a bit easier for me to work with her because of (knowing) what she'd been through." - Lisa*

Through the highlighting and filling of gaps in staff knowledge there was an increased likelihood of staff reaching an understanding surrounding the behaviours that service users might display during their involvement with the team.

3.2.4.3.2 Understanding behaviours

Through an increased shared knowledge of the service user and in combination with the structure of psychological formulation the team reported that they were able to develop an understanding of service users in relation to the underlying reasons for individuals presenting to the service in different ways.

> *"It just made me realise why she was behaving towards me the way she was. So it puts a different slant on things as well". – Lucy*

When discussing how they came to understand behaviours some staff described adopting a psychological approach to understanding of behaviour, often involving recognition of the impact of past trauma or current family dynamics.

> *"I think you've got to consider all of it. I mean there is a big link isn't there between like family histories and kind of like the way people behave?" - Eloise*

Some staff felt that due to team formulation being facilitated by a psychologist that this had encouraged them to adopt a 'psychology hat' when considering service users.

> *"I'm becoming more and more aware that for many people there's an added root cause, and I think I'm becoming more aware of looking at those issues first and saying 'hang on a minute, it might be something I can do with the support of a psychologist'…" – Lisa*

Staff reported their newly developed understanding of the service user by using the formulation to ensure that future interactions between staff and the service user were tailored to meet the service user's needs. This was achieved by mindfully holding topics in mind that the team were aware might be difficult for the service user to engage with.

"Formulation will give you new information and understanding, so you'll know that's the areas that you need to avoid or things like that, which you didn't kind of know before. That's why I find it really very helpful" - Lucy

When describing their understanding of behaviours staff talking about using information within formulation to assist them in identifying 'patterns' in behaviour. Staff were able to recognise these patterns within their work with service users that reflected the previous life experience of the individual.

"And I notice 'Oh, they're doing that with me, oh, their mother did that with them' and you think 'Oh God, this feels like the pattern they're doing with me'. Sometimes it's seeing patterns in their behaviour when they're talking about things that might have happened in their upbringing. You see it mirrored in their current behaviour. So sometimes for me it's a direct mirroring of something that's happened." – Lucy

Holding this understanding enabled staff to recognise the impact of their own relationship with the service user.

"It gives you that, you know, if you look at it from seeing my relationship with the service user it's definitely, it gives a greater understanding of what they may have experienced". - Sasha

Through the combined outcome of feeling validated, enacting changes in team relationships and understanding the service user, staff were able to break free from a sense of 'stuckness'.

3.2.4.4 Breaking free from 'stuck'

The outcome of formulation was reported as a shift from the sense of being 'stuck' with a service user. This was sometimes achieved by devising new intervention plans or ideas. The process of collaboratively devising new interventions to try resulted in a sense of relief for staff, and provided optimism for the future with regards to working with the service user.

"Everybody comes out feeling that sense of relief then that, right, we've got it now, we've made it. We've settled that – we've come out – we've got – sometimes you can go into one and think you might not be able to come out with something – with an answer or a solution. And when you do it, it just feels so good." Tim

Trying something new was perceived as the team taking a pro-active stance to manage the feeling of 'stuckness'. The concept of collaboration and working as a team was important in achieving this.

"We can feel that we're doing something productive and pro-active for the individual rather than just thinking 'I've tried everything I can', like that type of – so that can be very refreshing and reassuring and give a real sort of sense of team-working". – Hannah

For some members of staff holding a formulation meeting was seen as the primary team intervention for shifting the 'stuck' sensation. Staff had confidence in that calling these meetings would resolve the issue within the team.

"Sometimes... everybody is stuck with the individual, I think we need the formulation, the stuck formulation. And the outcome that shifts that would be new things to try, new approaches, something that I haven't thought of". – Sarah

However, staff felt that new interventions were not always necessary to facilitate a change in appraisal and to feel like they had moved past 'stuck'.

"You don't always get a result, say something that changes but you can – you still feel like you get something out of it definitely. I've never come out of a formulation thinking well that's just a waste of time, ever". – Lucy

The outcome of understanding the service user through more information was considered to be enough to shift staff feeling stuck, even if the information did not necessarily lead to new interventions.

"Sometimes, you have even more information and you just have to say 'well now I understand, they went through this trauma and I understand that they didn't have this love, and they were rejected, and this why they are…' and still not having the solutions but feel ok with that" - Lisa

Even in circumstances where the outcome of formulation was that the gaps in knowledge remained staff still perceived this as providing a positive outcome. The intervention in this case became to fill the gaps, which in the short term led to the member of staff feeling that they had still found a 'way forward' with the service user.

> *"Sometimes we come together, there's a formulation and the outcome is that there are gaps in our knowledge. You think 'Why don't we know this? We've been working with this person for ten years'... and that's really helpful because we almost have these gaps to fill as a way forward". – Eloise*

Staff reflected that they themselves were able to shift the sense of feeling stuck, even if the behaviour displayed by the service user did not change following formulation. Changing the way that staff interacted with the service user was still able to alleviate the feeling of being stuck with one particular service user.

> *"They (the service user) were just the same. But I think myself and my colleague's way of working changed, which then was easier for us really as well". – Hannah*

3.3 CONCLUSION

To conclude, a grounded theory was constructed following interviews with ten multidisciplinary members of staff who had experience of participating in team formulation. The resulting theory demonstrates the process of change emerging from team formulation as being dependent on two core components; the facilitator of the meeting and ensuring a safe environment to enable the meeting to reach maximum effectiveness from the perspective of staff. When both of these key ingredients are combined, staff perceive the formulation meeting as a unique setting, differing in a variety of ways from other multi-professional meetings. The underpinning philosophy behind formulation of creating hypotheses (accepting ambiguity), in combination with the availability of a safe environment in which to create said hypotheses enabled staff to perceive progress within the team. This was

reported to hold repercussions for both the service users at the centre of the intervention, but also for the everyday working of the teams. Staff felt empowered to challenge the existing hierarchy of professions in a safe and constructive manner in order to ensure that their voices and opinions were heard.

CHAPTER FOUR: DISCUSSION

4.1 OVERVIEW OF CHAPTER

This chapter provides a summary of the results of the study and links these findings to existing literature. The clinical and service implications of this research are considered, alongside the strengths and limitations of the current study. Finally, recommendations for future research into team formulation are provided.

4.2 RESEARCH FINDINGS

4.2.1 Summary of findings

The aim of this study was to explore multidisciplinary mental health staff experiences of participating in team formulation. This study adopted a grounded theory methodology to achieve this aim. There are a limited number of previous peer-reviewed studies that have used grounded theory in relation to exploring staff perceptions of team formulation. This is the first study to the knowledge of the author to provide an account of the process by which team formulation facilitates change amongst staff.

In keeping with the literature outlined in Chapter One, this study found that staff perceived multiple benefits of using team formulation, in relation to themselves, the wider team and service users. Staff found it more challenging to comment on the potential outcome of team formulation from a service user perspective, possibly due to the lack or service user involvement within these meetings.

Team formulation was perceived as being fundamentally different to other meetings held within the team. Through the exploration of staff experiences it emerged that staff placed the greatest importance on having a safe environment in which to hold the meeting. In this context, 'safe' meant a space where all members of the team felt equally valued and able to voice hypotheses without feeling that negative judgements would be made by other team members. Staff saw the facilitator as playing a key role in ensuring that this 'safe space' was achieved. The ability to fulfil this role was attributed to the skills that the facilitator held from their clinical role as a psychologist, alongside the values that the facilitator held with regards to team working. The main findings of the study will now be considered in relation to the existing literature.

4.2.2 Relation to existing literature

The findings of the current study are presented in relation to the existing literature. As recognised, there is limited quantity of previous research surrounding team formulation, therefore the study findings will be linked to the wider research context where applicable. For ease of reading in relation to the theory CORE CATEGORIES are presented in capitals, **categories** are in lower case and bold lettering and *sub-categories* are presented in lower case and italics.

