Stress, coping and support for those working within Mental Health Services –

the role of the Community Mental Health Team, Clinical Psychologist

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Declaration

This work is original and has not been submitted in whole or in part to any

other institution, or for the purposes of obtaining any other qualification.

Summary

Those working within mental health services experience considerable stress. Organisational change from hospital to community based, and single to multi-disciplinary provision of services, has been linked with increased stress due to heightened role ambivalence and/or role conflict. The empirical evidence for this supposition is reviewed. Evidence suggests that role ambivalence and/or role conflict is a stress of mid-range prevalence for mental health workers. There is some evidence that organisational changes heighten this stress and indication that home/work role conflict is a particular source of distress which is actively managed by workers.

Clinical psychology is identified within the review as a profession which is notable in experiencing role stressors within the current community mental health team (CMHT) structures. This is also a profession that have skills which could be of particular assistance in ameliorating stressors. The thesis reports a qualitative study investigating the experiences of CMHT clinical psychologists of giving and receiving support to and from colleagues. Findings suggest that although clinical psychologists' consider supporting colleagues part of their role, they experience difficulty in this function within their CMHT working. Key issues regarding this and patterns of support are identified, with consideration of the positioning of psychologists within CMHT and peer group sub-systems. The implications of attempting to foster and maintain effective cycles of support within this work setting are discussed.

The research process is also critically appraised and issues learned and how these inform future research and practice outlined.

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What is the evidence that role conflict and/or role ambivalence

is associated with

Community Mental Health Workers stress?

Abstract

Background: Over recent decades, UK NHS mental health services have moved from largely hospital based uni-professional teams, to community based multi-disciplinary team provision. Discursive and theoretical literature suggests organisational change is linked with mental health worker stress due to heightened role ambivalence and/or role conflict. This review considers the empirical evidence for this supposition.

Aim: To review empirical evidence for the presence and extent of role ambivalence/conflict within UK NHS mental health professional workers.

Method: Electronic data bases were searched using keywords and selection criteria applied focusing the review on 16, UK primary research studies, exploring NHS mental health professional worker stress and/or specific role related stressors.

Results: There is evidence that role ambivalence and/or role conflict stresses mental health workers, however this is usually has mid-range prevalence (eg third or fourth most reported stressor). There is some evidence of association with organisational structures and indication that home/work role conflict relates to significant distress.

Conclusions: Role stressors of mid-range prevalence are present for mental health workers, probably exacerbated by organisational changes over recent decades. Consideration of work role alone overlooks evidence that home/work role conflict is a particular source of distress which is actively managed by workers.

Keywords:

Role ambiguity, role conflict, stress, community mental health workers, multi-disciplinary team

1.0 Introduction

Mental health work is an area thwart with uncertainty, encompassing multiple theoretical

positions, informing many different interventions, with outcomes that are difficult to

predict. Each discipline brings its own perspective and understanding of the role it has in

facilitating mental well being. With this comes uncertainty and insecurity about the

effectiveness of one's own role, along with a range of expectations about the role of other

professions (Roberts, 1994a). Organisational restructuring of mental health services

within the UK, NHS, in the last few decades, has brought new role expectations and

changed working relationships between different disciplines (Cherniss, 1980;

Hinshelwood, 1998). Therefore the nature of the work and recent organisational changes,

heighten the likelihood of role issues for mental health workers. Role theory explores the

patterns of behaviour, or roles, assigned to and exhibited by individuals within different

situations (Goffman, 1959; Hardy & Hardy, 1988; Tajfel & Turner, 1979). With respect

to occupational roles, this has included consideration of the relationship between role

ambiguity, role conflict and factors such as stress, strain, job satisfaction and job

performance (eg Handy, 1993; Hughes, 2001; Parsons, 1951; Tubre & Collins, 2000).

Therefore in understanding mental health work, role theory is of particular pertinence.

1.1 Role conflict and role ambiguity – theory

Role conflict occurs where there are incompatible expectations of role, whereas role

ambiguity occurs where those expectations either differ and/or are unclear (Hardy &

Hardy, 1988). Meta-analysis of correlations has found a negative relationship between

role ambiguity and job performance, though not between role conflict and job

performance (Tubre & Collins, 2000). Hardy and Hardy (1988) have previously

suggested that role ambiguity is characteristic of professional roles and is usually more

detrimental in its effects than role conflict. Within this understanding, role stress is external to the role occupant, and role conflict and role ambiguity are defined by the social system. Role strain is the subjective experience, an individual response to the external conditions of social stress.

From a sociological perspective, structural role theory (Parsons, 1951), can be used to describe the systems of roles and role expectations within a role set. This provides a theoretical framework within which to consider the interactions which occur within a role set, along with the resultant role stresses and strains (Hardy & Hardy, 1988). With respect to a possible role set for a mental health worker, interposition of roles using this approach would be represented thus (Fig 1).

Figure 1. Example of interposition: Multiple roles or multiple positions
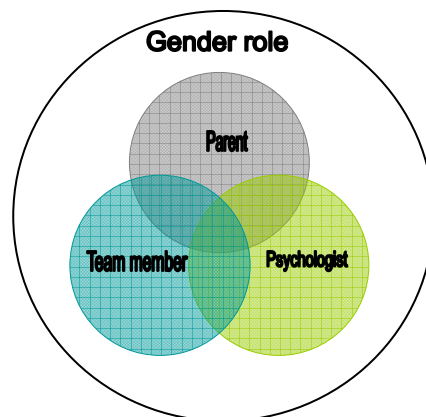
The interactions between role structure and social context and its effects on role performance is explored within the symbolic interaction literature (Eg Goffman, 1959; Strauss, 1963, Turner, 1979). Goffman (1959) suggested roles are enacted differently in specific social settings and his analysis of this interplay he termed the dramaturgical model. He emphasised the importance of establishing identity. Where an individual's identity is not congruent with the feedback and cues from role partners, he postulates

strain occurs in interactions. Hardy (1988) suggests this tension described by Goffman can be reconceptualised as role ambiguity. Social identity theory (Taifel & Turner, 1979) develops Goffman's (1954) ideas further in suggesting that a sense of social identity is derived from being a member of a group and inter-group comparison.

Parallel to sociological theories which emphasise social structures predominance in influencing individual roles, the organisational management perspective offers a different role theory, suggesting there is an interactional relationship between individuals and organisations (Kahn & Wolfe, 1964). This approach draws upon the person-environment model in which incongruence between an individual's objective and/or subjective needs and values and organisational values and needs can lead to strain (Lewin, 1951). This approach introduces the idea of resolving person-environment role tension through individual change (such as, goal setting, support groups). It has been criticized from the sociological perspective for not being empirically robust and minimizing the significance of social structure in dictating role performance (Kasl, 1978; Hardy & Hardy, 1988).

1.2 Role theory, professional identity and team working

Professionals can operate as lone workers, in single discipline, or in multi-disciplinary, teams and each setting provides a different role set, impacting differently on identity and inter-professional working. The prevalent mode of operation for NHS mental health workers is within multi-disciplinary teams. Onyett (2003) suggests that social identity theory predicts there will be less role conflict for professionals working in these teams, where the team goals are clear. He comments that clear team goals might not lead to greater team identification, if the individual's own role in reaching these goals is ambiguous or indistinct from the roles of others. Onyett suggests that this is due to the

threat such ambiguity has to valued professional identities, and that this might increase role conflict and possibly add to role ambiguity, even where team goals are clear. In considering potential resolution to this problem, he quotes Deschamps and Brown (1983:194)'s suggestion that 'policies aimed at integrating rival groups should endeavour to preserve or even enhance the social identities of their members by allowing each group some recognizable part in any joint activity'. In this way team roles become a way of protecting the individual and his identity from the pressures towards conformity exerted by the group (Handy, 1993). Hence it can be argued that within a multi-disciplinary setting, both same discipline and multi-disciplinary identities are important to maintain.

1.3 Changes in NHS and increases in role ambiguity?

There is a body of literature which suggests that the changes within NHS provision of mental health services over the last two decades have been detrimental to workers in terms of increased stress, burnout and reduced job satisfaction (Cherniss, 1980; Foster, 1998; Hinshelwood, 1989; Kahn, 2001). In particular, the change from single discipline provision of services to multi-disciplinary, community mental health teams (CMHT) and generic case management as the main vehicle for service delivery, has attracted comment that several disciplines now experience role conflict and role ambiguity and that this, along with the culture of change is increasing stress on workers (Galvin & McCarthy, 1994; Hughes, 2001; Norman & Peck, 1999; Rabin, Feldman & Kaplan, 1999; Stokes, 1994).

Within this literature the suggestion that multi-disciplinary working in mental health services within the UK has increased role ambiguity and that this stress has detrimental effects is often made with limited reference to empirical evidence (Kahn, 2001; Galvin &

McCarthy, 1994; Nightingale & Scott, 1994). In particular systemic and psychodynamic literature has contributed many ideas concerning this supposition without recourse to empirical studies (Foster, 1998; Roberts, 1994a,b; Roberts, 1998; Stokes, 1994). There does not appear to have been a review of the empirical evidence related to this particular suggestion.

2.0 Focus of review

This review aims to seek and examine the evidence for the premise that role conflict and/or role ambiguity is associated with community mental health worker stress. The review focuses upon UK NHS mental health services where service provision is free at the point of delivery and mostly provided via community multi-disciplinary teams.

3.0 Method

This review adopted two strategies for eliciting relevant literature. Firstly, there were searches for literature specifically focusing on role ambiguity and role conflict within mental health services. Then there was a search for studies aimed at exploring and identifying the nature of mental health professional worker stress. In this way, the search strategy approached the review question from different perspectives, not eschewing assumptions of a link between role conflict/ambiguity and community mental health worker stress, in order to minimize bias towards confirmation of the hypothesis. The searches sought literature relating to multi-disciplinary working, and also literature focusing on each key discipline typically represented within UK community mental health services (Onyett, 2003).

3.1 Search strategy

Searches were conducted using electronic data bases including:

AMID (Allied and Complementary Medicine) 1985 to date

BNID (British Nursing Index) 1994 to date

Kings Fund 1979 to date

EMBASE 1974, 1996 to date

Medline 1996 to date

Psych Info 1806 to date

The search strategy included Medical Subject Headings (MeSH), keyword and text searches.

MeSH search terms comprised,

- Community mental health teams

- CMHTs

- Multi-disciplinary teams

- Mental health nurses

- Psychiatric nurses

- Mental health occupational therapists

- Mental health social workers

- Psychiatrists

- Clinical psychologists

- Mental health workers

These terms were used in conjunction with the following key words

- Role ambiguity

- Role conflict

- Stress

- Stress management

- Coping strategies

From these searches, articles were identified, read and reference lists examined for further relevant material. As the search developed it included manual searches of literature and material identified through consultation with colleagues. In total 75 articles were gathered and grouped together by subject (organisational,14; mental health social work, 3; trauma, 8; multi-disciplinary teams, 12; mental health occupational therapists, 10; mental health clinical psychology, 3; psychiatry, 4; mental health nursing, 21).

3.2 Selection criteria

3.2.1 Criteria for inclusion

- Primary research study

- Reporting on mental health professional worker stress

- Relating to mental health services

- Research subjects working within UK NHS

- English language publication

- Including community based mental health worker participants

- Subjects are workers within core disciplines in mental health services (ie nursing, psychiatry, occupational therapy, social work, clinical psychology)

3.2.2 Criteria for exclusion

- Studies in which participants are solely hospital based mental health workers

Using the above criteria, 16 papers were identified for inclusion within this review.

4.0 Results

The 16 selected studies are outlined within Table 1. All studies, which dated from 1991-2005, included UK NHS community mental health workers participants. Three studies involved a mix of undifferentiated disciplines, eight studies involved single disciplines (ie one occupational therapy; five nursing; one psychiatry, and one clinical psychology) and five studies involved comparisons between different disciplines/settings. Nine studies specified community settings, four studies included hospital and community settings and three studies did not specify community/hospital setting. Ten studies offered general investigation of stress/coping and of these, six used standardized questionnaires and three qualitative methodologies and one used both methodologies. Six studies specifically investigated organisational/role issues and stress and of these, three used standardized questionnaires and three qualitative methodology.

Table1: Studies included in this review

Author(s) (year) Country	Research focus	Design and Analysis	Participants; sample size/response%; setting; gender/professional diff	Main findings	Limitations/ advantages for review
Brice (2001) UK	Identifying emotional demands on occupational therapists and their coping strategies	Semi-structured interviews. Qualitative 'framework' analysis	Mental health occupational therapists; n=6; community setting	**Key stressors**, - over involvement - **team work** - large caseload Coping strategies, - supervision - peer support	Small sample, opportunistic selection, lack of detail of team working stressors
Brown, Crawford & Darongka-mas (2000) UK	Exploring role blurring/professional identities with multi-disciplinary working	Semi-structured interviews. Qualitative grounded theory analysis	Community mental health team workers; n=29; community setting	**Blurring of roles in CMHTs liberating to some, stressful to others (role ambivalence?)** Indicated that community based professionals stressed by perceived, lack of structure and abandonment by management	No distinguishing between findings for different type professionals/ **Retention of professional boundaries due to new structures not remnant of past practices**
Burnard et al, (2000) UK	Exploring community mental health nurse stress and burnout	Questionnaire. Qualitative 'thematic content' analysis	Mental health nurses; n=301/49%; community setting	**Key stressors**, -workload/time -admin -client issues -lack resources -**role issues** **- interdisciplinary issues** Coping strategies, -colleague support	Lack of detail regarding role based issues
Carpenter et al, (2003) UK	Investigating relationship between organisation of mental health services, professional/team identification, team functioning and job satisfaction	Questionnaire established scales. Standard ANOVA & non-parametric (Kruskal-Wallis) ANOVA, regression	Mental health workers; Time 1 n=113; Time 2 (12months) n=77 At both times, n=49; community setting	-Strong team identity **-**high role clarity**, -role conflict (social workers) significantly associated with stress**, due to caseload/resources issues	Many dimensions examined, but sample sizes in individual cells small, small number of respondents at both times

Table 1 Continued (2/4)

Author(s) (year) Country	Research focus	Design and Analysis	Participants, sample size/response%, setting, gender/professional diff	Main findings	Limitations/ advantages for review
Cushway & Tyler (1994) UK	Investigating clinical psychologists' stress and coping	Questionnaire pack of 5 (including stress survey; coping; GHQ-28). Frequency, means, standard deviation	Clinical psychologists; n=151/67%; setting not specified; gender considered in analysis	**Stressors**: -too much work -poor management -conflicting demands -poor resources **-conflicting roles/ staff relationships** Coping strategies: -peer/ partner support -exercise	/Highlighted contrast in UK NHS psychologists' stress associated with reorganisation, poor resource &/or management stressor not significant for US psychologists
Cushway & Tyler (1996) UK	Development of Mental Health Professionals Stress Scale (MHPSS)	Questionnaire package of 7 (including MHPSS; social support; coping; job satisfaction; GHQ). ANOVA	Clinical psychologists, *n=154(70%)*; community and hospital mental health nurses, *n*=111(53%); community/ hospital setting; gender considered	Reliability and validity of MHPSS established MHPSS correlated with GHQ; job satisfaction; stress level, and social support	/Key stressors not necessarily cause of <distress Eg **Home-work conflict not major stressor, but predicts emotional distress**
Dallender & Nolan (2002) UK	Comparison of mental health nurses' and psychiatrists' perception of their work	Closed and open-ended questionnaire. Qualitative 'thematic' analysis	Psychiatrists, *n*=50; hospital mental health nurses, *n*=50; community mental health nurses, *n*=50; community/ hospital setting	Psychiatrists/CPNs gained job sat from autonomy. CPNs stressed by perceived excessive admin; poorly managed; undervalued as not involved in changes	/Valuable qualitative analysis eliciting how organisation changes impact, **but not associated with role conflict *per sec.***
Deary, Agius & Sadler (1996) UK	Comparison of psychiatrists' and physician/surgeons stress, coping, traits	Questionnaire (6, including work stress; work demands; coping; distress; personality; burnout scales). Statistical Package for Social Sciences(SPSS) analysis	Psychiatrists, *n=39;* physicians/ surgeons, *n*=149; response 75.2%; setting not specified; gender considered in analysis	Psychiatrists, lower workload & less conscientiousness; more emotional exhaustion; depression; openness; anxiety, and agreeability. **Organisation constraints, high stress (ie role issue?)**	Cross sectional study, so cannot conclude ongoing effects of stressors on health