4.2.2.1 The 'right' facilitator

The core category THE 'RIGHT' FACILITATOR captured the participant's need for a facilitator to be **skilled, part of the team** and able to create **'equalness'** amongst staff**.** The skills defined as being important were viewed as being held specifically by psychologists, (*psychologists as skilled/experts).* Lavender & Paxton (2004) note that the role of the psychologist within the modern-day multidisciplinary team has expanded to include skills in therapy, consultation, training and supervision, which is also reported in Division of Clinical Psychology (2007) guidelines regarding

psychologists working in teams. This document also purports the evolving role of the psychologist as taking an active stance in leadership and training within teams. The current study suggests that given the structure and content of team formulation psychologists are arguably utilising skills in all of the above roles to be a successful facilitator – empathising with and supporting staff who are struggling, using formulation as a vehicle to train staff in changing their perspectives of service users and offering guidance (consultation) within formulation meetings if requested. Ingham (2015) specifies that the facilitator needs to possess the skills to communicate the formulation at a level appropriate for an individual with no training in psychological models. This reflects staff within the current study placing importance of the facilitator's skill in *writing the formulation.*

Staff reported that they would not feel confident to facilitate team formulation due to not possessing the same professional skills as the psychologist. Dexter-Smith, Hopper and Sharpe (2010) delivered team formulation training sessions for non-psychology colleagues, with the aim of encouraging other professions to facilitate. However, despite 93% of the 100 participants reporting that the training had met their developmental needs, they still lacked the confidence needed to facilitate a formulation meeting following the training. This has required weekly on-going support from psychology in order to encourage staff to utilise their developing skills in formulation. As delivering psychological formulation is defined as a core competency of Clinical Psychology (British Psychological Society, 2010), it is likely that other professions will continue to position psychology 'in the driver's seat' of team formulation.

Staff spoke of the importance of the facilitator being *part of the team*. Where some participants had experience of an external psychologist facilitating this was perceived as having negative consequences for the formulation, in terms of staff not volunteering their ideas or information as readily and the process feeling 'stilted' as a result. Team formulation presents a space for staff to share and support each other whilst hearing distressing information about a service user (Ingham, 2015). The desire to have an internal facilitator (and thus keep all information 'within the team')

may reflect the desire that many clients feel whilst disclosing sensitive information within a therapeutic relationship, in wanting to keep the nature of their distress confined to the safety of the established relationship with their therapist and to feel safe in doing so (Farber, Berano & Capobianco, 2004). In this sense the team could be viewed as adopting the role of the client within team formulation. Previous professionals involved with team formulation have also purported the team as filling the client of team formulation, such as Johnstone (2013).

4.2.2.2 Co-Creating safety

Staff spoke of the importance of formulation being a 'safe' environment (CO-CREATING SAFETY). Previous research into team formulation has resulted in the general concurrence of formulation meetings as being 'safe', both from a multidisciplinary staff perspective (Summers, 2006; Wainwright & Bergin, 2010) and by clinical psychologists (Christofides *et al*, 2011). As in the current study, Blee (2015) reported that professionals also felt that safety was a requirement of team formulation, in order for professionals to share views and opinions without the fear of judgement.

The experience of a 'safe' environment within groups has been demonstrated in research within other contexts that are arguably similar to team formulation, such as in service user care training programmes for staff (Ingham *et al*, 2008), staff support groups (Haigh, 2000) and reflective practice (Collins, 2011).

Participants in the current study felt that in order to create a sense of safety between staff and the facilitator it was important to have the right conditions: **Style of meeting** (as informal and relaxed) and an **absence of judgement**. This seemed to allowed staff to freely contribute ideas, which led to the process of **Broadening Perspectives** within the meeting. Establishing these conditions could be likened to the six 'necessary' conditions for any effective therapeutic relationship (Rogers

(1959), in Prochaska and Norcross, 2007)). These conditions are summarised as Therapist-client psychological contact, client incongruence, therapist congruence, therapist unconditional positive regard, therapist empathetic understanding and client perception. In this context an effective therapeutic relationship is one that leads to change, such as the interaction between the team and the facilitator in attempting to shift the team from a sense of 'stuckness' through team formulation.

The process of team formulation described within this study demonstrates many of these conditions being met, when the team are viewed as the 'client' and the facilitator as 'therapist'. From the perspective of staff, the facilitator and the team viewed each other as being important. Staff believed that the facilitator valued all of the knowledge, experience and ideas brought by each team member to formulation meetings, and reciprocally staff viewed the facilitator as being skilled, thus meeting the first condition, which requires a relationship to exist between client and therapist where both view each other as important. Therapist congruence refers to the therapists' ability to be involved with the client and draw on their own experiences. Arguably THE 'RIGHT FACILITATOR' being *part of the team* enabled them to connect with the team experience and use this to recognise the distress that staff reported feeling when working with some service users, thus demonstrating the team's need for therapist congruence. The concept of 'Unconditional Positive Regard' from the therapist towards the client is arguably similar to the role of the facilitator in valuing all contributions within formulation meetings and promoting the **absence of judgement**. Staff themselves were also responsible for holding unconditional positive regard towards each other, which created an environment where staff felt that no idea would be considered 'silly' or 'irrelevant' by anyone present in the meeting. Rogers states that any therapist who embodies congruence, unconditional positive regard and empathy will enable clients to express their true feelings and views more confidently, without fear of judgement; a process that is arguably reflected by the facilitator and the team within the theory constructed via the current study.

4.2.2.3 A Unique Meeting

Staff explored how team formulation differs from other forums where difficulties with service users might be discussed, such as MDT meetings, professionals-only meetings and in supervision. Their descriptions surmounted to a perception of team formulation as A UNIQUE MEETING. This is the first time (to the knowledge of the author) that research has sought to explicitly explore differences underpinning the experience of team formulation in comparison to other core MDT and other professional meetings. However, as recognised by staff, this difference is **difficult to define**, which is possibly an attribution as to why previous research has yet to gain a firm grasp on this concept**.** Staff were able to identify formulation meetings as holding **shared ownership** amongst the team. Staff attributed this sense of equality to the *absence of* hierarchy between professions and through the process of *collaboration*. Staff also perceived formulation as a space where ideas were welcomed and there was no single avenue to consider when thinking about a service user, which was summarised as an **acceptance of ambiguity**.

One possible explanation for team formulation meetings providing this sense of **shared ownership** is that the meetings themselves reflect the underpinning nature of psychological formulation. As discussed in Chapter One, the aim of formulation at its core is to create a shared narrative between two sources (Division of Clinical Psychology, 2011) such as a therapist and client, or a facilitator and the team. Previous research supports the use of team formulation to draw professions together. Morton-Smith (2015) found that team formulation promotes the involvement of the whole multidisciplinary team and facilitates *collaboration*.

Staff described the pressure in other meetings to only speak if they felt they had the 'right answer'. In team formulation meetings there was a perceived **acceptance of ambiguity**, where any information contributed was held as an 'idea' rather than truth. This also likely reflects the nature of formulation as constructing provisional (and therefore changeable) hypotheses (Kuyken *et al*, 2005).

One model that contexualises this experience of feeling able to contribute ideas and create hypotheses is Mason's (1993) model of 'Safe-Uncertainty'. Within his framework Mason describes the process of systems moving from a position of unsafe-certainty towards safe-uncertainty. Applying Mason's framework could account for staffs' transition in formulation meetings from unsafe-certainty (staff awareness of feeling 'stuck' with service users) to a position of safe-uncertainty (even if team formulation has not provided 'the solution' for the service user, the team maintains a feeling of safety and peace with the outcome of meetings). **Acceptance of ambiguity** plays a key role within this, as it gives staff the freedom to share as many ideas as possible and *follow hunches*, which led to staff building the framework to move away from 'stuckness'.

Team formulation was seen to promote **holistic working** in a way that other meetings did not. This was broken down into the holistic approach to the service user through gathering *multiple perspectives* and gathering a deeper sense of the service user. This resulted in staff seeing *the bigger picture*. Team formulation has been advocated as a means of gathering multiple perspectives (Christofides *et al*, 2012). In the current study participants felt that gaining a greater depth of information regarding a service user's past enabled the team to consider the 'cause' of the service user's distress, and to take a pro-active stance in responding to this. Other meetings were viewed as operating on a more superficial level of knowledge based on the service user's recent experiences. Hood & Johnstone (2010) found that staff participants viewed team formulation as a means of achieving resolution, rather than treatment. As recognised by The Division of Clinical Psychology (2011), team formulation seeks to identify the core of difficulties, as opposed to being merely reactive to crises.

4.2.2.4 Changes for staff

Through participating in team formulation staff experienced CHANGES within their work. These CHANGES FOR STAFF were summarised as relating to feeling validated, which contributed towards better working relationships, termed inter-staff processes. Staff also felt that their understanding of service users was altered. All three of these led to staff feeling able to break free from feeling 'stuck'.

Interestingly the mechanisms underpinning change suggested by the current study appear to link closely to the mechanisms proposed by Summers (2006), who reported that benefits of team formulation hinged on bringing people's ideas together, increasing staff knowledge (and thus their understanding of patients) and having a space in which to think creatively. Although in this particular study staff did not refer to the safety of team formulation, whereas the participants in the current study emphasised the importance of this for them. This many indicate that different teams and systems require a unique environment to suit the individual team in order to perceive benefits in team formulation.

The structure and process of Team formulation enabled staff to receive and provide **validation** between each other. This gave staff the confidence that they were already doing the best within their professional ability to help the service user. **Validation** also referred to validating emotional responses within the team to difficult situations. Staff receiving validation of their clinical work was also a finding for Unadkat *et al (*2015). Staff within the current study found validation of particular importance if they were a lone professional within the team or if they considered their profession as being at the lower end of the professional hierarchy. There does not appear to be any literature to date that collaborates the impact of validation in team formulation across different professions.

Participants reported improving team dynamics (**inter-team processes**) depended on staff feeling able to *challenge the hierarchy,* which some staff reported was possible

due to the process of team formulation. Although there does not appear to be any previous research that specifically examines the impact of team formulation on inter-staff relationships, Johnson *et al* (2010) found that teamwork was essential in maintaining staff morale across all staff grades. Within this audit, staff working within mental health settings also reported the experience of 'the hierarchy'. When there was a 'non-hierarchical' atmosphere staff felt a sense of belonging to a wider community, which served as a protective factor during distressing work-related events. Similarly, in the current study staff recognised the role of supporting each other as being to create togetherness during difficult periods with service users. The use of formulation to change team culture has been demonstrated within the existing literature (Onyett, 2007). The Division of Clinical Psychology (2007) guidelines "Working psychologically in teams" stipulates that taking formulation into a wider (team) setting can be a meaningful method of shifting culture within teams. Arguably the findings of this study corroborate those of Summers (2006), which found that team formulation improved team working in a broader sense.

Staff reported *understanding the service user* in a deeper sense due to the amount of information and perspectives shared during the formulation meeting. One of the most replicated findings of team studies to date is that team formulation increases staff understanding of service users. This has been found within older adult settings (Craven-Staines, Dexter-Smith & Li, 2010), adult settings (Unadkat *et al,* 2015), forensic settings (Lewis-Morton *et al*, 2015) and young persons (Milson & Phillips, 2015). Although not a direct finding of their study, Blee (2015) concluded that the main difference between team formulation and other contexts where the same staff needs could be met (such as reflective practice or training) was the psychological understanding of service users that participants gained from the meetings. Staff in this study did not identify the understanding as being a unique component of team formulation, from their perspective however it was still an important change. It is also important to note that whilst the participants in the current study regarded a new understanding of service users as a positive outcome, Blee (2015) found that some participants found this new understanding unhelpful, as it challenged their

previous method of working with the service user. Mohtashemi *et al* (2016) identified one barrier to achieving a psychological understanding within team formulation came as a result of staff clinging to their professional backgrounds – for example some psychiatrists felt a loyalty to the medical model and viewed psychology as threatening their profession during the team formulation meeting.

Onyett (2007) promotes team formulation as a means of developing psychological understanding within teams. Staff within the current study demonstrated that during formulation meetings a perspective beyond psychiatric diagnosis was adopted, which encouraged staff to consider the underlying cause of psychological distress in relation to past trauma, or in consideration of the system around them such as challenging family dynamics.

Within **understanding of service user** was staff responses of increased empathy for service users following team formulation sessions. Previous research supports this finding (Summers, 2006; Christofides *et al*, 2012; Wainwright & Bergin, 2010). Relevant to this are the findings of Weng *et al* (2013), whose study suggested that it is possible to train empathy and compassion as a skill, as opposed to empathy being a stable trait. The training programme, delivered to 41 individuals, appeared to cultivate feelings of compassion and led to participants displaying increased altruistic responses to victims of social injustice.

The category **breaking free from 'stuck'** described staffs' perception that team formulation helped them to collectively shift from the emotional space that they inhabited prior to the meeting. This was usually in relation to feelings of frustration regarding a service user's perceived lack of progress or the emotional reaction when discovering previous traumas. This corroborates the findings of Hood & Johnstone (2013), who found that staff viewed the function of team formulation as providing as escape from feeling 'trapped' when working with service users who had not demonstrated any progress despite intensive team involvement. Unadkat *et al* (2015) also found that staff utilised team formulation to break free from feeling

stuck. As with the current research, feelings of stuckness tended to arise as a result of limited progress towards goals, a lack of change and the sense of "not knowing what to do".

4.3 CLINICAL AND SERVICE IMPLICATIONS

The current study offers potential implications for the use of team formulation within multidisciplinary teams. The theory co-produced from the data obtained has provided additional insight into the process of team formulation. The theory suggests that staff have certain conditions that need to be in place in order for staff to find team formulation a useful, beneficial process. Increasing our understanding of team formulation is of value so as to improve and advance its use within clinical settings, especially for service users deemed to be 'stuck' in the process of achieving change.

Staff indicated that they did not feel confident to facilitate a team formulation meeting and placed this as being a role for the psychologist. This holds implications for the role of clinical psychology within multidisciplinary teams. Whilst it might feel like a justified use of time and skills for psychologists to train other professionals to deliver team formulation evidence suggests that this is not sufficient to instil confidence in staff to facilitate (Dexter-Smith, Hopper & Sharpe, 2010). However, in the current professional climate where clinical psychologists are being expected to undertake an increasing range of roles and responsibilities within teams, it might be prudent for psychologists to continue to facilitate team formulations but to utilise lower intensity work such as reflective groups in order to promote psychological thinking amongst the team, thus 'sewing the seeds' of psychological perspectives at a lower level. If regular low-level contact with psychology and the team is maintained this may assist in other professionals gaining the confidence and skills to take on part, if not all, of a formulation meeting in the future.

Clinicians considering implementing team formulations in clinical practice could use the theory proposed by this study as a guide in their approach to developing team formulation.

In keeping with existing research (e.g. Lewis-Morton, Brown & Hider, 2015), the current study highlighted the importance of team formulation being a 'safe space', which arguably played a pivotal role in facilitating positive change for staff. Although not a novel finding, this emphasises the need for facilitators of team formulation in clinical settings to actively ensure that the environment in which the formulation meeting is held is considered as conducive as possible to being a relaxed and informal atmosphere. Facilitators should pay attention to their style of 'leading' the meeting, which the current study suggested was important for staff attending. Specifically, facilitators should ensure that team members feel valued and are actively encouraged to participate by suggesting any ideas they hold for the service user. All ideas should be welcomed, and handled in a professional manner that means staff do not feel judged for suggesting ideas that the team collaboratively feels may be unsuitable for that particular service user.

Team formulation was reported to increase staff empathy for service users, even in circumstances where formulation meetings did not result in changes in the behaviour displayed by service users. There is a significant body of research indicating that the relationship between caregivers and receivers of care (service users) is the most likely predictor of positive clinical outcome (e.g., Hovarth, 2001; Martin, Garske & Davies, 2000). Facilitators should view team formulation as an opportunity to promote understanding and empathy (Johnstone, 2013). Special attention should be given within team formulation to promoting a psychological and compassionate understanding of service users (Division of Clinical Psychology, 2011), based on the holistic approach to viewing psychological distress which is at the heart of psychological formulation.

The current research suggests that abandoning the traditional professional hierarchy within team formulation, or at the very least challenging it within multidisciplinary

teams can hold positive effects for staff morale in terms of improving inter-discipline working relationships and receiving validation from other professionals. Conversely, in meetings where the hierarchy was perceived as being present this potentially had the effect of inhibiting staff contributions. However as reported by Hudson (2001), organisational and managerial solutions alone may not provide the necessary environment for a team to thrive. Any challenges require sensitivity so as not to be perceived as threatening or undermining any single profession (Mohtashemi *et al*, 2016).

4.4 STRENGTHS AND LIMITATIONS

This study explored the experience of participating in team formulation from a multidisciplinary staff perspective. As outlined within Chapter One, literature to date on team formulation is sparse, and the quality of this research variable. The current study aimed to address this gap, and in doing so provide useful information to guide future research within this area.