Table 1 Continued (3/4)

Author(s) (year) Country	Research focus	Design and Analysis	Participants, sample size/response%, setting, gender/professional diff	Main findings	Limitations/ advantages for review
Edwards *et al.* (2000) UK	Stress in community mental health nurses	Questionnaire pack of 6 (including GHQ; burnout; self-esteem; stress and coping). Quantitative analysis: mean; chi; *p*.	Community mental health nurses; *n*=301/49%; community setting	Key stressors: Long waiting lists; poor resources; **others do not respect (ie role conflict/ambiguity?).** Coping strategies: Home support; peer support	No qualitative enquiry beyond given framework/ **role conflict/ ambiguity not key stressor;** largest UK study of type
Handy (1991) UK	Examines relationship between psychiatric structure, ideology and subjective experience of psychiatric nurses	Case study including observation, records of activity and semi-structured interviews. Analysis undefined	Community and inpatient mental health nurses, *n*=15; contrasted inpatient and community setting	**CPN key stressors:** Overwhelming sense of responsibility; **insecurity about having necessary skills (role ambiguity?)**	There is no clear account of how qualitative data was analysed
Gulliver, Towell & Peck (2003) UK	Examines staff morale in year following mental health and social care merger	Questionnaire posted after merger and at 10 and 22 months. SPSS, ANOVA, Bonferroni test, linear regression, Pearson's correlation coefficient	Adult mental health workers, *n*=117,107,133; response rates 44%, 34%, 37%; inpatient and community setting	Year post merger: **Significantly less, role clarity (ie role ambiguity?) and job satisfaction; significantly more, emotional exhaustion and depersonalization.**	Mix of inpatient and community settings not differentiated/ **empirical evidence of initial stress associated with less role clarity after structural change**
Leary *et al.* (1995) UK	Examines community psychiatric nurses' stress	Q-sorts, Q-methodology. SSPS factor analysis and varimax criterion	Community psychiatric nurses, *n*=44; community setting	Key stresses: Professional Isolation; **difficulty communicating with colleagues; others' unrealistic expectations (role conflict/ambiguity?).** Coping strategies: Time management; peer support; good inter-disciplinary communication	Methodology positive in eliciting stress items without the bias associated with predetermined questionnaire structure

Table 1 continued (4/4)

Author(s) (year) country	Research focus	Design and Analysis	Participants,, sample size/response%, setting, gender/professional diff	Main findings	Limitations/ advantages for review
Majomi, Brown & Crawford (2003) UK	Exploring stress within the interaction between work and home roles	Semi-structured interviews. Qualitative, grounded theory analysis	Community mental health nurses, *n*=20; community setting; gender considered in analysis	**Conflict between home/work roles key stressor. Can lead to sudden absenteeism. Stress actively managed**	Small scale, relied on retrospective self-reports/**Valuable insight into multi-faceted role conflict**
Onyett, Pillinger & Muijen (1997) UK	Investigating the relationship between stress and role clarity, team and professional identification, workload	Postal questionnaire (including burnout; job satisfaction; role ambiguity). Pearson correlation coefficient, ANOVA	Community mental health workers, *n*=445 (51.1%); community setting; profession considered in analysis	Overall high emotional exhaustion & job sat. **Soc workers and clin psych less clear on own role/ team role (role ambig?). Modest link job sat with role clarity/team ident.**	Direction of causality for assoc between role clarity, team identity and job satisfaction unclear/ **Valuable finding of role clarity importance**
Priebe *et al.* (2005) UK and Germany	Assess morale (team identity, job satisfaction, burnout) in community mental health teams in Berlin/London	Semi & structured questionnaires (5, including job satisfaction; burnout, and team identity). SPSS; means; ANOVA; Pearson's Chi-square. Qualitative thematic content analysis	London: Psychiatrists, *n*=30 (75%); CPNs, *n=30 (40%)*; social workers, *n*=30 (69%). Berlin: (49.6%); Psychiatrists, *n*=30, social workers, *n*=38, CPN's, *n*=31; community setting	London key stressors: Lack resources/time and bureaucracy. In Berlin, resources less of issue, as were problems with other professionals. Overall London vs Berlin: Higher burnout, lower job sat and less team identity.	Small sample size (type II errors possible), geographical group comparison questionable, though not focused upon for this review/**Team identity & role issues not highlighted**
Rathod *et al.* (2000) UK	Examine perceived stress, coping physical/emotional symptoms in mental health work/home	Questionnaire. Percentages; *t*-tests; logistic regression	Psychiatrists, *n*=67 (62%); setting not specified; gender considered in analysis	Key stressors: Long/out of hours working; difficult/hostile patients/ carers; bureaucracy; responsible for suicidal & homicidal patients	Non standardized scales/**Study acknowledged impact of NHS changing practices, but not significant**

Notes: Abbreviations: admin, administration; ambig, ambiguity; ANOVA, analysis of variance; CPN, community psychiatric nurse; GHQ, general health questionnaire, clin psych, clinical psychologists, ident, identity; psych, psychological; sat, satisfaction; soc workers, social workers; SPSS, Statistical Package for Social Sciences. Highlighted text of particular relevance to review aim.

4.1 Evidence for stress associated with role ambiguity or role conflict

The results show that there is empirical evidence of role issues being associated with stress within the current NHS mental health services (Brice *et al.,* 2001; Burnard *et al.,* 2000; Brown, Crawford & Darongkamas, 2000; Carpenter *et al.,* 2003; Cushway & Tyler, 1994; Edwards *et al.*, 2000, Gulliver, Towell & Peck, 2003; Handy, 1991, Leary *et al.,* 1995). However where studies have attempted to identify stressors through use of established scales, role has not been the major issue (Cushway & Tyler, 1994; Edwards *et al.*, 2000; Rathod *et al,.* 2000). Likewise in those studies which have attempted to elicit qualitative accounts of stressors, role does not appear to have been the main stressor (Brice *et al.,* 2001; Burnard *et al.,* 2000; Handy, 1991). Indeed, in two qualitative studies, role issues were not identified as stressors at all (Dallender & Nolan, 2002; Priebe *et al.,* 2005).

4.2 Key stressors for community mental health workers

It appears the key stressors for workers within UK NHS mental health services are issues of a perceived overwork, lack of time and resources, bureaucracy and client-related emotional stress (Brice *et al.,* 2001; Burnard *et al.,* 2000; Cushway & Tyler, 1994; Edwards *et al.*, 2000; Handy, 1991; Rathod *et al.,* 2000).

4.3 Level of stress from role issues

Although within the studies, role conflict/ambiguity was not identified as the major stressor, where it was identified it was between the second and fifth most prevalent, perceived stressor (ie 2nd, Brice *et al.,* 2001; 5th, Burnard *et al.,* 2000; 5th, Cushway & Tyler, 1994; 3rd, Edwards *et al.*, 2000; 2nd, Handy, 1991; 2nd, Leary *et al.,* 1995).

4.4 Association between organisational changes in mental health service delivery and role related stress

Those studies which specifically examined role conflict or role ambiguity indicate that organisational change within the NHS do appear to have impacted on role ambiguity-related stress (Brown, Crawford & Darongkamas*,* 2000; Carpenter *et al.,* 2003; Gulliver, Towell & Peck*,* 2003).

4.5 Differences in role conflict/ambiguity between professional disciplines

With respect to different disciplines, information on role ambiguity or conflict seems scarce and several studies which included different disciplines did not adequately differentiate them in their analysis (Brown, Crawford & Darongkamas, 2000; Carpenter *et al.*, 2003; Gulliver, Towell & Peck, 2003). Only Onyett *et al.* (1997) differentiated disciplines when investigating role ambiguity and found least role clarity for social workers and psychologists. Those studies that focused upon psychiatrists have not highlighted role ambiguity as a major issue (Deary, Agius & Sadler, 1996; Preibe *et al.,* 2005; Rathod *et al.*, 2000) and studies focusing upon nurse stress highlighted less clearly defined indication of role ambiguity, such as a perceived lack of respect/poor communication/unrealistic expectations from colleagues of other disciplines (Dallender & Nolan, 2002; Edwards *et al.,* 2000; Handy, 1991; Leary *et al,* 1995).

4.6 Differences related to gender

Five studies commented upon gender differences in perceived stress and role conflict/ambiguity. Gulliver, Towell and Peck (2003) found a relatively low proportion of variance in job satisfaction due to gender. Cushway and Tyler (1996) reported male mental health nurses experience greater psychological distress and less job satisfaction

than their female colleagues. They suggested this might be due to the expectation in their role to manage violent situations. Within the same study Cushway and Tyler found this gender difference reversed for clinical psychologists and this pattern of female heightened experiences of psychological distress has also been found in other studies (Cushway & Tyler, 1994; Rathod *et al.*, 2000). An explanation for this pattern is offered by Majomi, Brown & Crawford (2003) who found that potential work/home role conflict is a greater issue for females.

4.7 Relationship between stressors and psychological distress

Cushway and Tyler (1996) found that the major perceived stress is not necessarily the cause of greatest psychological distress. Within their results, despite not being a major stressor, 'home-work conflict' was the most reliable indicator of poorer mental health. Majomi, Brown and Crawford (2003) found that home-work conflict can be a key factor in sudden work absenteeism or sickness. They also found workers were active in managing this inter-role conflict.

5.0 Methodological Issues

The literature search employed within this review focused upon UK studies alone. This was due to the specific features of UK NHS mental health service provision and the review's aim of identifying whether these are associated with role stresses. Those studies reviewed which make comparison with US or another European country highlighted that the perceived overwork/resource stressor is not as marked as in the UK (Cushway & Tyler, 1994; Priebe *et al.,* 2005). This appears to confirm the chosen selection criteria of focusing upon UK only studies for this review.

In terms of the examination of studies reviewed, the review was restricted to a narrative analysis. This was due to the heterogeneity of studies and poor consistent operationalisation of key constructs (described below), which excluded the possibility of conducting a comparative analysis. Despite this limitation, the review was systematic in the application of the specified search strategy and selection criteria.

5.1 Limitations of findings

5.1.1 Lack of clearly defined terms

In several studies where role issues are identified, the exact nature of the stressor is not fully described (Burnard *et al.,* 2000; Deary, Agius & Sadler, 1996; Edwards *et al.,* 2000; Handy *et al.,* 1991; Leary *et al.,* 1995), creating uncertainty about whether the construct is role conflict or role ambiguity. Some studies did not specifically use terms 'role conflict' or 'role ambivalence', however the factors they described could possibly be described in this way or indicate these dimensions. For example, as noted in Table 1, Edwards *et al.* (2000) reported the community mental health nurses' stressor, 'others do not respect role', which is interpreted in this review as being indicative of role conflict and/or ambiguity. Within Table 1, where the interpretation of role conflict/role ambiguity is made by the author, it is indicated by 'ie role conflict/ambiguity?' placed in parenthesis after each of the research findings in question.

Within the reviewed studies, where there are general indications of role stresses, it is not always clear whether role conflict or role ambiguity is being described. For example, where Leary *et al.* (1995) report the community mental health nurse stressor, 'difficulty communicating with colleagues' and 'others' unrealistic expectations' (see Table 1), it is difficult to define whether this indicates role ambiguity, role conflict or both. These two

aspects of role stress, as defined earlier, are associated but not the same. This is further complicated by the use of the term 'role clarity', where the exact definition of the term and/or relationship with role ambiguity is not specified (Gulliver, Towell & Peck, 2003; Onyett, Pillinger & Muijen, 1997). This lack of clearly defined terms, limits the extent to which the review can specify what particular role stressors are present. It is also important to recognize that where associations between an aspect of role and other measures of well being are made, the causal direction is not necessarily determined (Onyett, Pillinger & Muijen, 1997).

5.1.2 Heterogeneity of reviewed studies

There are several other factors that limit the strength of the review. Although most studies were community based, some also included hospital based subjects and a few studies did not specify setting. This means that features identified within the review, although predominantly from community based worker data, are not purely related to or derived from community based mental health services. In addition, some of the studies are either small scale qualitative studies which have limited generalisablity (Brice *et al.*, 2001; Handy, 1991; Majomi, Brown, & Crawford, 2003) or quantitative studies with small cells being contrasted in analysis, increasing the likelihood of type II errors (Carpenter *et al.*, 2002; Priebe *et al.*, 2005).

5.2 Methodological limitations in reviewed studies

Within the review there were examples of qualitative studies which used a rigorous, transparent methodology, clearly describing details of a systematic, analytic strategy (Brown, Crawford and Darongkamas, 1995). However not all qualitative studies gave such a clear account. Handy (1991), despite referring to her research as an empirical

study, gave no clear account of systematic, qualitative analysis. Fortunately, the other

qualitative studies each indicated systematic analysis and despite their size, some of these

smaller sized qualitative studies provided valuable data of participant's open descriptions

of stressors, offering depth of insight into mental health worker's experiences. Other

larger quantitative studies have the strength of using reliable, standardized scales, with

findings that are more generalisable (Cushway & Tyler, 1994, 1996; Edward *et al.,* 2000;

Gulliver, Towell & Peck, 2003; Onyett, Pillinger & Muijen, 1997). However, the pre-

determined parameters of scales inevitably tend to exclude the depth and potential range

of data captured in exploratory studies. As inductive and deductive studies can often

exhibit different strengths and weaknesses, a positive feature within the review was the

relatively even balance between qualitative and quantitative focused research.

In addition to the methodological problems in Handy's (1991) qualitative study described

above, several other studies reduced their robustness and as consequence limited the

strength of findings of this review due to their methodological procedures. For example,

Brice *et al.* (2001) acknowledged that they had employed 'convenience and

opportunistic', rather than random, sampling and Rathod *et al.,* (2000) applied non-

standardised scales.

Finally, some of the results outlined are derived from only two or three studies. This was

the case for those results relating to gender and professional differences. In addition, some

features noted in the results, and highlighted as points of interest within the discussion,

are drawn from only one or two papers. For example, workers' active management of

home-work conflict was reported within just one paper (Majomi, Brown & Crawford,

2003). This does not mean that such a feature is not valid, but the limitations concerning assumptions of generalisability must be acknowledged.

6.0 Discussion

Evidence from the studies reviewed here seems to support the key hypothesis that issues relating to role do appear to have some association with stress for UK NHS community mental health workers. However support for this hypothesis is not without reservation. The role stresses identified do not appear to be the major stressor for this group of workers, though within the studies reviewed, it is fairly regularly reported as occurring with mid-range prevalence (ie Brice *et al.,* 2001; Burnard *et al.,* 2000; Cushway & Tyler, 1994; Edwards *et al.*, 2000; Handy, 1991; Leary *et al.,* 1995). Several of the studies although appearing to indicate role-related stressors, did not provide enough detail to identify whether role conflict or role ambivalence was the stressor (Burnard *et al.,* 2000; Deary, Agius & Sadler, 1996; Edwards *et al.,* 2000; Handy *et al.,* 1991; Leary *et al.,* 1995) and it is important to highlight that two studies found no evidence that could be attributed to role conflict or role ambiguity (Dallender & Nolan, 2003; Priebe *et al.*, 2005). It was therefore not possible within this review to differentiate role ambivalence from role conflict or to ascertain whether role ambivalence, as opposed to role conflict, is the greater role related stressor, as previously suggested (Hardy & Hardy, 1988; Tubre & Collins, 2000).

With respect to the potential impact of organisational change on role related stresses, there is some evidence that merging of various professional groups to create multi-disciplinary community mental health teams does create role related stressors particularly in the first year of change (Brown, Crawford & Darongkamas, 2000; Carpenter *et al.,* 2003; Gulliver,

Towell & Peck, 2003). Gulliver, Towell and Peck (2003) note the impact of

organisational change on role related stresses appears greatest in the initial months

following major reorganisation. Given these findings it would seem to be beneficial for

role stresses to be considered within planning of organisational change. This could

involve an expectation of a period of adjustment following reorganisation and monitoring

role-related stresses. It might also be valuable learn from role theory as suggested by

Onyett (1993), in recognizing the importance of workers maintaining professional

identities during periods of organisational change and through providing clear team and

individual aims within new structures.

In terms of the occurrence of role-related stress across the different mental health

professional groupings, the review was limited by only three of the studies having

considered this factor. Social workers and to a lesser extent, clinical psychologists were

identified as experiencing most role ambivalence or least role clarity when compared with

other professions within the multi-disciplinary team (Carpenter *et al.*, 2003; Onyett,

Pillinger & Muijen, 1997). Although Onyett, Pillinger and Muijen (1997) also found

nurses experience role ambivalence, this was to a lesser extent than some other disciplines

and in other nurse only studies reviewed here it was mostly reported as being of mid-

range prevalence. Psychiatrists appeared less likely to report role ambivalence problems.

However as noted above, it is very difficult to compare with any accuracy relative levels

of reported stresses across the studies. Clinical Psychology is a minority profession

within CMHTS and Onyett, Pillinger and Muijen (1997) suggest that their more prevalent

reporting of role ambiguity might be due to them experiencing professional identity as

being undermined by team membership. Occupational therapists are similarly usually a

minority profession within CMHTS and although other literature has indicated that role

ambiguity is a key stress for occupational therapists in Australia (Lloyd, McKenna & King, 2004), which has a health care system similar to the NHS, this pattern was not revealed within the UK studies reviewed here. With respect to social workers, the role stresses seemed to be the most pronounced of all the disciplines (Onyett, Pillinger & Muijen, 1997; Carpenter *et al.,* 2003).   Carpenter *et al.* (2003) suggest that within CMHTs, social workers are in the position of being both a minority discipline and isolated in being embedded within health service rather than social service culture. In addition, Carpenter *et al.* (2003) highlight they carry responsibilities under the Mental Health Act which can add to conflict within the role. Given these issues it is not surprising that evidence has indicated particular difficulties for social workers which are associated with role stresses. This seems to indicate that it might be particularly important to provide opportunity for social workers and other minority disciplines within community mental health teams maintain their professional identities and where possible seek agreement, clarity and shared understanding about their tasks within teams.

With respect to the development of multi-disciplinary teams as the major mode of delivering mental health services, Brown, Crawford and Darongkamas (2000) conclude that the blurring of roles and absence of clear management direction accentuates workers' need to maintain strong professional identities. They highlight that although professional disciplines focus on maintaining identity might be viewed as a remnant of historical professional 'tribalism', in fact it can be understood as a product of the newly instigated organisational structures. They suggest that open, flat structured loosely defined teams can lead workers to maintain and reinforce professional boundaries to provide some surety, structure and to regulate demands in the present. So ironically, the very focus of new service provision in overtly valuing multi-disciplinary working over uni-disciplinary

service provision might be creating role stresses which leads to behaviour which is contrary to the declared intention of change. Again this finding appears compatible with the supposition by Onyett (2003), that in order to promote effective multi-disciplinary functioning, each profession requires a specific role which could be facilitated by professional peer support. In examining the findings of the studies reviewed, along with the background literature, it appears that paradoxically, encouraging professional identification might be necessary to enable effective multi-disciplinary identification, team functioning and to lessen the potential role stresses which can occur through organisational change.

In examining the selected literature with respect to gender issues, a mixed picture emerged. There was some contradiction about whether male or female workers experienced greater stress *per sec*. However two studies indicated a greater degree of psychological distress for women and they appeared to associate this with home/work role conflict (Cushway & Tyler, 1996; Majomi, Brown and Crawford, 2003). Interestingly, it was noted by Cushway and Tyler (1996) that the most reported stress is not necessarily the greatest source of psychological distress. They highlight that although home/work conflict is not reported as the most prevalent stressor, it does appear to be significantly associated with emotional distress.

Majomi, Brown and Crawford (2003) suggest that it is too simplistic to consider work roles in isolation. They found that home/work conflict can be a significant variable in sudden periods of sickness/absenteeism. Their study also highlighted that rather than being acted upon by the social system, as described within social structural theorizing (Hardy & Hardy, 1988), workers are active in managing the home/work role conflict.

This suggestion challenges the arguments of Hardy and Hardy (1988) that social structure alone defines role and provides some empirical support for aspects of Kahn and Wolfe's (1964) work by evidencing that workers are active in their own management of stresses related to role. Although most studies indicate role related stressors as being of medium prevalence, this might belie their actual impact in terms of psychological distress. In addition, it is possibly too simplistic to consider role issues solely within one domain of life, as the interplay between home-work roles appears to be of importance and this interplay might account for apparent discrepancies in prevalence of role stressors and related distress. These findings suggest that a theoretical position incorporating both social structural (Hardy & Hardy, 1988; Goffman, 1959) and individual managerial approaches (Kahn & Wolfe, 1964) to role might be relevant and helpful in understanding dynamics for home/work role issues.

7.0 Conclusion

Overall this review of empirical evidence has indicated that role conflict and/or role ambivalence is present as a stressor within present day community mental health services. This is possibly accentuated by the occurrence of organisational change in the last few decades as services have moved from hospital based to community multi-disciplinary team delivery of mental health services. Interestingly, it may be that it is not just the process of change, but structural aspects of the new organisation that have heightened role conflict and perpetuate a need for professional identification, despite the focus on multi-disciplinary team working as the main vehicle for service delivery. It might, therefore, be beneficial to consider role related stressors in the planning of organisational change, through valuing professional identities and being clear about individual tasks within team goals.

In general, although present, work role conflict and/or role ambiguity does not appear to be a major stressor or main contributor to psychological distress for community mental health workers. In considering this finding, it appears that it might not fully reflect the impact of role related stresses for mental health workers. Role issues could be more pertinent to minority professions than to the majority of community mental health workers. It might also be the case that role-related stressors become elevated over a relatively short period of time, for example, in the months following a particularly high level of organisational change. In addition, work role is only a part of workers' roles within life. Studies indicate that home/work role conflict needs to be considered as the interplay of conflict between work and home roles is probably a greater contributor to psychological distress/burnout than work role ambiguity alone.

Finally, there is some indication that workers are active in managing the stress within role/home conflicts and hence possibly both organisational and individual factors need to be considered when understanding the interplay of this role conflict. Indeed this is already being recognized by some organisations through their support of home/work life balance initiatives. These schemes facilitate workers in their active management of competing demands from home and work, for example, by offering a variety of flexible working arrangements, with the overall aim of maintaining a healthy, stable workforce.

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Section two: Research Report

- Written as for Journal of Community and Applied Social Psychology (Appendix 2)

Exploring CMHT Clinical Psychologists' experiences of offering and receiving support from colleagues

Abstract

This study examines the experiences of CMHT clinical psychologists, in giving and receiving support from colleagues.

Six 1½ hour interviews are conducted with CMHT clinical psychologists to explore their experiences of support with colleagues. Transcripts are analysed using a grounded theory methodology.

Experiences within CMHT appear more troubled and created greater ambiguity than those outside the team. Issues of psychologists' needs being hidden within support attempts, an imbalance in professional and human aspects of support and problems with mutual validation are highlighted within CMHT working. Successful and unsuccessful patterns of support are identified and movement between these patterns and the corresponding positions of psychologists within CMHT and peer group sub-systems are considered.

The implications of attempting to foster and maintain effective cycles of support within this work setting are discussed. These include, retaining the human aspects of support, maintaining a position on the 'boundary' of the team and enhancing clinical training's consideration of the emotional task and theoretical understanding of giving and receiving support.

Key words:

Community mental health teams (CMHT); clinical psychologist; support

1.0 Introduction

1.1 Mental health work – Stress and coping

One of the core characteristics of those entering a caring profession is a desire to effect positive change in others' lives (Grosch & Olsen, 1994). Mental health work is a field of caring where the task and the desired outcomes are not always clear (Pines, 1993). Skills and knowledge, but also personal backgrounds and interpersonal aptitudes are demanded (Dickson, 1989; Miller, Stiff & Hartman Ellis, 1988), and the system often undervalues these personal attributes and interpersonal work (Dickson, 1989; James, 1989). The nature of mental health work, which increasingly focuses on those experiencing severe distress, such as psychosis, might also heighten emotional responses in workers, involving conflict, splitting and polarisation (Foster, 1998; Hinshelwood, 1998; Hess, 2001; Nightingale & Scott, 1994). Elements that are often elusive in mental health work, such as a sense of achievement, ability to control a manageable workload and a feeling of fulfilment, are associated with job satisfaction and negatively correlated with stress, burnout and stated intention to leave caring professions (Cooper, 1990; Fimian, Fastenau & Thomas, 1988; Fong, 1993; Glass, McKnight & Valdimarsdottir, 1993; Tyler & Cushway, 1992). It is therefore not surprising that mental health is an area where stress and burnout is regularly documented, attracting interest in understanding, alleviating and preventing this phenomenon (Cherniss, 1980; Pines, Aronson & Kafry, 1981; Payne & Firth, 1987).

In recent years there have been considerable National Health Service (NHS) organisational changes. The NHS, like other organisations, has moved away from a traditional institutional framework to develop more fluid structures bringing increased expectations of employee self-reliance and less security and hierarchy in which to 'hold'

and manage anxieties (Kahn, 2001). This trend is notable within NHS mental health services with the decline of psychiatric institutions and the development of community services (Hinshelwood, 1998).

In addition to stresses intrinsic to mental health and organisational stresses, personal motivation for caring can contribute further strain. Professional carers may have both conscious and unconscious motivations for caring (Roberts, 1994b). Unconscious motivations can include the need for 'reparation' or making good failing situations, linked with common early experiences of infantile struggle to make good relationships with childhood caregivers. This inner drive can fuel workers' idealistic hopes for positive change and increase the disappointment when this is not achieved (Roberts, 1994b).

Individual ways of coping with stress can vary and it has been suggested that preferred coping styles might predispose workers to pursuing particular caring professions (Stokes, 1994). Stokes (1994) suggests tendencies for nurses and doctors to adopt hierarchical patterns; whereas social workers externalise problems, deploying 'flight/fight', and therapists and psychologists persist in believing a therapeutic relationship will bring solutions, despite evidence to the contrary. He suggests this can lead to professional cultures of subordination, paranoia and collusion respectively and that the bringing together of these professional differences can lead to conflict and misunderstanding within multidisciplinary working.

The overall effects of intrinsic and organisational factors on workers in this field may be to generate stress in relationships with clients, colleagues, organisation and indeed with themselves (Cherniss, 1980). This stress manifests through workers' experience of clients

being uncooperative and unappreciative; colleagues appearing unsupportive and conflictual; organisational demands appearing unwieldy, tedious and undermining, and with respect to self, a sense of inadequacy and incompetence, despite having years of training (Cherniss, 1980). Research examining these issues focuses on how stresses can be lessened, coping increased and burnout prevented (Matheny, Aycock, Pugh, Curlette & Silva Cannella, 1986; Leiter, 1990; Oehler & Davidson, 1992; Kahn, 2001). Social support is one approach often associated with alleviating stress and burnout (Ogus, 1990; Boyle, Grap, Younger, & Thornby, 1991; Bennett, Evans & Tattersall, 1993).

Social support is defined in a wide variety of ways. Some definitions emphasise the role of a social network (Matheny *et al.* 1986), others the action of giving/receiving support (Richman, 1990), and others the perceived availability of assistance (Wethington & Kessler, 1986). All attempt to describe a process by which individuals receive, beneficially, through relation with others (Pierce, Sarason & Sarason, 1996). With respect to the current fluidly organised workplace, there is a need for social support to create a 'holding environment' in which anxieties can be processed and difficulties resolved (Kahn, 2001). This support can occur and be sustained where there are optimum levels of anxiety and the availability of trusted and competent emotional 'holding' qualities, which include empathy and validation with self-reflection, and a focus on understanding and negotiation. Such trusting exchanges can involve mutual experiences of support (Kahn, 1993), but are vulnerable to breakdown (Kahn, 2001), where trust is lost through a caregiver's hidden agendas (Milton and Davison, 1997) or through their self-serving motivation (Eisendrath, 1981).

As the institutional psychiatric population has declined, mental health services have been organised in ways that might provide more opportunity for supportive relationships between workers, through the formation of community mental health teams (CMHTs). Such changes might also have increased the need for social support to provide emotional 'holding', as institutional structures made way for more fluid community services (Kahn, 2001).

1.2 Community Mental Health Teams (CMHTs)

Within mental health services, the provision of services through multi-disciplinary CMHTs was established to enable a comprehensive and 'seamless' delivery of care between hospital and community (Foster, 1998). CMHTs reflect the open and chaotic nature of the community within their unpredictable work structure, which requires considerable employee self-reliance and increased need for co-worker support (Kahn, 2001). Although CMHT configurations might theoretically provide the opportunity for good co-worker support, such an insecure environment encourages attack or escape responses to stress and the diverse disciplines within the CMHT provide much opportunity for internal conflict hindering well-functioning, integrated teams (Foster, 1998). The emotional discomfort that transition from single to multi-disciplinary working might involve could hinder integration, increase professional isolation and heighten identification with peers outside of the team (Foster, 1998). Arguably from a systemic perspective, team members need to regulate the boundary and their position between self and others in order to carry out their roles effectively (Roberts, 1994a). This position enables monitoring of the interface between the team and the surrounding organisation and might be important for most disciplines (Roberts, 1994a). Where effective functioning is aided by being on the boundary of the team, resources gained from outside

the team (such as professional peer groups), may be essential to enable them to hold this position.

1.3 Clinical Psychology and support

Observers of the profession have noted that clinical psychologists, more than other health professionals, are active in offering support to colleagues in terms of clinical supervision, facilitated support groups, training, consultation and advice (MAS, 1989). Despite apparently specialist skills in such support, clinical psychologists encounter issues similar to other caregivers in experiencing stress (Cushway & Tyler, 1994) and in struggling to foster support for themselves (Grosch & Olsen, 1994). This paradox has been encapsulated in the phrase, 'do as we say not as we do', highlighting the contrast between theory and practice for clinical psychologists working in mental health services (Walsh & Cormack, 1994). This difficulty gaining support may occur through organisational ambivalence, professional value system and personal reluctance to identify self with clients.

Clinical psychologists are often minority, sole profession members of CMHTs, with professional support received through a psychology department (Berger, 1991). Some psychologists have argued that difficulties in functioning within CMHT are due to fundamental problems with inter-disciplinary working (Anciano and Kirkpatrick, 1990; Galvin and McCarthy, 1994; Paxton, 1995). Others have argued that clinical psychologists are reticent to embrace CMHT working due to reluctance to work with those experiencing long term mental health problems (Onyett, 1999) or concerns about losing status (Norman and Peck, 1999). The discussion has therefore centred on whether or not CMHTs are effective and whether psychologists should participate within them,

with less focus on investigating the possible roles and process of practising, given their presence within these teams.

It would seem that those qualities identified by Kahn (2001) for facilitating co-worker support, might be available from clinical psychologists, given the skills and patterns of practice in assisting colleagues recognised by MAS. Although there have been accounts of consultancy and facilitation of staff support (Eisendrath, 1981; Lederberg, 1998; Bramley, 1990; Bolton & Roberts, 1994; Milton and Davison, 1997; Hess, 2001) these have been discursive rather than empirical and focus on formal support groups, rather than the specific challenges for clinical psychologists working within CMHTs. Nevertheless, these accounts highlight several interesting features which might relate to clinical psychologists' experience in this area and so the pertinent features are outlined here.