4.4.1 Design and methodology

The design used is arguably a strength of the research. As observed by Willig (2013), adopting a qualitative methodology facilitates a richer description and way of understanding individual experience, which is relevant given the aim of the current study. Arguably an alternative methodology could have been adopted to fulfil the aims of the study. As outlined in Chapter One, Interpretative Phenomenological Analysis (IPA) (Smith, 1996) was not deemed to be as appropriate as this framework considers data on an individual level, and does not aim to provide a theory. However, Framework Analysis (Richie & Spencer, 1994) would have provided an alternative methodology that also seeks to develop a theory that is grounded within the data. This may have been a suitable methodology for the current study, given

that Framework Analysis has the scope to answer research questions more specifically than Grounded Theory. This would have arguable made the resulting theory more generalisable, however as noted by Herhaus (2014), the limited consensus to date surrounding the precise utility and applications of team formulation would present a challenge in applying Framework Analysis within this context. Overall the researcher believes that Constructivist Grounded Theory (Charmaz, 2006) was the most relevant research method to adopt for the purpose of this study.

4.4.2 Recruitment and sampling

Participants were recruited from two adult mental health teams working in South Wales, one team was based in the community and the other was a locked-door (inpatient) unit, which gives a broader representation of the use of team formulation across different settings. Ten participants were recruited to participate, all of whom had attended at least three team formulation meetings in the past year. This could be perceived as a weakness due to the comparatively limited experience that other participants held in team formulation. The data potentially represents an imbalance of gender, with 8 female participants and 2 male. However, the proportional gender demographics of those working in adult mental health in Wales are unclear, which means that this sample may still be representative of the population of interest.

Participants initially self-selected to participate in the study, which might imply that those who took part in the initial interviews held stronger views surrounding the use of team formulation than other colleagues. The latter participants from one of the teams were recruited by the link psychologist, who was also the facilitator of formulation meetings within the team. It is therefore possible that participants from this team were subject to sampling bias, as the psychologist may have been more likely to select participants that they felt would provide positive accounts of team formulation.

It is notable that all of the participants who participated viewed team formulation as a positive process. In latter interviews the researcher was mindful of asking participants whether they were aware of any alternative perspectives, in order to 'test' the developing constructed theory (Charmaz, 2014). One participant responded that a colleague had found formulation meetings a negative process due to the depth of information elucidated in meetings, which they reported finding invasive. However, when informed of the study (by the previous participant) this colleague declined to participate. This reflects the constructed theory in this study as being limited to the context in which the data was collected.

One limitation of the current study was arguably the sample size. A total of ten participants were interviewed for the purpose of this research, at which point the researcher believed that saturation of the data had been reached. Although Riley (1996) advocates that it is possible to achieve saturation in quality research through as little as eight participants, it is recognised that the small sample used within the current study potentially limits the generalisability of findings. Had more participants opted to take part, perhaps this would have resulted in a richer theory being constructed.

4.4.3 Data collection and analysis

The participants were all aware of the researcher's position as a trainee clinical psychologist. Given that the facilitators of team formulation across both teams were clinical psychologists it is possible that participants may have viewed the researcher as being in alliance with the facilitators. As observed by Charmaz (2014), how your participant perceives you will influence what they tell you. Participants may have positioned the researcher as being a 'future facilitator', which may have influenced how participants talked about the role of the facilitator.

Through the adoption of Constructivist Grounded Theory approach to analysis the researcher must emphasise that the resulting theory, whilst grounded within the

data) is their own interpretation of the data. It is therefore entirely possible that another researcher could utilise the same data and construct a different theory. The data itself is also a representation of one context and associated conditions, which limits the generalisability of the theory to other contexts (Hutchinson, 1993). During the analysis process the researcher sought secondary opinions from other trainee clinical psychologists in order to strengthen the validity of the interpretations made from the data, as recommended by Guion (2002). This had been found to be lacking in previous research (Summers, 2006). The use of memos and a reflective journal throughout the data collection and analysis process aimed to promoted self-awareness of the researcher and subsequent ownership of data interpretation.

4.4.4 Impact of researcher perspective

One potential limitation that spans the research process is the potential for researcher bias. As noted by Charmaz (2014) within grounded theory research the interviews are co-constructed, therefore the interviewer has the potential to influence the direction of interviews based on their own interests, which would impact the resulting data. As the researcher stated through their position statement (section 2.2.3.1) they openly adopt a pro-formulation stance, therefore it is possible that the direction of interviews and their subsequent interpretation of the data within this research was influenced by their personal stance. However the researcher kept both a reflective journal and memos in order to promote their own awareness of their impact on the data interpretation. The researcher also made a conscious decision to ask participants at the end of each interview whether they knew of any other members of staff who would likely share a different (i.e. negative) view of formulation, so as to broaden the opportunity for different perspectives to be sought and gathered.

During the process of writing the thesis although the researcher has endeavoured to adopt a neutral stance in reporting the research and surrounding process, it is possible that their passion for team formulation may have influenced them to

portray formulation in a positive light. However it is noted that during the systematic review process one reflection made during supervision with the academic supervisor was that the researcher had found the overall lack of supportive evidence for formulation surprising and thought-provoking in terms of how large a role it holds within the field of clinical psychology.

4.5 RECOMMENDATIONS FOR FUTURE RESEARCH

Future research related to the current study could aim to test the overall theory (presented in figure 3.1), which suggests that through a combination of the 'right facilitator', a 'safe' environment and adopting a shared stance of curiosity and openness to new ideas staff were left feeling validated in their role. This led to staff feeling valued and equal within the MDT, gaining a better understanding of service users and feeling positive about future work (feeling less 'stuck'). The overall theory could be tested via a number of routes, such as triangulation, presenting the theory to original participants or by seeking consultation from a working group, such as the Division of Clinical Psychology who publish guidelines on psychological formulation.

Alternatively future research could test processes that occurred within the core categories. The emerging theory from the data in this study suggested that higher levels of validation resulted in higher levels of satisfaction for staff and led to them feeling less 'stuck' (Core Category four: Changes for Staff). Through adopting a quantitative methodology future research could seek to test this aspect of the theory using validated measures pre- and post- team formulation meetings.

Future research in the field of team formulation may wish to further explore the nature of team formulation as **a unique meeting**, given that this arguably a finding of interest from the current study. Although it appears challenging for staff to freely articulate the differences between team formulation and other 'sharing' contexts within the MDT. It would be of interest to gain further understanding of this process

to inform its increasing use within clinical settings. Given that staff found this difference difficult to define future studies may wish to utilise an observational approach in order to obtain an outside perspective of what these differences might be in further detail.

The current study also provided an initial exploration of the outcomes of team formulation, as experienced by staff. The idea of formulation being used to challenge the hierarchy is of particular interest, which future research would be well placed to build upon. It is unclear from the current study to what extent the hierarchy is challenged beyond other meetings, or whether this experience would be duplicated across teams using team formulation.

It was also of interest to the researcher that across the two teams formulation was utilised in different manners. One team relied on team formulations only for clients who they felt 'stuck' with, whereas the other had sought to imbed team formulation into everyday practice, and ensured that all inpatients received at least two team formulations during their admission. Team formulation was therefore a core feature in developing care plans for patients. Further research into the impact of using team formulation in this way would be of interest, with particular attention as to whether benefits of using formulation are perhaps more widespread due to increased staff participation.

As a more general consideration, the current study utilised staff as participants with the decision to use only 'non-psychology' staff, as arguably they would not possess the training or predisposed knowledge of formulation held by psychologists. However, it neglected to consider service users in the sample. This decision was made in reflection of finding that service users were often not directly involved with formulation within the two teams of interest for this study. However, it would be of great value for future research to seek the perspective of service users across settings where they are more actively involved (as with Herhaus, 2014). Given the existing research which suggest that service user experience of individual formulation is mixed (Chadwick *et* al, 2003) it would benefit researchers to explore

to what extent service users are aware of team formulation and the impact that this holds from their perspective.

4.6 CONCLUSIONS

Despite a growing popularity in the use of psychological formulation in teams there is a surprisingly limited evidence base for its use clinical settings, or a firm understanding as to what makes team formulation 'work'.