1.3.1 The complexity of staff support

The overall task of offering supportive interventions to staff appears to be one of considerable complexity. Psychotherapists have commented upon the difficulty in attempting to facilitate staff support (Bramley, 1990; Milton & Davison, 1997). Professional carers can find difficulty accepting support (Grosch & Olsen, 1994), and might have learnt to put their own needs second to others from early in life (Kahn, 2001). Nevertheless unconscious needs are likely to be present, despite explicit rejection of help and these needs can manifest within the act of caring itself (Roberts, 1994b). Such implicit needs apply to those offering support to colleagues as much as the colleagues themselves (Walsh and Cormack, 1994). The task of facilitating staff support requires considerable therapeutic maturity (Lederberg, 1998). Facilitators of staff support need to monitor and understand dynamics and refrain from explicitly naming this understanding

(Hess, 2001) as explicit use of psychotherapeutic techniques can undermine the support process (Lederberg, 1998).

1.3.2 Added complexity of support within CMHTs

There are indications that attempts to support from within the CMHT might carry further complication (Anciano & Kilkpatrick, 1990). Consultancy within one's own team is prone to difficulties due to the conflict of loyalties that are likely to occur between sharing the team's perspective, as a team member, whilst presenting different views, as might a consultant (Huffington & Brunning, 1994). Reflection and discussion with peers external to the multidisciplinary team is important to maintain the therapeutic distance necessary to provide internal supervision and consultancy (Nightingale & Scott, 1994). This connection with external support, to assist in holding a reflective position within a team, is echoed by Roberts (1994a) systemic perspective concerning the importance of being positioned on the boundary of the team. As CMHT clinical psychologists are core members of the MDT, but with certain consultancy skills, it is likely they might share similar dilemmas to those of an internal consultant.

1.3.3 There are cultural differences between disciplines

Different professional coping styles and cultural background might also influence the experience for clinical psychologists in offering and receiving support (Stokes, 1994). The psychotherapeutically oriented training of psychologists is likely to preposition them to believing support is achieved through understanding and facing problems, rather than solely through encouragement and validation, as might be the perspective of other disciplines (Hess, 2001). These cultural differences might be magnified within a highly stressed, low control environment where problem focused

coping is too threatening and emotionally focused coping preferred (Compas,

Banez, Malcarne & Worsham, 1991; Sullivan, 1993). It is therefore possible that

clinical psychologists will experience cultural isolation within CMHTs (Berger,

1991), and this difference might increase if they offer 'supportive' input valued

more by themselves than by other disciplines (Hess, 2001).

1.3.4 Support processes are fragile

Difficulties in the process of giving and receiving support can be experienced as rejecting,

particularly by professional carers who may be driven by strong conscious and

unconscious drives to help (Roberts, 1994b).   Helpers react to rejection by experiencing

negative affect and derogatory attitudes towards the recipient, with this reaction

increasing where there is a high expectation of success (Rosen, Mickler & Collins, 1987).

It is possible that the motivation for offering support to colleagues within the CMHT

could be complicated by the psychologists' own needs as team members (Roberts,

1994a). The process of giving and receiving support is also vulnerable to the helpers'

emotional or physical withdrawal, for example, following experiencing rejection (Kahn,

2001) and where their own needs predominate (Eisendrath, 1981). Given the cultural

differences and stress related likelihood that colleagues within CMHTs will have

difficulty accepting clinical psychologists' offers of help, the resulting rejection, coupled

with the need to be accepted as team members could lead to clinical psychologists

working within CMHTs being susceptible to emotional withdrawal and mixed motivation

for offering further support.

1.4 Summary

In summary, although the position of CMHT clinical psychology in offering support to colleagues is not well documented, there are indications of several issues that CMHT clinical psychologists might face. These suggest that the task for CMHT clinical psychologists might be complex and challenging, particularly where they attempt to assist colleagues from within their own team. Direct exploration of this aspect of clinical psychologists' experience would assist in establishing whether CMHT clinical psychologists do view offering support to colleagues as an integral part of their role and provide some research evidence as to whether or not they experience the complications indicated by this review of related literature.

Given that it is important that all aspects of clinical psychologists' work are explored to inform clinical practice and identify training needs, investigation of the experiences of clinical psychologists in offering support to colleagues is required. In addition, as clinical psychologists are often part of CMHTs which have particular needs and difficulties in terms of support, it would seem appropriate to examine the experience of CMHT clinical psychologists.

1.5 Research Questions

1.5.1 Main question

How do CMHT clinical psychologists experience their attempts to provide 'support' for colleagues?

1.5.2 Sub-questions

How do clinical psychologists define 'support' in the context of their working relationships with colleagues?

What are clinical psychologists' experiences of offering, providing and receiving support from colleagues?

How are clinical psychologists prepared for and sustained in offering and providing 'support' to colleagues?

1.6 Rationale for the use of qualitative research methodology

It appeared most appropriate to employ a qualitative research methodology for several reasons.

Firstly, the research questions are inductive in nature, seeking to develop understanding and generate theory regarding psychologists' experiences of attempting to support colleagues. Qualitative methodologies can be effective in studying phenomena where theories are absent or deficient (Henwood & Pidgeon, 1995). The overall lack of an extensive body of research into this psychological phenomena indicates the appropriateness of using qualitative approaches (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997).

The process of giving and receiving support is a broad and, socially and psychologically complex phenomena (Pierce *et al.*, 1996). Qualitative approaches provide a depth of examination of complex and multi-faceted phenomena (Patton, 1990), are effective in accessing the meaning of experiences from the perspective of the participants (Henwood, 1996).

Finally, qualitative approaches acknowledge and address researcher assumptions through procedures making explicit the researcher's reflexivity (Lincoln and Guba, 1985). This enables researchers to explore areas in which they may be able to access unique perspectives, such as from within their own sub-culture, and to have procedures within the methodology to enable them to manage their own biases and influences that they bring to the study (Denzin & Lincoln, 1994). Within this study, the researcher explored issues for her own profession, with participation from colleagues working in the same locality, and issues regarding reflexive practice and an account of the researcher's perspective is given within the methodology.

2.0 Methodology

2.1 Research Design

In order to develop understanding of potentially complex and multifaceted experiences an inductive, qualitative research design appeared most appropriate (Denzin and Lincoln, 1994). The study involved six semi-structured (1 - 1½ hour) audio taped interviews (Smith, 1995) with CMHT clinical psychologists, all having given written consent. The data was analysed using a grounded theory analysis (Charmaz, 1995; Pidgeon and Henwood, 1986).

A background to qualitative research and grounded theory and the use of interviewing is provided within Appendix 3.

2.2 Rationale for using a grounded theory methodology

A grounded theory approach was chosen for this study as it addressed both the aims and epistemological position of the study. It enables the development of theory, grounded in data that is systematically collected and analysed (Charmaz, 1995).

The current study seeks to develop theory in an area in which other studies are scarce and grounded theory has been recognised as being particularly useful where existing theory is incomplete or absent (Henwood and Pidgeon, 1992).

Grounded theory also provides methodological rigour which gives a structure in which the researcher can manage their interpretative task, minimising researcher bias through grounding interpretations in the data, exploring anomalies through

theoretical sampling and adopting reflexive practices (Elliott, Fischer & Rennie, 1999). This is particularly important in the current study, where the researcher is from the same discipline and works in the same locality as participants.

With respect to alternative qualitative approaches, interpretative phenomenological analysis (IPA) could also have been used to generate theory, however its structure is less prescriptive than grounded theory (Smith, 1995). Given the researcher's relative inexperience in qualitative approaches and with the study's focus upon her own profession, clear structures for maintaining methodological rigour would assist her in ensuring conceptual analysis is explicit and driven by the text rather than by other potential sources of information. Therefore the relatively more prescriptive grounded theory was chosen in this study rather than the more fluid methodological approach of IPA.

Discourse analysis (DA) provides an even more detailed analysis of the content of the text than grounded theory. However DA is highly time consuming, reducing the amount of material that can be examined within a certain time frame and it is less focussed upon wider conceptualisation and theory generation (Potter and Wetherell, 1995) and therefore this approach was not adopted for this study. In contrast to DA, grounded theory offered the capacity to examine a considerable amount of material with the aim of theory generation.

Finally, grounded theory is most compatible with the epistemological positions of realism or contextualism (Madill, Jordan & Shirley, 2000). The epistemological

position of this study, outlined below, fits with the choice of grounded theory

methodology and analysis.

2.3 Researcher's Assumptions

Over the last 11 years the researcher has worked within a range of multidisciplinary teams

within hospital and community settings in adult mental health rehabilitation and recovery

services.   Her work has often included consultation, supervision and staff support and

developing understanding of mental health systems. In her experience the process of

offering support to colleagues is often complex and fraught with difficulties. She is

interested in clinical psychology, what is specific to the discipline and why individuals

enter the profession. The researcher, although not greatly experienced in qualitative

research, has a growing interest in this methodology. This study has grown from these

combined interests.

The relationship between researcher and participants is an important factor within this

study. All the participants within this study are colleagues working within CMHTs within

the same trust as the researcher and all are line-managed by the same director of

psychological therapies and members of the department of psychological therapies. The

department comprises of at least 16 clinical psychologists and over 50 other counsellors

or therapists. The researcher has no experience of directly working as a clinician with any

of the participants, although she has participated with them all in clinical psychology

meetings and peer supervision forums. Interview accounts must be understood within the

context of previous and future contact between researcher and participant and it is likely

that participants would mediate what they disclosed at interview in the light of this. It is

possible participants might have withheld information they would have shared with

someone with whom they had no other relationship, however in some instances they might have disclosed more because of the pre-existing relationships.

In approaching this study, throughout interviews and analysis, the researcher was aware that her own experiences and background, and her prior knowledge of participants and their shared work locality could lead her to make false assumptions about participant's account. She addressed this during interview by regularly seeking clarification about her understanding of what was being said and in analysis through discussions with her academic supervisor and field research peer and comparing the researchers' coding with independently coded sections of text. Research memos and the use of a research diary also facilitated the researcher's reflecting on and maintaining an awareness of these factors. The researcher's aim in this study is not to eliminate variables, but to be as transparent as possible about them so that the reader is in the best position to consider the study and its analysis for themselves.

2.4 Researcher's Epistemological Position

The researcher's epistemological position within this study is one of a critical realist, embracing aspects of contextual constructionism (Madill *et al.,* 2000). That is, she acknowledges that the context and cultural meaning ascribed by researcher and participants guides interpretation and understanding, but consider that underlying social practice can be discovered within grounded discursive accounts.

2.5 Participants

The participants were six clinical psychologists, each working in a different CMHT, all employed at A grade by the same trust and all with the same line-management from a department of psychological therapies. There were two male and four female participants. The participants had been qualified between 1½ and 14 years. Some were in their first post and others had up to two previous clinical psychology posts. All were currently the sole clinical psychologists within their CMHTs. Each described having therapeutic orientations drawn from a variety of approaches including psychodynamic, humanistic, person-centred, gestalt and cognitive perspectives. Most had or were engaged in additional psychotherapeutic training post-qualification in the above approaches. This information is tabulated within Appendix 4.

2.6 Procedure

2.6.1 Recruitment of Participants

Ethics committee approval was sought and granted for this study (Appendix 5). The participants volunteered following an invitation given by the researcher at an adult mental health psychologist meeting. This included background to the study and its procedure as explained within the participants' information sheet (Appendix 6).

The researcher contacted each volunteer participant and provided them with a copy of the participants' information sheet (Appendix 6) and consent form (Appendix 7) and gave a verbal account of this information and answered any additional questions. An interview time and venue most convenient for the participant was agreed.

2.6.2 Interview procedure

At the interview, the researcher reiterated the background information, clarified any queries and asked the participant to re-read and sign the consent form.

The audio tape was started and the researcher began the interview, following the research schedule (Appendix 8) which had been developed following the approach described by Smith (1995). Interviews lasted between 1-1½ hours.

At the end of the interview the audio tape was switched off. The researcher thanked participant and reminded them that they would be given a copy of their own transcript for comment to ensure they were satisfied identifiable features had been appropriately coded to ensure confidentiality.

The researcher made research memos of the process of the interview.

2.7 Analysis

2.7.1 Transcription

Each audio tape was transcribed verbatim, excluding demographic information (see Addendum and Appendix 9). The transcription was as described by Smith (1995) with pauses and verbal emphasis noted to aid the interpretative process (Silverman, 2000). The researcher replaced participants' names with pseudonyms and coded or altered any identifiable features to disguise identity, whilst attempting to maintain meaning. This process was verified by participant feedback on the transcripts. A copy of the transcript was given to the participant involved with the request for comments about any identifiable features which required further amendment. The researcher further amended the

transcript, if requested and returned to participant, repeating process until the participant was satisfied.

2.7.2 Line-by-line coding

Transcripts were analysed using a grounded theory method (Charmaz, 1995; Pidgeon & Henwood, 1996). All transcripts were coded line-by-line with the researcher making memo notes in parallel with the coding (Appendix 9). Following the transcribing and line-by-line coding of the first two interviews, 10 page sections from each interview were independently line-by-line coded by an experienced researcher in qualitative analysis. This analysis was compared with the researcher's analysis. There was broad agreement and any anomalies were discussed (detailed further in Appendix 11 and Critical Appraisal 6.4, pp 127). The researcher then continued the process of line-by-line coding the remaining interviews.

2.7.3 Focused coding

The line-by-line coded transcripts were then re-examined along with the memos and these initial codes were condensed into focused codes. The focused codes were examined and reoccurring themes were noted (Appendix 10). The process was iterative with repeated and cyclical examination of the transcripts, as new themes emerged.

2.7.4 Constructing categories and developing theory

These themes, or emerging categories, were written on separate index cards under which all related line-by-line codes were noted to ensure the more advanced coding could be readily be traced back to the original text. Text references that captured useful quotations were marked accordingly. New categories were created where focused codes did not fit

existing categories and existing categories were collapsed into each other where they held

the same meaning. The remaining categories were physically sorted by placing the cards

over a large area, identifying meaningful groupings and through this process determining

final categories and their sub-categories. The relationship between the categories was

examined and possible configurations of these categories in relation to each other were

derived. This whole process involved continuous re-examination of the data and themes

in a cyclical pattern, which gave coherence to the analysis and its findings (Elliott *et al.,*

1999).

The researcher focused the analysis upon CMHT working which was the area of greatest

ambiguity for participants and re-examined the relationship between the categories

relating to the experience of support within CMHTs, producing a variety of interpretations

and conceptualisations.

The researcher demonstrated the paper trail of the analysis to her research colleague who

examined the links from raw data to core categories, the decision-making process was

discussed and agreement reached between researcher and research colleague and memos

of these discussions were made.

2.7.5 Memo writing

Memos were written throughout the study and assisted the process of data collection and

analysis (Appendix 11). These included theoretical, operational and code notes as

described by Strauss and Corbin (1990), along with supervision notes.

The researcher has provided participants with written copies of the research findings and will give verbal feedback to the local adult mental health clinical psychologists' meeting following submission of this paper.

2.8 Credibility and Validity

The analysis involved several features which maintained methodological rigour and checks on credibility and validity.   In order to ensure internal consistency and robustness of analysis, methods of constant comparison with comprehensive examination of the data and deviant case analysis were employed (Silverman, 2000).

2.8.1 Constant comparative analysis, deviant case analysis and theoretical sampling

Text, codes, memos, and emerging categories were constantly compared, contrasted and reviewed throughout the analysis. The data was comprehensively analysed through fully transcribing and line-by-line coding each interview. The researcher became immersed in the data through the thorough examination and re-examination of the transcribed texts within the analysis.   Although constraints of this study limited the theoretical sampling of new data, as the analysis progressed, the data was constantly revisited to re-examine areas of theoretical interest and the data was searched for examples of theoretical anomalies. This deviant case analysis provided a greater depth of understanding and enabled consideration of other dimensions of the emerging theory. (An example of this is detailed within the Results, section 3.10.2, pp 85-87). Due to the limitations on theoretical sampling within this study, full saturation was not achieved, because more detail of categories could have been obtained through further theoretically focused sampling. Nevertheless, the analysis did reach a point approaching saturation in which no new categories were emerging from the data.

2.8.2 External checks and balances

The detail of early analysis was scrutinised through comparison of the researcher's line-by-line coding with independently coded sections. Further external examination was provided by on-going discussions of the analytic process with the field research peer and academic supervisor, including the demonstration of the analytic paper trail. During the interview, the researcher often sort clarification concerning unclear issues and asked for confirmation that her emerging understanding was in accordance with what the participants' had intended. The process of returning transcripts to the participants also added validity to the process of transcription.

During the process of analysis, the researcher repeatedly discussed emerging concepts and understanding with psychologists in a supervisors' forum and a consultancy special interest group, with each group including participants from the study. This process tested the credibility and resonance of emerging categories and proposed conceptualisations, through feedback from those who participated in the study and from those with similar background and experiences (Elliot *et al.*, 1999).

2.8.3 Reliability

The process of grounding the analysis with examples from the raw data enables the reliability of the findings to be readily assessed (Perakyla, 1997). The attention paid to the detail of transcribing the data, including noting pauses and verbal emphasis also assists the reliability of the interpretation within the analysis (Silverman, 2000). The reflexive practice of the researcher, in making her background and assumptions explicit within the study assists the reader in assessing the reliability of interpretations.

3.0 Analysis

3.1 Overview

The analysis of the six transcripts is described within this section. The categories

and subcategories along with an indication of saturation are outlined in Table 2.

Table 2. Number of codings within categories, subcategories

Category	Sub category	No of codings	Totals
In the same boat (11)	(1) Ambivalence about being "In the same boat"	14	
	(2) Disappointment with the team	19	
	(3) Ambivalence about seeking support	9	
	(4) Ambivalence valuing/respecting team colleagues	10	
	(5) (Self) alienation from the team	16	
	(6) Support within team works best when implicit	8	76
I gain more and give support more easily outside the team (12)	(1) Difference within and outside of team	6	
	(2) Able to receive support explicitly	12	
	(3) Give support explicitly	5	
	(4) More validation given/received	8	43
I need support too (26)	(1) Hold responsibility for own care	13	
	(2) Try to help others as they have been helped themselves	5	
	(3) Unsure of self and effectiveness as supporter	14	58
Support role part of job (5)	(1) Support role within structure of job	16	
	(2) Key forms of support offered by psychologist	16	
	(3) Key effects of providing support	11	
	(4) Training OK, but some gaps	19	67

Humanity within support (12)		(1) Developing friendships	7	
		(2) Fuzzy boundaries	8	
		(3) Shared understanding and respect	12	39
Own needs hidden within attempts to support (13)	I need support too/ Support role part of job	Multiple agendas in support transaction	17	
		Mismatch of expectations of support transaction	7	37
Mutual validation important (18)	I need support too/ Humanity in support	Good support is reciprocal	9	
		Good support if matched/shared views	9	36
Duel aspects professional/personal in support (6)	Humanity in support/ Support role part of job	Multifaceted elements to supportive relationship	16	
		Differentiate psychologist role and personal characteristics	9	
		Making support explicit(more professional) changes it	9	
		Supervision/support the same	7	
		Professional aspect hindrance to support	14	61

The researcher's understanding of the participants' accounts of their experiences of gaining and receiving support from colleagues is represented in Figure 2. Eight inter-related categories emerged from the analysis. Participants described contextually related experiences of being 'in the same boat' within their community mental health teams (CMHTs) and contrasted this with experiences of 'gaining more and giving support more easily' outside of these teams.
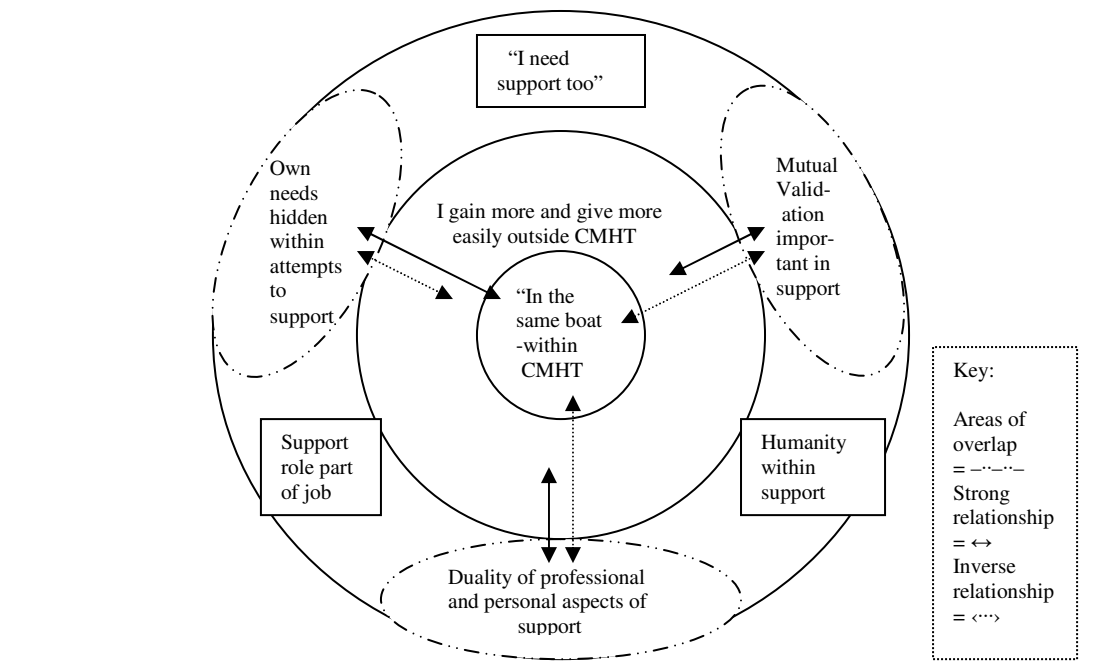
Figure 2. A representation of participants' experiences of giving and receiving

support to and from colleagues

They also described their experiences of the process of support and these six

categories are represented in Figure 2, positioned in a ring surrounding the two

context related categories. The categories of 'I need support too', 'support role part

of job and 'humanity within support' overlap with each other and these overlaps

create the three categories of 'own needs hidden within attempts to support',

'professional and personal dual aspects of support' and 'mutual validation important

in support'. The relationship between these overlapping 'support process'

categories and the 'support context' categories are also displayed in Figure 2.

Each category will be explained with examples from the transcripts and the link

relationships will also be described, with examples.

The analysis will then focus further on categories relating to the process of support and context of CMHT working and this will involve presenting three different conceptualisations of these relationships.

3.2 Category - "In the same boat"
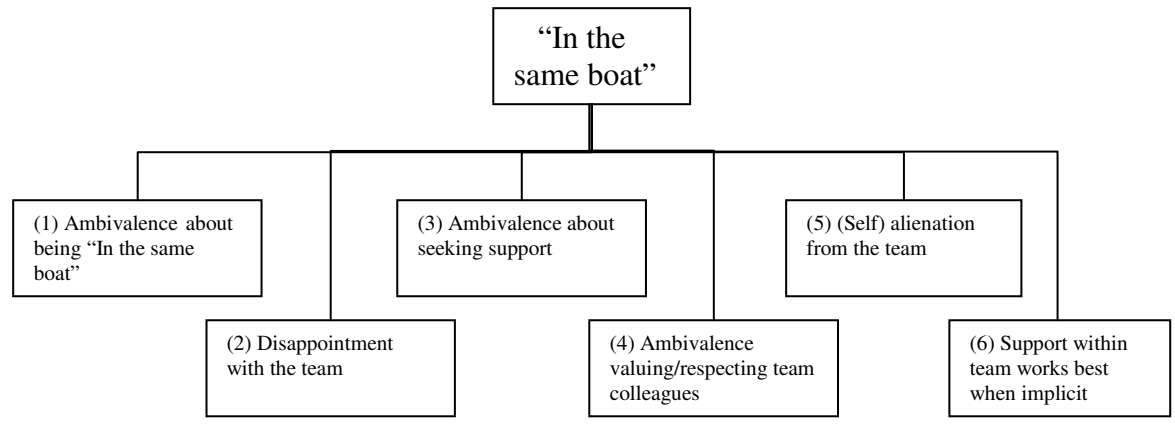
The name of the category is a verbatim phrase (Participant 'Jon' Text 309-316) which encapsulates the participants' experience of working within a CMHT, and it appears analogous to the experiences of people placed together in a boat by circumstance rather than by choice and struggling or having to adapt themselves in order to function within that situation. Another participant similarly described the family nature of CMHT working and highlighted the difficulty this presents.

> Eve. "…I find it very difficult to supervise people within my team. That's never been, for me, a very, mmm, that's never come off really, to be honest. I talk about people in, in the, kitchen, with people in (laughs) our team. I think it would be very, I, it's always been difficult to get that kind of separate, it's too much, we're too family, really, we're too much

in the grist of everyday to be able to take time out to be able to take time

out to come in, in the same kind of way. I've never found it easy within

the actual team I work, mmm, no."(Text 179-191)

The participants described support and supervision as interlinked and all
participants used the terms interchangeably, describing clinical supervision as a type
of support they offer and receive and a particular function of being a psychologist
(discussed further in category 'support role part of job').
This category encompassed six sub-categories which described ambivalence and
difficulty for participants in functioning within CMHTs.

3.2.1 Ambivalence about being "In the same boat"

Participants expressed ambivalence about being positioned within teams and this
was most clearly articulated by 'Jan'.

> *Jan. "…I came to this Department for the psychology, mmm, ideas that*
>
> *were in it. I didn't even visit the CMHT base. I didn't ever want to be*
>
> *in the CMHT. I don't believe in being core members of CMHTs as*
>
> *psychologists so, who knows? I may have set up those things, mmm or*
>
> *not helped. I'm not sure I'm a big team player."(Text 650-657)*

3.2.2 Disappointment with team

The participants described disappointment in their experiences of offering and
receiving support in the team.

Eve."I can think of a time in the team where I think I supported a team

manager quite a bit…

… you put a real investment in the person, supporting and listening to

difficult things and, holding confidences; all kinds of stuff, and then

maybe part of you, you're, you kind of got them to a certain place and

that's like, 'Wow, they'd sell me down the river to-morrow' (laughs).

That's been very, very hurtful."(Text 469-482)

3.2.3 Ambivalence about seeking support

The participants described being cautious about asking for support or revealing their own neediness to colleagues.

Sam. "They don't see me as needing support. And that maybe, but also

I don't turn to them for support, so they don't see, I don't reveal myself

as having those kinds of needs either. Mmm, it's supportive when, if I

need them to see someone I'm seeing. That's the kind of support I want

but that's always such a, nerve-wracking experience (laughs). Well,

that's the kind of support I'd prefer…

…So my experiences of asking people in the team to see somebody that

I've been seeing, frequently been horrible…

…For years I didn't ask them to see anybody I was seeing, mmm,

because of bad experiences of doing that, and also because I've wanted

to protect people I was seeing from lots of the people in the team,

mmm."(Text478-497)

3.2.4 Ambivalence about valuing/respecting team colleagues

Related to the above sub-category, participants described inner conflict about whether they value or respect what team colleagues might have to offer.

> *Jan. "…I don't really get those kind of everyday support needs met from my team and, and maybe it's arrogance on my part but there's nobody in my team I'd go to for supervision. I don't, there's just nothing that I feel they've got to offer me and I hate it. I have to accept that. For about five years I thought it can't be that, can't be that…" (Text 603-608)*

3.2.5 (Self) alienation from the team

Participants described withdrawing from the team, as a response to the lack of support and disappointment described above, but also to attempt to model boundaries and create distance from, for example team gossip, and in doing so regain some of their reflective function. Although most participants appeared reluctant to risk revealing their own needs to team colleagues, one participant described her current attempts to reverse her self-alienation.

> *Eve. "It's quite new really; it's quite early but I, it felt very freeing to be saying, actually, 'Something that I do is to go and hide myself in my office and, mmm, you probably would think that I'm completely self-sufficient, or whatever, but actually (laughs) mmm, that's not always that case and mmm, I'd like to stop doing that. So, you know, I'd like*

you to help me stop doing that sort of thing', and that being very well

received." (Text 532-538)

3.2.6 Informal (implicit) support works better in teams

Participants described adapting their work with colleagues to enable them to function effectively. In particular, they identify that being informal and not explicitly defining offers of support is important within this setting and conversely being more formal or explicitly naming 'support' or 'supervision' can undermine the very aim of being supportive.

Sue. "…if you don't call it 'supervision' and call it something else, then

I don't, that helps me to offer it, I think it also helps other people to take

it up, mmm, so if I don't kind of say let's meet regularly even either, so

just say, 'Do you want to meet to talk about that?' Every time they talk

about that, somehow I say, 'Well, let's make a time then. Let's set aside

a good portion of time to talk about that', without calling it something

particular, it sort of evolves. It's also hard because if people say

they're having supervision, mmm, with me, as well as management

supervision, the managers get a bit edgy about that, saying, 'you're

spending too much time in supervision', whereas it's all right to just

meet with me informally and talk about something."(Text 48-60)