This study constructed a theory of team formulation as it occurred within two adult mental health teams across community and inpatient settings. It has bridged a gap in the previous research by offering one explanation in relation to how team formulation as 'different' to other meetings and has explored the mechanism behind which factors drive the changes experienced by staff as a result of team formulation. In this case many variables needed to be in place for team formulation to be a success for staff: having an internal facilitator who was able to skilfully manage the meeting and write the resulting formulation; the meeting itself needed to feel safe in order to staff to contribute ideas without any fear of judgement. In combination, these variables produced a meeting that felt distinct compared with other multidisciplinary meetings. Staff felt that this unique environment empowered them to challenge the professional hierarchy outside of the formulation meeting, as well as providing them with a new understanding of the service user, which lent itself to staff feeling more empathetic towards service users in consideration of previous life events.

There is still a limited research base for the used of psychological formulation, both individually and within teams. The current study has provided some novel findings regarding how staff who are not from the psychology profession perceive team formulation. Future research is warranted to create an evidence base for the growing use of team formulation in clinical practice.

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APPENDIX A: SURE (2013a) QUALITY FRAMEWORK ASSESSMENT OF QUANTITATIVE PAPERS

Criteria	Berry et al (2008)	Chadwick et al (2003)	Dudley et al (2015)	Nattrass et al (2015)
1. Does the study address a clearly focused question/ hypothesis?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**Yes (2)**
Details	*Outlines two aims of the study and three hypotheses based on the outcome of intervention.*	*Outlines two aims and five hypotheses to cover experiments 1 and 2*	*Outlines two aims and five hypotheses to cover studies 1 and 2*	*Identifies three aims of the study, although no hypotheses given due to methodology.*
1.1 Population/ Problem?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**Yes (2)**
Details	*Psychiatric staff working with individuals experiencing psychosis.*	*Individuals experiencing psychosis*	*Therapists with experience of adopting a CBT framework*	*Patients with OCD who received CBT therapy.*
1.2 Intervention?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**Yes (2)**
Details	*Devising a psychological formulation.*	*Experiment 1 – Devising a formulation and sharing this via diagrammatic representation and accompanying letter.* *Experiment 2 – Case formulation and cognitive restructuring (of both negative self-beliefs and delusions).*	*Study 1 – rating treatment suitability based on a pre-written formulation* *Study 2 – devising a formulation based on a vignette from study one*	*CBT formulation*
1.3 Comparator / Control?	**No (0)**	**No (0)**	**Yes (2)**	**No**
Details	*No control or comparator group used.*	*No control of comparator group used.*	*Novice vs. experienced therapists*	*No control or comparator group used.*
1.4 Outcomes? Can you identify the primary outcome?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**Yes (2)**
Details	*Clear outcome measures outlined (Two measures of illness perception were identified as being used to create the measure in this study).*	*All outcome measures clearly defined across both experiments.*	*Outcome measures to assess treatment suitability and quality of formulation explained, including the validation process where measures were created for the purpose of the study*	*Three outcome measures described for assessing symptomology, therapeutic alliance and symptom reduction. Quality of formulation also assessed using a coding manual.*

2. Was the population randomised? If YES were appropriate methods used?	**n/a**	**n/a**	**No (0)**	**n/a**
Details	*n/a*	*n/a*	*Participants were allocated to groups based on their clinical experience.*	*Audio recordings used post therapy*
3. Was allocation to intervention or comparator groups concealed?	**n/a (0)***	**n/a**	**Can't tell (0)***	**n/a**
Details	*n/a*	*n/a*	*No details regarding the concealment of group allocation.*	*n/a*
4. Were participants blinded to group allocation?	**n/a**	**n/a**	**Can't tell (0)***	**n/a**
Details	*n/a*	*n/a*	*No details regarding participants being informed of blinding*	*n/a*
5. Were interventions (and comparisons) well described and appropriate?	**Yes (2)**	**Yes (2)**	**Yes (1)**	**Yes (2)**
Details	*Process of team formulation described in detail. Total number of meetings (number of groups in the study) not reported.*	*Intervention phases described chronologically and in detail across both experiments. Invention appears appropriate given study aim.*	*Procedure for both studies described in sufficient detail. Study one gave pre-determined interventions, which is arguably a simpler task than self-generating.*	*All measures described. Procedure gives a clear outline of process undertaken to assess recordings and outcome assessments.*
6. Was ethical approval sought and received?	**Can't tell (0)***	**Unclear (1)**	**Both studies = Yes (2)**	**Yes (2)**
Details	*No reporting of ethical approval being sought despite the study utilising real patient data.*	*Ethics reported as being sought and gained for Experiment 1, however not reported for Experiment 2.*	*Ethical approval reported as granted*	*Ethical approval recorded as being sought and obtained*
7. Was a trial protocol published?	**n/a**	**n/a**	**Can't tell (0)***	**n/a**
Details	*n/a*	*n/a*	*No details reported*	*n/a*
8. Were the groups similar at the start of the trial?	**Can't tell (0)***	**No (0)**	**No (0)**	**Can't tell (0)**
Details	*Study loosely identifies that seven formulation meetings were held, but does not identify the demographics of each group*	*Participant demographics and detailed pre-intervention measure scores provided for experiment two. This*	*Study 1 - Novices had significantly fewer years in education or clinical experience compared to 'Experienced'.*	*All recordings featured clients who met diagnostic criteria for OCD, but no data regarding severity of symptoms or*

	individually.	*demonstrates that the four participants started with varying levels of self-reported engagement and beliefs regarding auditory hallucinations. Lack of detail for experiment one therefore difficult to ascertain whether participants were similar at start.*	*Study 2 – As above; novices also had significantly fewer research publications, delivered fewer workshops and had seen fewer CBT cases than experienced.*	*demographics. Large range between total sessions (6-31).*
9. Was the sample size sufficient?	**Can't tell (1)**	**No (0)**	**Can't tell (0)***	**Can't tell (0)***
Details	*Sample size not cited as a limitation, possibly due to this being a pilot study. However recommendation made for future studies to recruit higher number of participants.*	*Sample size not referenced as a limitation, however both experiments consisted of very small samples, 13 and four respectively.*	*Sample size not cited as a limitation.*	*Sample size not cited as a limitation.*
10. Were participants properly accounted for?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**n/a (0)+**
Details	*100% of participants completed follow-up measures (between 1-6 hours after intervention)*	*Experiment 1 began with 15 participants, however two dropped out of therapy, leaving 13 who completed all measures and time points.*	*Study 1: No missing data* *Study 2: Four missing values were identified during treatment rating- data was replaced with the mean of the participants' rating on other items.*	*No follow-up completed*
11. Data Analysis **11.1 Are you confident with the authors' choice and use of statistical methods?** **11.2 Were estimates of effect size given?** **11.3 Were the analytical methods appropriate?** **11.4 Was the precision of the intervention effects (confidence intervals) given?**	**11.1 Yes (2)** **11.2 No (0)** **11.3 Yes (2)** **11.4 Yes (2)**	**11.1 Yes (2)** **11.2 No (0)** **11.3 Yes (2)** **11.4 Yes (2)**	**11.1 Yes (2)** **11.2 Unclear- Study 2 (1)** **11.3 Yes (2)** **11.4 Yes (2)**	**11.1 Yes (2)** **11.2 Yes (2)** **11.3 Yes (2)** **11.4 Yes (2)**

Details	*11.1 Authors gave justification for choice of analysis taking sample size into account* *11.2 No effect size reported* *11.4 Exact p value stated (unless p=<0.001)*	*11.1 Authors justify analysis given methodology* *11.2 No effect size reported* *11.4 p values reported for both experiments.*	*11.1 Analytical method (ANOVA) is well suited considering study design and hypotheses.* *11.2 Cohen's d reported for results obtained in study 2.* *11.4 Exact p values stated (unless p=<0.001)*	*11.1 Provided justification for analysis* *11.2 Effect size reported* *11.4 P values reported*
12. Results **12.1 Were outcome measures reliable (e.g objective or subjective measures)?** **12.2 Were outcome measures complete?** **12.3 Were all important outcomes assessed?** **12.4 Are the authors' conclusions adequately supported by the results?**	**12.1 Unclear (1)** **12.2 Yes (2)** **12.3 Yes (2)** **12.4 Yes (2)**	**12.1 Unclear (1)** **12.2 Yes (2)** **12.3 Yes (2)** **12.4 Yes (2)**	**12.1 Unclear (1)** **12.2 Unclear (1)** **12.3 Yes (2)** **12.4 Yes (2)**	**12.1 Unclear (1)** **12.2 Can't tell (0)*** **12.3 Yes (2)** **12.4 Yes (2)**
Details	*12.1 Generalisations about reliability of illness perception Likert scales asserted but no evidence of having tested their measure made for this study.* *12.2 All outcome measures were completed by retained participants* *12.4 Provides some positive pilot data that requires more rigorous replication*	*12.1 All measures were subjective due to reliance on self-report, however authors cite reliability and validity of the measures themselves.* *12.2 All measures completed* *12.4 Conclusions recognise the non-significant findings whilst presenting these alongside positive qualitative accounts of formulation from participants.*	*12.1 Outcome measure for treatment planning criticised for being too simplistic and therefore not assessing true ability to measure this variable. Weak ecological validity.* *12.2 All outcome measures completed (with data alteration to account for 4 missing data values)* *12.4 Results are framed to recognise that participants used formulations to successfully select (rather than generate) relevant treatment ideas.*	*12.1 Outcome measures were mostly self-report, so subjective.* *12.2 No details given* *12.3 All outcomes assessed in order to meet study aim* *12.4 Conclusions re: distress reduction and therapeutic alliance are justified by the analysis.*
13. Is any sponsorship / conflict of interest recorded?	**No (2)**	**No (2)**	**No (2)**	**No (2)**