3.3 Category - I gain more and give more easily outside the team

```
              ┌─────────────────────┐
              │ I gain more and give │
              │ support more easily  │
              │ outside the team     │
              └─────────────────────┘
        ┌───────────┬────────────┼────────────┬───────────┐
┌──────────────┐ ┌──────────────┐ ┌──────────────┐ ┌──────────────┐
│ (1) Difference│ │ (2) Able to  │ │ (3) Give     │ │ (4) More     │
│ within and    │ │ receive support│ support      │ │ validation   │
│ outside of team│ │ explicitly   │ │ explicitly   │ │ given/received│
└──────────────┘ └──────────────┘ └──────────────┘ └──────────────┘
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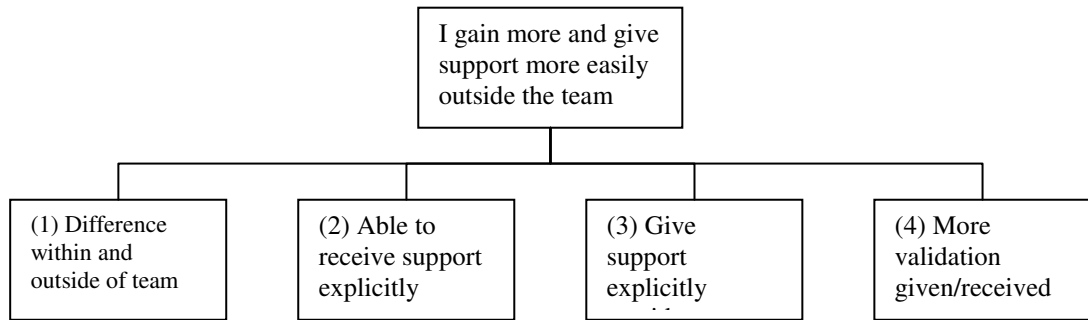
Although the name for this category is not verbatim, it captures the overriding

message from participants represented through several focused codes and many

line-by-line codings.

3.3.1 Difference within and outside of team

All participants contrasted their experiences of offering support to colleagues within

and outside of the team. They highlighted the apparently successful explicit and

formal delivery of support to colleagues outside of their team with the necessity for

such work to be informal and implicit within the team (as described in the previous

category).

> *Eve. "It seems like it's (sic. support for team colleagues) got to be more*
>
> *ordinary, than 'support' and 'supervision', or that it's got to be more*
>
> *that kind of we do do it in the team room or mmm, around team*
>
> *meetings or whatever, but it happens, but it's not formalised, it just*
>
> *doesn't, it doesn't ever seem to be successful. People come to me from*
>
> *other systems, places to have supervision and it kind of, that's held and*

boundaried and quite formal and that seems to work much, much

better." (Text 595-603)

3.3.2 Able to receive support explicitly

All participants described receiving more support from out with their CMHT

than from within. This was through individual and group clinical supervision,

peer discussion, training and friendships at work and home.

3.3.4 Give support explicitly outside team

Participants commented that people outside of the team approach them for clinical

supervision which is clearly named as such, and formalised with openly

acknowledged boundaries and that this appears to offer successful support for these

colleagues, as highlighted in the quotation above ('Eve', text 595-603, pp69)

3.3.5 More validation received/given

Participants were more confident about the success of their support of colleagues

outside of their teams and highlighted the mutual validation that appeared to

accompany these experiences.

> *Jan. "So the fact that I can go from, say, the group supervision of two*
>
> *nurses (sic. outside CMHT), just and we just have a great hour of*
>
> *supervision. It's only once a month and they just suck everything out of*
>
> *it that's valuable and just give me something back, but it's not remotely*
>
> *a dependent relationship. It's very adult. And it's just like, well, that*
>
> *sustains me for a long, three months. Like I said, lots of, other people*

and they don't find anything helpful. Just that one bit is, is, is so important and I hadn't realised how thirsty I was for it, until like I step outside of my CMHT." (Text 809-819)

The first two categories describe issues relating to the participants' experience of support with respect to their position within the system and are represented diagrammatical as central rings within Figure 2. The next three categories were also salient aspects of the process of support giving and receiving and are represented as three poles surrounding the context related, central rings within Figure 2.

3.4 Category - "I need support too"
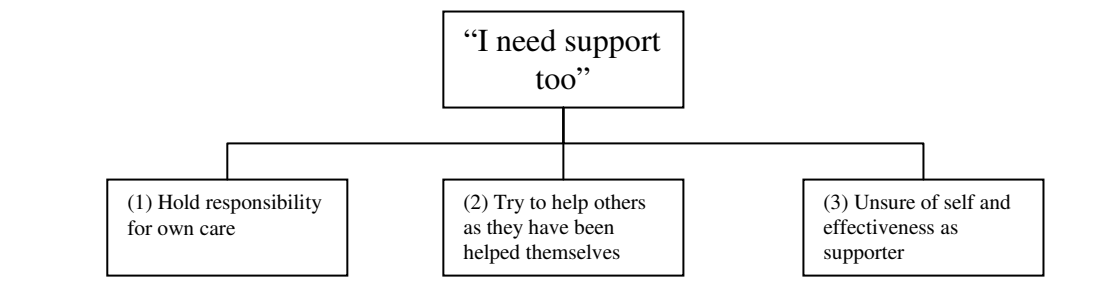
Eve. "I think that's sometimes the reality in the teams, mmm, and I've kind of addressed it a bit more in our, this team, that, actually, I need support too. I think I, I think it's me and I think it's partly psychology (cough) psychiatry, too, a bit, that our position is that we go in and offer something, we don't have, we don't have any idea they might give us anything, or that I might need something from them, mmm."(Text 524-530)

66

This category was particularly salient, and within it participants further expressed disappointment that their attempts to support were not reciprocated, particularly within their own teams.

> Lyn. "I think that one of the huge dilemmas is if, when you offer support, people I think make an assumption that you don't need it for yourself. So then, when you ask for support from them, there's an unwillingness to reciprocate and, mmm, and that's an experience that I've had in the team, not just in the team supervision, but in the wider team, mmm, that when I've then gone, I've said whatever the scenario is, 'I'm struggling to hold this or think about it on my own', even though I might have my own supervision and I need the team to kind of, you know, support me in this, mmm, and been really rebuffed, mmm, and, you know, 'We can't, we can't do that'…
>
> … so I've actually had to go and get that support and supervision in a sense from outside of the team." (Text 284-320)

Within this category participants highlighted that they recognise that their needs are present and that they value the support they do receive and as a result hold responsibility for their own care (ie subcategory, 1) and try to help others as they have been helped themselves (ie subcategory, 2). Participants also revealed their insecurities about the effectiveness of what they offer, particularly within their teams (ie subcategory, 3).

Jan. "…there's also that bit of me going, 'You'd like to think your

conversations been a bit helpful' and 'Maybe they'd have got to that

point without you' and 'Who are you to think that, you know, you've

helped them along?' So subtle the things you might want to do. If you

do them well, the more subtle they should be, really, and then you think,

'Well, where's my feedback to tell me I'm doing a good job?'" (Text

527-534)

3.5 Category – Support role part of job

```
                    ┌─────────────────────┐
                    │   Support role part  │
                    │       of job         │
                    └──────────┬──────────┘
       ┌───────────────┬───────┴───────┬───────────────┐
┌──────────────┐ ┌──────────────┐ ┌──────────────┐ ┌──────────────┐
│(1) Support   │ │(2) Key forms │ │(3) Key       │ │(4) Training  │
│role          │ │of support    │ │effects of    │ │OK, but some  │
│within        │ │offered       │ │providing     │ │gaps          │
│structure     │ │by psychologist│ │support       │ │              │
│of job        │ │              │ │              │ │              │
└──────────────┘ └──────────────┘ └──────────────┘ └──────────────┘
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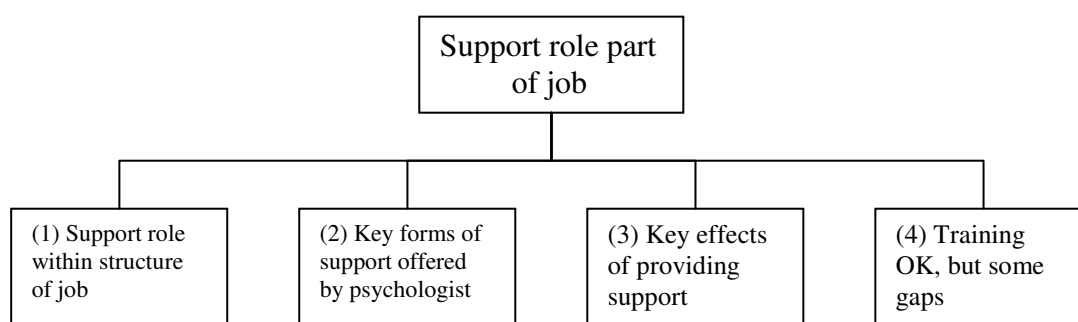
Participants described various aspects of a supportive function as being part of their

work as psychologists. They commented upon the parameters of their job, the

specifics of what they offer and what they seek to achieve in offering support to

colleagues and the nature of their training in this area.

3.5.1 Support role within structure of job

Participants described support in terms of supervision, consultation, training as

being named within their job descriptions, facilitated by their manager and the

scope their role provides for this role compared with their non-psychology colleagues.

> Sue. *"So, the fact that I don't do the same job, not on the same, not, not being in the same demands of, mmm. I've got the time and I also not have to, not, not sort of feel so bogged down by bits of paperwork and, mmm, statutory kind of, filling in boxes and having to get everything right. I think that means you can, just being more creative, and more, questions, 'Well, what would it be like if we did this instead of that?', rather than, 'Well, we've got to do that anyway' and then that leaves no space or energy to think about alternatives, mmm, so, yes, being a bit distant. I suppose it's the very thing that sometimes makes it harder for people to approach you as well (cough), but I guess it's about having different kinds of support, isn't it? You can't be supportive in every way to somebody." (Text 386-399)*

3.5.2 Key forms of support offered by psychologists

Participants described offering support in terms of reflective space and facilitating alternative ways of approaching issues, formally in supervision or informally through *ad hoc* conversations at the team base, which not very visible and unacknowledged by others (eg quotation 'Sue', text 386-399, pp73). They described supporting key individuals within the team or organisation (eg quotation 'Eve', text 469-482, pp65). They also described a range of other forms of support for colleagues including, training; research focused on helping tackling team

dilemmas such as the duty system, and practical support in offering use of psychologist's room.

3.5.3 Key effects of providing support

Participants described the aim of support as 'helping colleagues to do their job better' (see addendum. 'Sue', text 15-19).

> *Sam. "…I do know, the people I've offered support and supervision to, who've been in the team a long time have done some fantastic work with people (sic. service-users)...*
> *… I have helped them to understand people and sustain their drive and energy to keep going really."(Text 790-799)*

3.5.4 Training OK, but some gaps

Participants commented upon the value of practical clinical experience following training and general experiences in life in equipping them for this aspect of work as a psychologist and most questioned whether formal training on 'how to support' would be appropriate. They did however highlight that the experience for newly qualified psychologists challenged them to learn rapidly, particularly if their first job was working as the sole psychologist within a CMHT. Several participants suggested that more training in this area for newly qualified psychologists might be helpful and it was also suggested that more experientially focused training on this area within clinical training would have been beneficial.

Lyn. "…my experience (sic. of clinical training) was that they kind of

targeted particular kind of issues …

… it wasn't about actually what is it to be a Clinical Psychologist, and

what's it like, you know, when you're working in team environments or

what's it like when you are working in isolation…"(Text 432-440)

…if I had done a different kind of training, I might make some really

different decisions, I think, partly about my own awareness, of how I

might get caught up in offering support when, actually it says more

about me than it does about the other." (Text 503-507)

3.6 Category - Humanity within support

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                    ┌─────────────────┐
                    │    Humanity      │
                    │  within support  │
                    └─────────────────┘
        ┌───────────────────┼───────────────────┐
┌───────────────┐   ┌───────────────┐   ┌───────────────┐
│(1) Developing │   │(2) Fuzzy      │   │(3) Shared     │
│friendships    │   │boundaries     │   │understanding  │
│               │   │               │   │and respect    │
└───────────────┘   └───────────────┘   └───────────────┘
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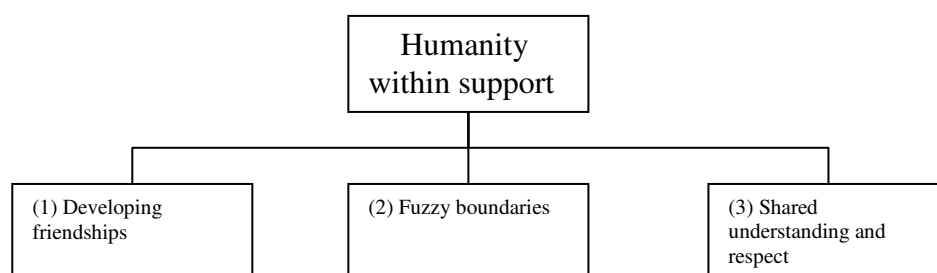
Participants described the importance of being a 'human being' not just 'a psychologist' in offering effective support (eg addendum'Eve', text 103-106). They described how good support is often associated with developing friendships (ie subcategory, 1) and that these have the benefit of becoming longer term, with shared knowledge over time. This seemed to link with the experience of boundaries becoming less significant when support occurs (ie subcategory, 2).

Sam. "But also I might talk about just being really burnt out so that, and

then talk about the supervision and things. And with (sic. my

supervisor) being my manager, so sometimes, you know the boundaries

are very fuzzy, so it's, I can talk about whatever I want and, because

we're friends as well, we might talk about, do you know? Like, like my

partner and child have been ill and so we talked about, when I went

there this week, we talked about that for a quarter of an hour. That's

quite, you know, that's supportive and that's helpful … (Text 420-429)

One participant commented that where a supervision relationship appeared to be less successful the need for boundaries was more apparent

Sam. "I've not found that having fuzzy boundaries in the relationships

with people I'm having supervision with has been problematic

because the supervision has not been problematic. That's a, (laughs)

I think the boundaries are useful when something's a mess and neither

side is comfortable or happy or it's not being productive." (Text 389-394)

Participants also identified the mutual nature of humanity and shared understanding within support (ie subcategory, 3). Interestingly this was described as involving a movement in 'the supported' towards 'the supporters' more psychological position.

Lyn. "In the team, I think, mmm, I've had a really good experience with

one of the nursing staff who was undertaking a CBT course and wanted

supervision and space to talk about things and, as a consequence of

that, we've become quite good friends outside of that supervisory

relationship, mmm, and mmm, and I've really enjoyed working with her.

I think she's really sort of grown and, you know, taken on some, you

know, more interesting, a more interesting way of looking at the way she

works compared to the medicalised way that she'd previously worked."

(Text 188-196)

The three further categories are positioned as overlapping aspects of these first three

'process of support' categories and are represented in Figure 2.

3.7 Category – Own needs hidden within attempts to support
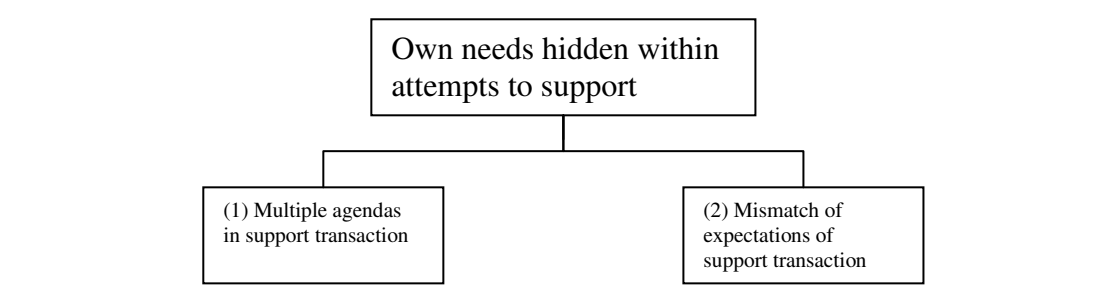
The title given to this category attempts to encapsulate the examples participants

gave of them disguising their own needs for support within their offers of support to

others, as part of their role. Hence this category represents overlapping aspects of

the "I need support too" and 'support part of role', categories and is derived from

sub-categories (1) Multiple agendas in support transaction and (2) Mismatch of

expectations of support transaction.

Lyn. "…, and what I was really aware of, which I was unaware of, which I was unaware of to start with, but in my checking out with other people, I actually think it was saying more about what I was needing in the team because I, then, became aware that I was feeling hugely unsupported by the team. So, in my reaching out to them, to say, 'Don't forget to kind of come and have lunch' or 'I'm here and let's go and do something'. I think, actually, it was more about, 'I'm feeling really wobbly and there's nobody around' and nobody was kind of reaching out and looking out for how I was. So, mmm, I hadn't realised that to start with. I was, I thought on solid ground and just offering that reminder but, actually, it was like, I think it's me, really, who needs this kind of support." (Text 31-42)

The participants commented that their hidden needs were often to receive support themselves, but one also highlighted the hidden need to be seen as 'supportive' or to exert their own power, for example, in terms of publicly supporting a less dominant team member against a more powerful one (see addendum 'Eve', text 294-309). It was generally acknowledged within these examples that the attempted support proved less successful where the participants' own needs were hidden agendas.

This category appeared strongly linked with participants' experience of offering and receiving support within their CMHT (ie category "in the same boat") as all the examples of 'own needs hidden in attempts to support' were within their own team setting. This was contrasted with an inverse relationship, with no examples linking

this category with outside own team working (ie category, 'I gain more and give more easily outside team'). As oppose to hiding needs, it appeared both the participants' own needs and their offers of support were far more explicit when working outside the team. These direct and inverse relationships are represented diagrammatically in Figure 2.

3.8 Category – Professional and personal dual aspects of support

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                  ┌───────────────────────────┐
                  │ Professional and personal │
                  │ dual aspects of support   │
                  └───────────────────────────┘
                    │                      │
        ┌───────────────────┐      ┌───────────────────┐
        │ (1) Good support is│      │ (2) Good support if│
        │ reciprocal         │      │ matched/shared views│
        └───────────────────┘      └───────────────────┘
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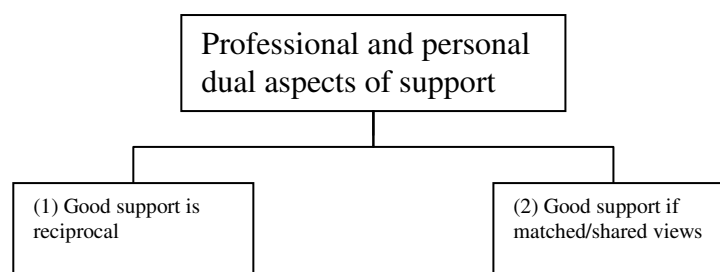
This category is drawn from sub-categories (1) Good support is reciprocal and (2) Good support if matched/shared views. This category describes the duality of professional (ie category, 'support role part of job') and personal (ie category, 'humanity within support'), attributes of the support given to and received from colleagues. Within some examples, there appear to be the presence of professionally driven approaches, in the absence of the personal or human aspect of support. In particular, where an individual is recognising a problem in support giving/receiving and seeks support from peers, this appears to be associated with a focus on professional approaches, possibly in an attempt to resolve difficulties.

Lyn. '…I'm moving to a position now of actually I'm feeling really quite

vulnerable and I can't manage this (sic. service user) on my own and I

would really like some people (sic. in the team) to support me…

… I was thinking about this the other day, one of the strategies in

assertiveness is use the broken record technique isn't it? And keep on

saying and, mmm, actually what I've experienced in our team is by

doing that, mmm, just frustrates people and there's a sense of, 'God,

here she goes again'… (Text 310-334)

… so what I've ended up doing is using the system of formally, writing

and logging and, and re-referring, you know, this particular client to the

team again'. (Text 393-395)

In this example, the participant has departed from the duality of professional and

personal aspects of support. She notes the frustration this appears to provoke in

colleagues, but attempts to resolve the impasse by redoubling her efforts in

becoming more 'professional'.

3.9 Category - Mutual validation important in support

Mutual validation important in support

(1) Multifaceted elements to supportive relationship

(2) Differentiate psychologist role and personal characteristics

(3) Making support explicit(more professional) changes it

(4) Training OK, but some gaps

(5) Professional aspect hindrance to support
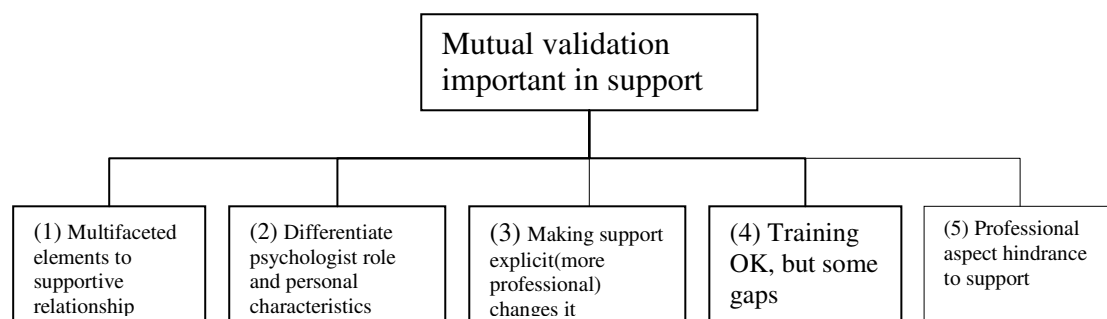
Participants repeatedly referred to the significance of giving and receiving validation in terms of mutually valuing, appreciating and confirming each others' efforts within support (eg quotation, 'Jan' text 809-819, pp70). This category appeared to bring together aspects of the category, 'I have needs too' and category, 'humanity within support', and is positioned between them within Figure 2. Participants described how difficult it was to offer or receive support in the absence of validation. This problem was particularly highlighted in several participants' experiences within CMHTs and this inverse link between mutual validation and CMHT working is shown in Figure 2. Sub-categories that feed into this category are (1) Multifaceted elements to supportive relationship, (2) Differentiate psychologist role and personal characteristics, (3) Making support explicit (more professional) changes it, (4) Training OK, but some gaps and (5) Professional aspect hindrance to support.

> *Jon. "You know, because **really** a part of what's difficult about getting*
> *support (from the team) is actually really believing that this wide range*
> *of colleagues, so-called colleagues you've got, **see** it your way. You*
> *know? Because a lot of them **don't!** I really believe that."*
> *(Text 853-858; NB. verbal emphasis in bold)*

As the last and following quotation illustrates this category is drawn from emotionally-charged accounts from participants. The presence or absence of validation seemed key to the perceived success of support and attempting to be supportive in its absence, appeared a painful process, whereas offering or receiving support in its presence appeared to provide tremendous satisfaction.

Jan. "…and part of the reason that (sic. work with a different team)

kind of grew and grew and I wanted to do more of it was absolutely to

do with, I did little bits of work and people gave me so much, 'Oh this is

great. Thanks. Can we have more?' And I was getting so nothing in my

CMHT, mmm, that I'd even forgotten that some people could do that. I

did, I remember having a conversation with 'Eve', I think when I went,

'Am I stupid or what?' I thought I'd just assumed that, as a

psychologist, you just went and worked and nobody ever said you were

helpful (laughs). I just assumed you had to go on theories and other

Psychologists telling you that you're helpful. And I'd forgotten that

some people might say, 'We want you to come and work here. We

really…' (laughs) rather than just, mmm, it's not that I have hostility all

the time in my CMHT, don't, don't get me wrong about that but, maybe

I make it hard for people to say I do a good job. I don't know. But I

feel that I go around saying, 'Hey' that's a really good idea' or, 'Well

done for doing that'. But people don't say that back to me…" (Text

142-158)

As in the above example, almost all descriptions of validation within support related

to participants' experiences outside of their immediate team. This strong link is also

highlighted in Figure 2.

3.10 Focussing the analysis on CMHT working

The experience of offering and receiving support within the CMHT was both central and full of ambiguity for the participants. It therefore appeared appropriate in the analysis to focus closely upon this 'context of support' category, and its relationship with the other 'process of support' categories. In exploring the relationships between these categories the researcher will present three ways of conceptualising what participants described.

3.10.1 Relationship between categories relating to support in CMHTs

Firstly, the key relationships between CMHT related categories can be examined through stripping away the other categories represented in Figure 2, as displayed in Figure 3.
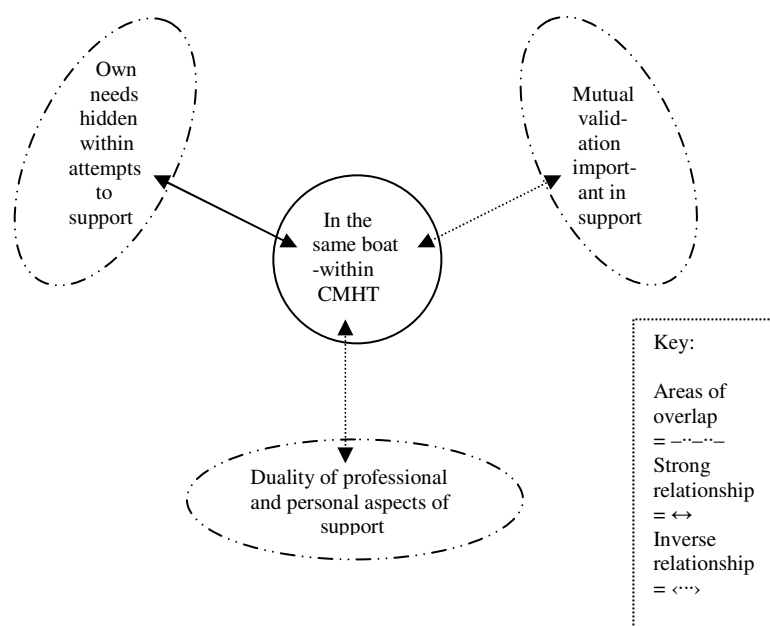
Figure 3. Focus upon the relationships between the four categories relating to support within CMHTs

Within most of the accounts given by participants they described a predominately negative experience of giving and receiving support within their CMHTs. This was characterised by a lack of mutual respect (eg quotations 'Jan', text 603-608, pp 66; 'Jon', text 853-858, pp80-81), a hiding of own needs within offers of support to others (eg quotation 'Lyn', text 31-42, pp 78) and an imbalance in the professional and human or personal aspects of support in which professional aspects dominate and personal aspects diminish (eg quotation 'Lyn', text 310-334, 393-395, pp 79-80). Within these descriptions it appeared to the researcher that each characteristic fed into the other, creating a cycle of perceived unsuccessful or non-supportive experiences.

3.10.2 Cycles of perceived successful and unsuccessful support

The second conceptualisation of the categories relating to support within CMHTs followed from the recognition of cyclical patterns in the difficulties in giving and receiving support, and this is represented within Figure 4.
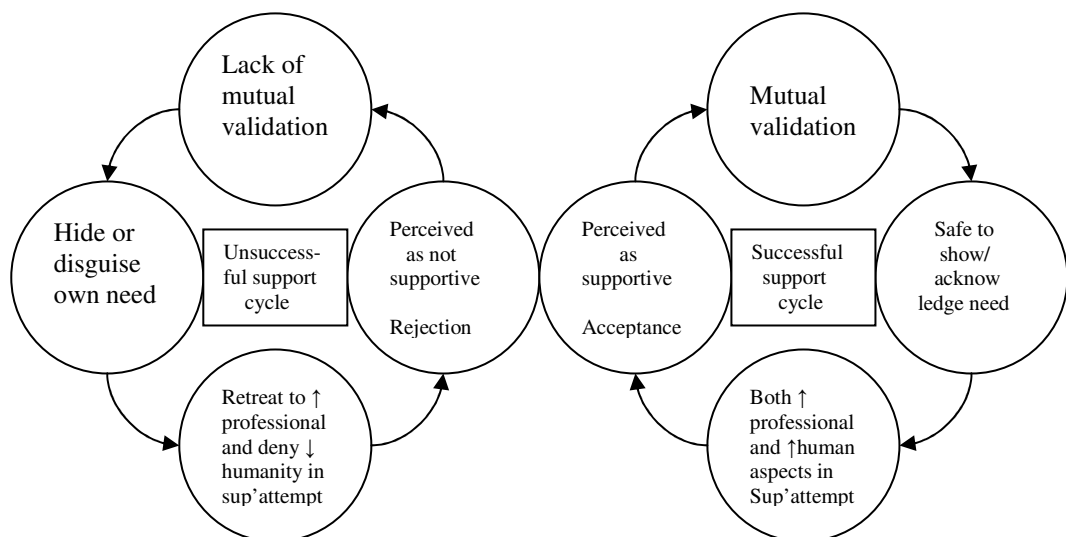
Figure 4. Perceived successful and unsuccessful cycles of support

One participant, 'Sue', presented an exception to the overall accounts of participants' experiences of support within their team, in particular that of receiving support from colleagues.

> R. 'And, and what about your experience of receiving support from
> colleagues? What has that been like?
> Sue. Mmm, good, actually. People are, I mean this, this same
> colleague, that I've just been talking about, has been very supportive,
> people(sic. in the CMHT) are always ready to, sort of ready to drop
> things. If people, it's a funny thing, you know, my policy is always to
> kind of say, 'Well, let's make a time to talk about that' and people, they
> will drop whatever they're doing, you know, even though I say, you
> know, if you haven't got time now, could I talk to you later on about
> this? They'll usually say, 'Oh, go on'. They put their things aside
> (laughs)' (Text 255-265. NB R = Researcher)
> …'Mmm, and actually their, mmm, their kind of support is often very
> sensitive and very, person-centred, so they don't try to tell me what they
> think I should do. They just sort of say what they think. Or they might
> say what they would do in my situation but then they would come with
> an appreciation of our roles being different. (Text 270-275)

Interestingly, in addition to this participant valuing the contribution of colleagues, she also expressed not being highly attached to her professional identity and offered some pros and cons about how much the role of a psychologist enables this function

of supporting colleagues. For example, she acknowledged psychologists have the 'space and distance' necessary to offer reflective space, but that this same distance and more boundaried style of psychologists' working might make them less accessible to support others (see quotation 'Sue', text 386-399, pp 73). This participant did recognise that her own needs were sometimes hidden within apparent offers of support, however this appeared to be tolerated within her mutually validating relationship. She recognised that her colleague's response to her was another example of kindliness towards her in allowing her to ask about their needs at a time that suited her in order for her to connect with that colleague. As such this appeared far less of a one-sided masquerade, rejected by the recipient, but more a mutual social dance in which the 'masquerade' was accepted by the 'recipient'. Overall it appeared far more acceptable for this participant to express their own needs, and to balance the professional and human aspects of support, far more akin to the accounts all participants gave of their experiences of giving and receiving support outside of their team. This more positive experience of support is also represented in Figure 4.

One participant, 'Sam', described the situation of previously having been within a positive cycle of support with colleagues in their team and then more recently moving into a negative cycle, in particular with respect to offering support in terms of clinical supervision.

> Sam. *'Supervision I came to think of as that was probably the most productive way… (Text 178-180)*

… So I thought it was that, I don't know whether I got a bit burnt out

with it. So I started to not enjoy it. And then several people didn't feel

they, you know, stopped seeing me. It, it, you know, they no longer

found it helpful so it was probably part of it. (Text 186-190)

Some of the people that I met with for quite a while now often come

once a month or something like that. They're a bit overwhelmed

though, they've, I've tried to put it to them, that as they get more

overwhelmed, they should have more supervision, but their way of

responding is to cancel supervision more. So it's not, that's been not

that effective. And two people that I've provided long-term supervision

for have been off sick with stress at work. (Text 233-243)

R. Right. And is that, did that all happened before or after you were,

been thinking, 'Actually, I'm doing a bit much of this supervision?'

Sam. Yes. Round the same time and, but, and after. There were times

more recently when I could have provided more time. So not, not totally

but, you know, the team's, mmm, like all CMHTs in that certainly in the

past eighteen months individual people are just cracking, you know. I

don't think the work's different it's more, it's different things, but the

impact is greater on the individual workers than it was a couple of years

ago. (Text 252-262)

It appeared from this account that the mutual increase in stress levels influenced

both the participant's and colleagues' capacity to give and receive support. There

was a sense of mutually held overwhelming feelings within the team and that the

participant as team member, 'in the same boat', shared the same position. Later in

his account this participant remarks contrasts the amount of support received from psychology peers and the lack of support from colleagues. The more successful supportive cycle within the team appears to have become less successful, whilst the participant continues to have helpful experiences of support from peers.

3.10.3 Systemic understanding of support processes within CMHT and peer groups

A third conceptualisation of the core categories is derived from re-examining participants' accounts of support within their teams and the analysis above, from a systemic perspective. It appeared to the researcher that as participants experienced different patterns of support within their team, they were positioned in different configurations within the CMHT and their peer group. The participant, 'Sue', who presented the exceptional experience of mostly positive experiences of support within her CMHT also described positive peer support. She acknowledged that her role as psychologist distanced her from team colleagues and identified the pros and cons of this, acknowledging limitations of the psychologist's role and expressing some ambivalence about her own professional identity, and caution about her role within her CMHT. It appeared that from a systemic perspective, that her position lay somewhere as indicated in Figure 5(a).