Details	*None reported*	*None reported*	*None reported*	*Not reported*
14. Did the authors identify any limitations?	**Yes (2)**	**Unclear (1)**	**Yes (2)**	**Yes (2)**
Details	*Participants asked to complete the pre and post measure within a very short period of time, possibly led to demand characteristics. Absence of control group affects attribution of findings. Repeated analysis increased the probability of type 1 errors.*	*Experiment 1 – Ecological validity questioned as in practice formulation is not introduced in one go, rather across sessions. If formulation is interwoven into CBT then it is difficult to attribute impact to purely formulation as opposed to other aspects of therapy. No limitations considered for experiment 2.*	*Study one utilised a measure that was potentially too simple, rendering it a recognition task and may account for no significant difference between novices and experienced therapists in this study. The case vignette itself was also too simplistic, which resulted in experienced therapists scoring highly in study 2.*	*Identified that not including reformulations was a limitation in hindsight, also a lack of control group. The validity of using the CFCCM to assess formulation quality is also questioned.*
15. Are the conclusions the same in the abstract and the full text?	**Yes (2)**	**Yes (2)**	**Yes (2)**	**Yes (2)**
Details	*Positive study findings are reported along with the need for further studies to replicate results.*	*Both positive and negative outcomes of formulation are reported both in the abstract and full text.*	*Balanced review of findings and limitations provided in both abstract and full text. It is clearly identified that these findings cannot argue that formulation guides the development or generation of treatment plans.*	*Reflection that formulation may reduce attrition in therapy due to the increase in therapeutic alliance early in treatment. Also recognises the need for future research.*
Total	**32/44 (73%)**	**31/44 (71%)**	**34/50 (68%)**	**31/44 (70%)**

Please note that responses for criteria 13 are reverse-weighted due to a lack of conflict of interest being viewed as a study strength.

In the event of all studies scoring ‘0’ across one criteria due to not being applicable, the overall possible score for studies gas been adjusted to reflect this.

APPENDIX B: SURE (2013b) CHECKLIST FOR QUALITATIVE RESEARCH

Criteria	Christofides *et al* (2012)	Mohtashemi *et al* (2016)	Summers (2006)
1. Does the study address a clearly focused question? **1.1 Setting?** **1.2 Perspective?** **1.3 Intervention or phenomena?** **1.4 Comparator/Control (if any?)** **1.5 Evaluation/Exploration?**	**1.1 Yes (2)** **1.2 Yes (2)** **1.3 Yes (2)** **1.4 n/a** **1.5 Yes (2)** <u>Details</u> *To investigate clinical psychologists views of using psychological case formulation in multidisciplinary teams.*	**1.1 Yes (2)** **1.2 Yes (2)** **1.3 Yes (2)** **1.4 n/a** **1.5 Yes (2)** <u>Details</u> *Exploration of psychiatrists' use and understanding of formulation within an adult psychiatry context.*	**1.1 Yes (2)** **1.1 Yes (2)** **1.2 Yes (2)** **1.3 n/a** **1.4 Yes (2)** <u>Details</u> *Aim clearly outlined in relation to exploring benefits and limitations of formulation from a staff perspective*
2. Is the choice of qualitative method appropriate? **2.1 Is it an exploration of e.g. behaviour / reasoning /beliefs?** **2.2 Do the authors discuss how they decided which method to use?**	**2.1 Yes (2)** **2.2 Yes (2)** <u>Details</u> *Exploration of psychologists' accounts of using team formulation. Justified use of qualitative methodology.*	**2.1 Yes (2)** **2.2 Yes (2)** <u>Details</u> *Use of qualitative methodology justified through study aim of exploring beliefs.*	**2.1 Yes (2)** **2.1. No (0)** <u>Details</u> *Explored staff views on the impact of formulation.*
3. Is the sampling strategy clearly described and justified?	**3.1 Yes (2)** **3.2 Yes (2)** **3.3 Yes (2)**	**3.1 Unclear (1)** **3.2 Yes (2)** **3.3 No (0)**	**3.1 Yes (2)** **3.2 Unclear (1)** **3.3 No (0)**

3.1 Is it clear how participants were selected? **3.2 Do the authors explain why they selected these particular participants?** **3.3 Is detailed information provided about participant characteristics and who chose not to participate?**	<u>Details</u> *Justification provided for seeking participants from adult mental health settings. Participant demographics provided including response rate to participation invitation.*	<u>Details</u> *Reasoning for seeking psychiatry perspectives is described, however no details surrounding how participants were selected. Age demographics provided but no response rates to participation, gender details or estimate of experience of formulation discussed.*	<u>Details</u> *Strategy identified but no justification given as to why staff with no experience of formulation were included in the sample. No participant demographics other than job title included.*
4. Is the method of data collection well described? **4.1 Was the setting appropriate for data collection?** **4.2 Is it clear what methods were used to collect data?** **4.3 Is there sufficient detail of the methods used?** **4.4 Were the methods modified in the study? If yes, was this explained?** **4.5 Is there triangulation of the data? (More than one source of data collection?)** **4.6 Do the authors report**	**4.1 Yes (2)** **4.2 Yes (2)** **4.3 Yes (2)** **4.4 No (2)** **4.5 Yes (2)** **4.6 Yes (2)** <u>Details</u> *Data collection method described, example themes of questions given. Saturation reported after ten interviews.*	**4.1 Yes (2)** **4.2 Yes (2)** **4.3 Unclear (1)** **4.4 Unclear (1)** **4.5 Yes (2)** **4.6 No (0)** <u>Details</u> *Due to time constraints the researcher adopted a 'theoretical sufficiency' approach rather than saturation. This means that any new insights within the last few interviews were not explored further.*	**4.1 Yes (2)** **4.2 Yes (2)** **4.3 Yes (2)** **4.4 No (2)** **4.5 Yes (2)** **4.6 No (0)** <u>Details</u> *No report of achieving saturation.*

achieving saturation?			
5. Is the relationship between the researcher(s) and participants explored? **5.1 Did the researcher report critically examining/reflecting on their role and any relationship with the participants?** **5.2 Were any potential power relationships involved?**	**5.1 Yes (2)** **5.2 Can't tell (0)*** <u>Details</u> *Position statement of main researcher provided including their stance on formulation. Recognises that participants were aware of the researcher's stance.*	**5.1 Yes (2)** **5.2 Can't tell (0)*** <u>Details</u> *Reflexivity explored through on-going supervision throughout the research process. Researcher positions themselves as coming from a clinical psychology background and considers the impact of this on the data.*	**5.1 Unclear (1)** **5.2 Can't tell (0)*** <u>Details</u> *Researcher acknowledges their pro-formulation stance, but not the relationship between participants and researcher. Does not disclose their job title, therefore unclear whether power issues would exist.*
6. Are ethical issues explicitly discussed? **6.1 Is there sufficient information on how the research was explained to participants?** **6.2 Was ethical approval sought?** **6.3 Are there any potential confidentiality issues in relation to data collection?**	**6.1 No (0)** **6.2 Yes (2)** **6.3 Can't tell (0)*** <u>Details</u> *No details provided regarding how research was presented to participants, but ethical approval recorded. Confidentiality not discussed.*	**6.1 No (0)** **6.2 Yes (2)** **6.3 Unclear (1)** <u>Details</u> *Ethical approval reported. No details given regarding how the study was described to participants. Pseudonyms were chosen by the participants, however no discussion of how confidentiality was maintained during transcription or recording.*	**6.1 No (0)** **6.2 Can't tell (0)*** **6.3 Can't tell (0)*** <u>Details</u> *No ethical approval reported*
7. Is the data analysis/	**7.1 Yes (2)**	**7.1 Yes (2)**	**7.1 Unclear (1)**

interpretation process described and justified? **7.1 Is it clear how the themes and concepts were identified in the data?** **7.2 Was the analysis performed by more than one researcher?** **7.3 Are negative/discrepant results taken into account?**	**7.2 Yes (2)** **7.3 No (0)** <u>Details</u> *Transcription and coding method described. Themes were cross-checked by 2 supervisors and 4 participants to ensure validity.*	**7.2 Yes (2)** **7.3 Yes (2)** <u>Details</u> *Emerging theory was discussed with the researcher's supervisor, who highlighted gaps in the theory and informed the structure of remaining interviews.*	**7.2 No (0)** **7.3 Yes (2)** <u>Details</u> *Very brief description outlining process of analysis. Unexpected negative views of formulation also included.*
8. Are the findings credible? **8.1 Are there sufficient data to support the findings?** **8.2 Are sequences from the original data presented? (e.g. quotations and were these fairly selected?)** **8.3 Are the data rich?** **8.4 Are the explanations for the results plausible and coherent?** **8.5 Are the results of this study compared with those from other studies?**	**8.1 Yes (2)** **8.2 Yes (2)** **8.3 Unclear (1)** **8.4 Yes (2)** **8.5 No (0)** <u>Details</u> *Direct quotations provided to support choice of themes. Length of interviews not reported, however the sample had sound experience of facilitating team formulation.*	**8.1 Yes (2)** **8.2 Yes (2)** **8.3 Can't tell (0)** **8.4 Yes (2)** **8.5 Unclear (1)** <u>Details</u> *It is reported in the discussion that participants who had more experience of team formulation the more they integrate this into everyday practice, which is compared with previous research, however this finding is not reported in the results section.*	**8.1 Unclear (1)** **8.2 Yes (2)** **8.3 Can't tell (0)** **8.4 Can't tell (0)** **8.5 Unclear (1)** <u>Details</u> *Maximum interview time was 20 minutes, no minimum provided. Combined with five participants who had never attended a formulation meeting or written a formulation this brings into question the quality of the data. Interviews were written rather than audio recorded, author recognises that they were not*

			completely verbatim, which could affect the validity of codes. One of the emergent categories is compared with previous research.
9. Is any sponsorship/ conflict of interest reported?	**No (2)** *Details* *None reported*	**Unclear (1)** *Details* *None reported, however the researcher's position as a clinical psychologist is acknowledged as impacting on the way interviews were conducted and at being in contrast to the position held by some of the participants.*	**No (2)** *Details* *None reported*
10. Did the authors identify any limitations?	**Yes (2)** *Details* *Limitations in terms of sample and potential participant bias identified by authors.*	**Yes (2)** *Details* *Researcher's background may have impacted on data collection and interpretation. Participants self-selected which may have implied that they held strong views regarding formulation – results may not reflect the profession as a whole.*	**Unclear (1)** *Details* *Some basic limitations recognised but no acknowledgement of some participants being included despite not having experienced the phenomenon that was being explored.*
11. Are the conclusions the same	**Yes (2)**	**No (0)**	**Unclear (1)**

in the abstract and the full text?	*Details* *Conclusion that further research is needed is stated in the abstract and supported within the full text.*	*Details* *Abstract neglects to detail the clinical implications or conclusions discussed within the main body - including the need for further research and the need for psychiatrists to have access to reflective practice.*	*Details* *Abstract refers to creative thinking yet this is not mentioned within the full text. Abstract also states that staff felt formulation benefits care planning, whereas the results state that staff felt that formulation had a limited impact on care plans.*
Total	**51/62 (82%)**	**44/62 (70%)**	**35/62 (56%)**

+ = not applicable

*** = unknown / can't tell**

Also please note that considerations 4.4, 6.3 and 9 are reverse-weighted, resulting in an award of 2 for a 'no' response and 0 for 'yes'. This was decided in recognition that not altering the methodology, providing evidence of avoiding confidentiality issues and having no conflict of interest were regarded as study strengths.

APPENDIX C: EMAIL CONFIRMATION OF UNIVERSITY ETHICS APPROVAL

Mark Jones
To: Naomi Manuel, Andrew Vidgen
Ethics Feedback - EC.15.12.08.4395R

15 December 2015 10:18
Hide Details

Dear Naomi & Andrew

The Ethics Committee has considered your revised project proposal: Multidisciplinary staff views on using team formulation (EC.15.12.08.4395R).

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Mark Jones

APPENDIX D: NHS R&D APPROVAL LETTER

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol [redacted]

Your Ref/ eich cyf
Our ref/ ein cyf: JG/AJE
Date/ dyddiad: 13/01/16
Tel/ ffôn: [redacted]
Fax/ ffacs: [redacted]
Email/ ebost: [redacted]
Dept/ adran: Research & Development Dept

Miss Naomi Manuel
Trainee Clinical Psychologist
School of Psychology
11th Floor
Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Miss Manuel

Re: CT/598/187014/15 Multidisciplinary staff views on using team formulation

Thank you for clarifying the points raised at the Risk Review Group (RRRG) held on 17th December 2015. I have pleasure in confirming that this project now has full approval to commence in [redacted] However commencement of the project should be upon the receipt of ethical approval if required. If the project is a multi site study it is advised that you also obtain approval from all other Health Boards before commencing the project at individual sites.

The Group reserve the right to information on the progress of the project at any time and should receive a progress report six monthly and a written report on completion.

Random audits will be carried out to ensure that projects comply with the clinical guidelines of research. Any serious adverse incidents relating to the project should be reported to the R&D office and a Clinical Incident Form filled in.

If your project includes participants or resources from other Health Boards it is your responsibility to contact the relevant R&D Office(s) in order to gain R&D approval to commence. Without individual R&D approval from all Health Boards involved in the study Welsh Risk Pool indemnity will not be afforded to the researcher.

On completion of the project it is important that you inform the Health Board Research & Development office.

It is a requirement of approval that a synopsis of your project and its findings (if not commercially too sensitive) be submitted to the R&D department upon completion. This synopsis can then be placed on the R&D departments' web page to provide a useful R&D resource for other research active professionals across the Health Board.

Return Address: [redacted]

Participant Information Sheet

Study title: Multidisciplinary staff views on using team formulation.

I would like to invite you to take part in my study. Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to investigate more closely via semi-structured interviews how multidisciplinary mental health staff understand team formulation within their work.

This research is also being undertaken in contribution towards a Doctorate in Clinical Psychology. The student undertaking the research will be supervised by Dr Andrew Vidgen (Clinical Psychologist) and Dr Clare Sandford (Clinical Psychologist).

Why have I been chosen?

You have been asked to participate as it has been indicated to the researcher that you are a non-psychology member of staff who has experience of involvement in team formulation through your place of work.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

You are being asked to take part in an interview to obtain your views on utilising team formulation within your work. The interview will last for approximately 45-60 minutes and will take place at your workplace. The interview will be recorded to obtain an accurate record of your views and opinions. The recording will be kept securely in a locked filing cabinet until it is transcribed. Once transcribed, the recording will be deleted. Any personal or other identifiable data will be removed during the transcribing process.

What are the possible benefits of taking part?

We hope the information will help us to understand how staff experience being involved in team formulation and how it helps understand clients and inform their approach. This information will help to provide an evidence base so that other mental health services can be made aware of any potential benefits and allow them to feel empowered to adopt this process within their own services.

What are the possible risks and disadvantages of taking part?

During the interview you will be asked about routine clinical practice, which we do not believe will be distressing. The only foreseeable disadvantage would be taking approximately 45-60 minutes out of time to take part in the interview.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions [Naomi Manuel - 02920 870582) or Dr Andrew Vidgen (Academic Supervisor, same number as above). If you remain unhappy and wish to complain formally, you can do this through the NHS Redress Scheme. Details can be obtained from [redacted] Health Board's Concerns team (Telephone Number: [redacted]) and [redacted] website ([redacted])

Will my taking part in this study be kept confidential?

All the information from the study will be treated as strictly confidential. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the study team as part of ensuring the quality of the research (e.g., the academic supervisor). They may also be looked at by representatives from Cardiff University to ensure the study is being carried out in a proper manner. All will have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed. Direct quotes from your interview may be used in the final report of the study but your identity will remain anonymous.

Please note however that in the event that a serious patient safety issue is identified during the interview, this would need to be reported for the organisation to take action on, and this could therefore compromise your anonymity.

What will happen to the results of the study?

The results of this study will be written up to form my thesis and will be submitted as part of my accreditation for a Doctorate in

Clinical Psychology. In future this study may be disseminated via publications or conferences. However you will not be identified in any report or publication.

Who is organising and funding the study?

The study has been organised by Naomi Manuel. The study is being sponsored and funded by Cardiff University as part of a three year doctorate in Clinical Psychology.

Who has reviewed the study?

This study has also been given approval to commence by [redacted] and Cardiff University through the School of Psychology Ethics Committee.

Contact for Further Information:

Please feel free to contact me if you have any further questions at Naomi.Manuel@wales.nhs.uk or ManuelN@cardiff.ac.uk

Thank you for taking the time to read this information sheet and for considering taking part in this study.

APPENDIX F: PARTICIPANT CONSENT FORM

CONSENT FORM

Version 1 – 23/06/15

Title of Project: Multidisciplinary staff views on using team formulation.

Name of Researcher: Naomi Manuel

		Please initial all boxes
1.	I confirm that I have read and understand the information sheet dated **23.6.15** (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and this will not affect my employment rights.	☐
3.	I understand that the data collected during the study, may be looked at by individuals from Cardiff University (Academic Supervisor: Dr Andrew Vidgen) or from [redacted] Health Board's Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my data.	☐
4.	I agree to take part in an interview and understand that the interview will be tape recorded. I understand that the tape will be erased once transcribed.	☐
5.	I understand that the data will be used for a thesis, which will lead to a Doctorate of Clinical Psychology being awarded. The data may also be used in reports, which may include direct quotes. I understand that my identity will not be known as the data will be anonymised and any reference to an individual name will be removed.	☐
6.	I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Name of Person (taking consent)	Date	Signature

APPENDIX G: INTERVIEW SCHEDULE AND EXAMPLE EVOLUTION

Initial schedule:

1) Can you tell me, what's your understanding of the word 'formulation'?
   - Do you think this is a shared definition or do others view it another way?
2) What was your first team formulation like?
   - What do you remember thinking afterwards?
3) Can you describe a 'typical' team formulation for me – who requests them, who attends, who leads etc.?
4) What are the benefits of using team formulation from your perspective?
5) What are the drawbacks of using team formulation from your perspective?
6) What (if any) do you feel the outcome of a team formulation is for:
   - Yourself?
   - Your colleagues / the wider team?
   - The service user?
7) How (if at all) have your feelings about team formulation changed over time?
   - What do you feel has facilitated/ caused this change?
8) How do you understand team formulation as being different to discussing a case informally with a colleague or in supervision?
9) What (if anything) would you change about formulation meetings?
10) Do you feel that participating in team formulation has changed your practice in any way? (if so, how?)
11) What do you think is the most important part of a team formulation?

- (Prompt: Are there any formulations that felt particularly helpful or unhelpful? What was it about that specific formulation meeting that left you with a positive or negative impression afterwards?)

12) What (if any) are the barriers to implementing team formulation from your perspective?
13) Has anyone in the team expressed a different view of formulation to yourself?

14) Is there anything additional that you feel would be helpful for me to know about team formulation?

Additional Questions following interviews 1,2 and 3 (exploring facilitator role):

- Some of the people I've spoken with have talked about the impact that the facilitator has on their experience of team formulation.
    - Please tell me about your experience of the facilitator in team formulation–.
    - What is their role from your perspective?
    - What made them a good / poor facilitator?
    - Have you always experienced the same facilitator for team formulations?
        - If not: What was your experience of working with two facilitators?
        - How did those formulations differ from each other?
    - Does the facilitator impact the outcome of team formulation?
        - How?

APPENDIX H: EXAMPLE OF CODING

Interview Data (Verbatim)	Initial Code
What are the outcomes of participating in team formulation?	
I think it can depend. You know, sometimes we come together, there's a formulation and the outcome is that there are gaps in our knowledge. Why don't we know this? We've been working with this person for ten years and that's really helpful because we almost have these gaps to fill. One of the most helpful outcomes I think is that we do come together and we end up with a formulation of a- and I understand that formulations are hypotheses, of what a team feels are maybe happening for the person. So we have a theme, you know, we think "this person might have had attachment" or, you know, the whole "this has happened" and there's a trauma focus here. Our psychologists are brilliant at writing up our formulations in a very cohesive and very understandable way. And I think for me one of the most useful, helpful outcomes of the formulation is to have a user-friendly written formulation that the most appropriate member of who's working with that client will share.	*Outcomes not fixed* *Bringing the team together* *Outcome = Unresolved questions* *Lengthy engagement with Sus* *A way forward* *Defining formulation, not fixed* *Collaborative approach* *Understanding the SU* *Skill of psychologist (writing formulation)* *Accessibility of written formulation* *Responsibility of disseminating formulation*
And does that always happen?	
No, it.... I'm trying to think of the factors that would influence that... I think it depends on the client obviously and the factors that would affect whether a client would take that on board and what stage they're at and whether they're ready to accept that and who's got the best relationship.	*Person-centred care, not for everyone* *Timing of sharing as important* *Need for the 'right' professional*

APPENDIX H: EXCERPTS FROM MEMO WRITING

January 2016

Completed my first interview today. Became increasingly aware as the interview unfolded that formulation is such second nature to psychologists, yet to others it holds such different meaning. Seemed to be more about sharing ideas for this professional... and formulation as an intervention in itself for the team?

February 2016

Not just defining formulation – such different levels of engagement with the meetings! Spoke with someone today who spoke about benefits of formulation/ team working in general -(where is the line between the two I wonder?), yet also seemed slightly disengaged from the interview itself. Was that a reflection on me and my interview stance... or a reflection of ambivalence regarding the topic?

February 2016

Many staff seem to almost speak more after the Dictaphone has been switched off. Sense of wanting to 'chat' about formulation. Today was the second occasion when the hierarchy is mentioned again after the interview... maybe the Dictaphone affects staff feeling safe, as in formulation meetings? Safety really coming across as important to staff within meetings... what makes it safe? (CORE CATEGORY > FEELING SAFE??)

March 2016

Really difficult for some participants to explain *why* formulation is different – but still adamant that it is! What's that about?

April 2016

Having spent time with both psychologists who hold the meetings I'm noticing that the team appear to mirror the values held by the psychologists – One team coming across much more openly anti-diagnosis than the other. Formulation in that team seen as almost 'rivalling' psychiatry.

APPENDIX I: REFLECTIVE JOURNAL EXTRACTS

22nd March 2016

I'm noticing at times during some interviews I have a tendency to 'seek quotes' in my mind rather than truly being present in the moment with the member of staff. Some members of staff have a more naturally eloquent way of framing their experiences... must make a conscious note not to overlook participants in the write up who take more of a relaxed stance in verbalising their views. I'm trying to remind myself that beyond this being an academic requirement I should view this as an opportunity to discuss something that makes me feel passionate – the interview seem to flow better when I bring this stance into the room rather than wearing my 'quote detective' hat.

20th April 2016

Read Mohtashemi *et al*'s very recent article to add in to my systematic review. Felt slightly despondent reading that psychiatry viewed team formulation as representing psychology a threat to their profession. I suddenly realised that I really haven't had much experience of reading negative accounts of team formulation prior to this, and also that despite the participation invitation being open no psychiatrists have elected to participate in my research. Subsequently can't help but wonder if this may have impacted on my data in some way as a missing perspective. However it felt good to touch base with the part of me that is strongly pro-formulation and confirmed my own values and stance on psychiatry. With the pressure of collecting data and writing the thesis I realise that I'd lost touch with this at times.

25th April 2016

Starting to tentatively review all of my interviews and codes. The fact that participants seem to have collectively provided an account of *how* formulation works for them almost seems too simple... (is this Grounded Theory?!) The knowledge that research to date hasn't provided this leaves me feeling both excited that my study may actually contribute new 'knowledge', but also apprehensive that it's all much more complicated that this and that's why no previous research has ventured into this ground. But then when I think about how much value I've placed on feeling safe within regards to placements on clinical training it makes much more sense to me.