CMHT   Peer Group

Figure 5(a)

CMHT   Peer Group

Figure 5(b)

CMHT   Peer Group

Figure 5(c)

Key:

✦ = Participant

◯ = Sub-system
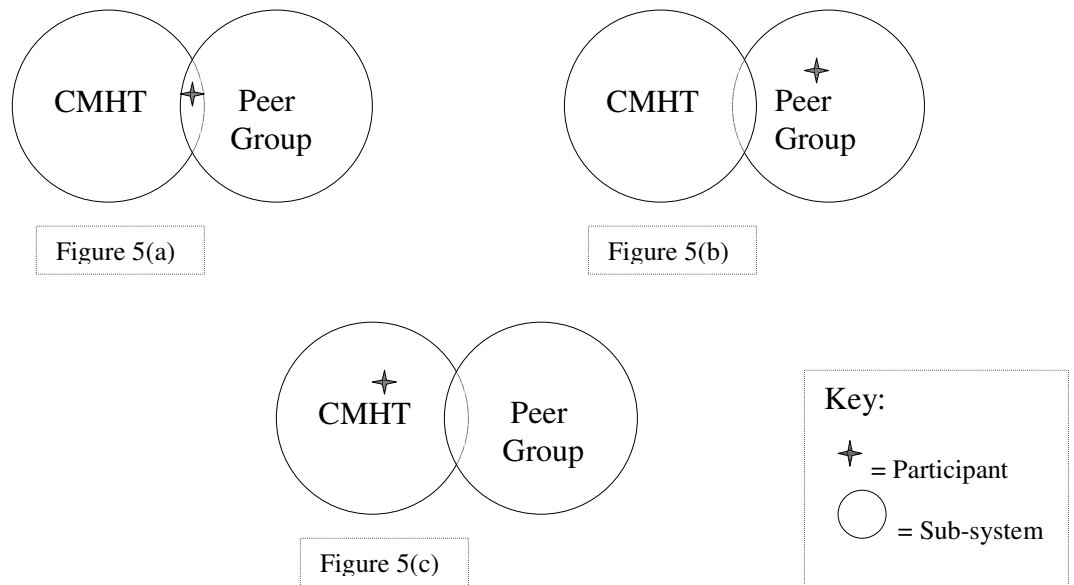
Figure 5. Differing positions of participants in relation to CMHT and peer group

Participants describing unsuccessful experiences of support with CMHT colleagues expressed feeling so alienated or self-alienated that their position seemed outside of the team. They all highlighted positive and successful experiences of giving and receiving support with their peer group, with one participant explicitly stating that they wanted to be positioned within a group of psychologists rather than within the CMHT (eg 'Jan', text 650-657, pp65). It appeared that these accounts described the participants being positioned as in Figure 5(b).

The participant 'Sam', who described the changing pattern of positive to negative experiences of offering support within their team seemed to indicate that his position in relation to his CMHT also changed (eg quotation 'Sam', text 178-180; 186-190; 233-242; 252-262, pp 86-87). He described a period offering support to colleagues which appeared successful, whilst also receiving support from peers. The researcher postulates that during this period the participants' account is most in

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keeping with being positioned as represented in Figure 5(a). The participant went on to describe a change to experiencing support efforts as being unsuccessful around the time both he and the team were experiencing increased stress. This shared team experience of 'being in the same boat', might be indicative of the participant becoming more enmeshed within the team experience and positioned as represented in Figure 5(c). He described responding to this stressful period by gaining more support from peers and deciding to limit what he offered (although interestingly, team colleagues requests for supervision reduced without him ever having to explicitly say 'no' to them). It appeared that his position within the system had swung from that represented in Figure 5(c) to that of Figure 5(b).

4.0 Discussion

The analysis provided an overall representation of the data and then detailed three different conceptualisations of the categories relating to CMHT working. Each of these representations will be discussed followed by a summary of the issues highlighted by this study, consideration of the limitations and shortcomings of this research and proposals for further investigation.

The participants highlighted that the context in which they gave and received support to colleagues was central to what happened (Figure 2). Their experience of "being in the same boat" by each being positioned as members of CMHTs was powerful and appeared to create considerable ambivalence in all the participants. This concurs with the challenge and discomfort identified by Foster (1998) for workers with different professional cultures and histories moving from previous adversarial positions to one of being 'part of us' within multi-disciplinary teams. The participants were clear in expressing that they have needs (ie category 'I have needs too'), but suggested that this often was not recognised by others, particularly colleagues from within their own team. They also emphasised that offering support to colleagues is a specific part of their role (ie category 'support role part of job'), referred to within job descriptions, supported and expected by their manager. They suggested that this role was not held by other disciplines and was often not recognised by others again particularly within their own team. The type of support offered appeared to be the provision of reflective space and alternative perspectives. This is embodied within supervision and training, but most clearly within consultation (Huffington and Brunning, 1994). The participants' accounts appeared to confirm Huffington and Brunning's (1994) suggestion that consultancy within one's own team is prone to difficulties. Given these experiences

within the CMHT, unsurprising it was in their own team, participants appeared to hide

their own needs within their attempts to support (Figures 1 & 2). Some participants

recognised this pattern and identified that their need to 'connect' as a member of the team

and to lessen their isolation was disguised within their offers of assistance to others. This

again supports Huffington and Brunning's (1994) suggestion that issues of membership

and loyalty might influence and cause tension for an internal consultant. This factor also

appears to link with the debate over the participation of clinical psychologists within

CMHTs and whether or not they identify with CMHT working (Galvin & McCarthy,

1994; Paxton, 1995; Norman & Peck, 1999; Onyett, 1999).

The participants identified the human aspects of support (Figure 2). Qualities such

as respect, validation and friendship within supportive work relationships were

highlighted. Most participants associated these characteristics with the supportive

experiences with peers and other disciplines outside of their CMHT. They confirm

Kahn's (2001) suggestion of the close links between good friendship and support

and reinforce his emphasis on the necessity of the human qualities of compassion,

acceptance, empathy and validation to create a safe, 'holding environment' to

contain anxieties and facilitate reflection on problems and effective decision

making. Participants noted that both human and professional aspects of support

were present (Figures 1 & 2), particularly in their more positive experiences of

giving and receiving support. These were often outside of their CMHT where they

described being able to be explicit about types of support offered and received, such

as clinical supervision. Participants highlighted the positive support they received

from local peers and intonated this support enabled them to continue working within

the CMHTs. Participants reported that as the supportive process occurred, the need

for boundaries appeared to lessen. They described 'fuzzy' boundaries between supervision and friendship and a merging of personal or human and professional aspects of the supportive exchange. They also described the reciprocal nature of the support process, mutual validation being particularly notable. Therefore ironically it appears where the helper seeks to meet their own needs, the supportive process often falters, but where the supporter is not implicitly seeking support, the supportive process is more likely to succeed and inadvertently involves the supporter receiving too. This observation echoes the comments of Kahn (1993) that in successful support reciprocation of support to the giver is, 'incidental (albeit pleasurable) rather than as their due'.

The complexity regarding support within CMHTs suggested in the literature (Roberts, 1994a; Foster, 1998; Kahn, 2001) appears to be reflected within participants' experience. As Kahn (2001) highlights, all have emotional needs and the participants identified their own needs and expressed disappointment at team colleagues for seeming to ignore these. There seemed a genuine confusion and bewilderment that despite the participants', attempts to offer support to colleagues, this was not reciprocated. Participants appeared more aware of their unmet needs in this area, expressed professional isolation and misunderstanding from colleagues, more hiding of needs as they persisted in attempts to offer support as part of their role, and greater emphasis on professional and less on human aspects within what was offered, with the experience of little reciprocal validation (Figure 3). Foster (1998) suggests that the more an individual is in need of support, the more difficult it can be for them to give and receive support. It also appeared the participants confirmed Lederberg's (1998) and Hess' (2001) suggestions that supportive

processes can be hindered if the giver is relying on technique. Lederberg (1998) petitions those offering staff support to abandon technique but retain all their insights and Hess (2001) similarly suggests facilitators of staff support monitor and understand dynamics and refrain from explicitly naming this understanding. Indeed the participants also recognised that giving a name, formalising or making explicit their attempts to support was often counterproductive within team settings, however it appeared that when under the stress of feeling unsupported themselves and where the human aspects of support were inaccessible the participants relied more on professional theory and approaches.

Given the complexity and difficulty regarding support within their CMHT, it is not therefore surprising how much more comfortable the participants appeared in their work and experience of giving and receiving support outside of their team (ie category 'I gain more and give more easily outside of team'). This experience involved less disguising of needs, both professional and human aspects being represented in the process, with considerable mutual validation experienced.

As the area of CMHT working proved the most difficult and demanding for participants with respect to their experience of giving and receiving support, it was this area on which the latter stages of analysis focused. Figure 3. represented this focal area and was drawn from the overall data representation of Figure 2.

Participants repeatedly described occasions of their own needs being hidden within their explicit offers of support to others. In particular, it seemed the participants' 'human' needs of being valued and cared for, were neglected by team colleagues.

Participants appeared to respond to this by withdrawing and distancing themselves, attempting to hide these needs from the team and meeting these needs elsewhere. Although some participants resigned themselves to this lack in the team, their disappointment implied that they still hoped for more and although ambivalent about being 'in the same boat', they indicated the need to 'connect' or be part of the team. The participants appeared to experience the tension referred to by Huffington and Brunning (1994) of both needing to connect with their team and the need to affirm themselves through exercising their professional skills. The participants appeared to combine these needs by seeking to offer their skills, in terms of reflective space and alternative perspectives to their colleagues, explicitly aiming to be helpful, but also implicitly hoping to gain validation and support for themselves in return. Therefore in their CMHTs participants reported hiding their own needs within offers of support, which appeared to become more professionally driven and lacking human aspects, due to participants' protective withdrawal of emotional availability. The participants reported that such offers were often rejected. This created confusion, further lack of validation, possibly increased emotional withdrawal and some described a redoubling of professional efforts both to offer support and to receive it (eg formal referrals for co-worker support from the team). This problem with support reflects Kahn's (2001) suggestion that a positive supportive experience can quickly falter if trust is lost in the care giver or if the giver appears to be no longer emotionally available.

The detrimental effects of those offering support attempting to meet their own needs in the process has been highlighted (Milton and Davison, 1997; Kahn, 2001). Sensitivity to the motivation of the caregiver and its effects on perceived

trustworthiness and safety experienced by potential recipients of support has also been emphasised (Eisendrath, 1981). It is therefore likely that although participants expressed seeking to hide their own needs, their colleagues perceived the presence of these hidden needs and this raised questions about true motivation for these offers of 'support'. In addition, if participants had reduced emotional availability, fuelled by previous experiences of rejection, their colleagues would be even less likely to accept their advances. It could be that participants are confused by this rejection, because their training and cultural background indicate that such offers would be useful to others. Although, there was some acknowledgement from participants that there might be a difference between what different disciplines seek and perceive as being helpful in terms of support. Participants appeared to confirm Hess' (2001) suggestion that psychotherapeutically trained facilitators tend to believe support comes through understanding, facing and working through difficulties, rather than through validation and encouragement alone, as other disciplines might seek. Indeed their confusion at their rejection within the CMHTs is likely to have been compounded by their experience of this type of active reflective support being far more positively received outside of their team.

In summary, a cycle which undermined support processes appears to occur in which participants were left with their training and job encouraging them to offer support to colleagues, but the type of support they offered being declined. This rejection made it more difficult for them to be emotionally available to offer the human aspects of support. This resulted in them withdrawing emotionally, whilst still trying to 'do their job' through offering 'support', with an imbalance between professional and personal aspects of support giving. That is, the participants

attempt to rectify the problem by becoming more 'professional', but offer support without the human elements they had identified as essential in successful support, most notably mutual validation. With a lack of support from team colleagues, participants relied on peers for more support and guidance. This further reinforces cultural beliefs and appears to encourage renewed efforts to exercise 'professional' techniques of standing back and distance self and which inadvertently legitimised and reinforced the participants' previous instinctive reaction to withdraw and might have furthered the participants' alienation from the team. Unfortunately, this increased alienation and attempts to offer support 'professionally' devoid of human aspects of support might only serve to fuel the vicious cycle.

The splitting of experience, with the increasing contrast between the negative experience within the team and the positive ones with the peer group or outside of the team appeared to lead to participants finding it increasingly difficult to value and see positives within team colleagues and further fuels this cycle of negative experience (Figure 4). The cyclical representation corresponds with Kahn's (2001) proposal that cyclical patterns can occur in support processes, with support vulnerable to break down.

Participants also described a cycle in which successful support occurs (Figure 4). The experience is of support offered with both professional and human aspects present, participants feeling safe to express their own needs and the presence of reciprocal validation which in turn reinforces the giving of support and the expression of need. Kahn (2001) highlighted some of the same features expressed

by participants, for example, validation, friendship, trust, reflective skills as being important within the successful cycle of support.

One participant, 'Sue', who described more positive experiences of giving and receiving support within their CMHT appeared less comfortable with their 'professional' identity and more questioning of professional styles such as 'stepping back' and distancing oneself in order to reflect and maintain boundaries. She recognised that she exercised these approaches, but was more questioning of them, commenting on her own limitations in offering support and emphasising that colleagues from different disciplines with different approaches have much to offer her. 'Sue' still described some difficulties within the CMHT and greatly valued peer support, but overall indicated she experienced a much more positive experience of support in this setting than other participants.

'Sue' appeared to have less experience of unsuccessful support within CMHTs than other participants. This could be because of her ambiguity about her own professional identity, leading to her being less comfortable with adopting her own 'professional' approaches, and more respectful and valuing of other disciplines style of support giving and receiving. Systemically, she appeared positioned as represented in Figure 5(a). She greatly valued peer input, but also valued CMHT input and whilst acknowledging the limitations of her support role within the CMHT, expressed positive experiences of working within the team. This position corresponds with Roberts (1994a) suggestion that being positioned at the boundary of subsystems can be very valuable in maintaining effective functioning.

Interestingly another participant, 'Sam', described a changing situation where he appeared to move away from a cycle of successful support to a cycle of negative experience of support within their CMHT. Critically, it appeared this transition occurred at a time when 'Sam' and team colleagues were feeling stressed and overburdened. He withdrew, gained more support from peers, becoming more alienated from the team and what had felt a positive experience began to feel more negative. 'Sam' described that once he had considered offering supervision to colleagues one of the most influential, effective and enjoyable parts of his work within the CMHT. During that time as subsequently, peer support had been an important constant supporting their work. Systemically it would appear that during this positive period 'Sam' was positioned as in Figure 5(a). It appeared that during the stressful period prior to the change in supportive processes he might have moved towards the position in Figure 5(c). At this stage it appeared 'Sam' was drawn towards the middle of the team, sharing the stress and overwhelming aspects of the work. In order to survive this situation, the instinctive response is to withdraw, gain support from outside and this withdrawal might be further reinforced by professional approaches of 'stepping back to reflect'. As 'Sam' became more closely positioned within his peer group, he might have moved from Figure 5(c) to 4(b). This position rescues him from the stresses that led to others in their CMHT entering long term sickness, but might have made it difficult to resume the positive supportive functioning most possible to attain from the position of being on the boundary as in Figure 5(a). Likewise another participant, 'Jan', expressed feeling very positive about her professional peer group, but reservation about 'being in the same boat' and operating as a core member of a CMHT. It appeared that systemically her position was most closely represented by Figure 5(b) and she too

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expressed concern about unsuccessful experiences of support giving and receiving within her CMHT (as represented in Figure 4).

4.1 Summary of factors which might facilitate CMHT clinical psychologists' experience of giving and receiving support within their teams

This study highlights three areas which might enhance psychologists' experience of giving and receiving support within CMHTs.

4.1.1 Attempt to retain human aspects of support

It appears important for psychologists to recognise that humanity must be part of effective support giving and receiving and cannot be compensated for by more formal or 'professional' approaches. Therefore it might be important that peer support encourages efforts to establish mutual validation, by valuing other disciplines and acknowledging the limitations of the kind of support offered by psychologists, particularly where positioned within a team. It might also be important for psychologists to recognise the pitfall of their 'own needs hidden within support attempts', that when working within a team they will have needs to connect and this will effect their functioning within the team, particularly in terms of consultation. The task of recognising value in others, whilst at times experiencing rejection and a lack of support from those same individuals requires external support and probably a balance in work so that psychologists are able to practice their consultancy skills without such complications by offering input to colleagues outside of their CMHT. The most effective aim of this 'same profession' peer support, with respect to rectifying problems in support processes, might be to enable the psychologist to re-establish the position of Figure 5(a), through focussing

on the task of establishing or regaining the mutual validation necessary for successful support, rather than reinforcing and justifying the psychologist in distancing themselves from their team (ie Figure 5b).

4.1.2 Aim to maintain position on the 'boundary'

There appears a challenge for CMHT clinical psychologists in maintaining their position at the boundary of their team (as in Figure 5a). Support from the external peer group appear essential in maintaining this position, enabling psychologist to maintain contact with their team whilst being able to hold sufficient distance to maintain their reflective function in the team. Those participants who described the positive experience of support giving/receiving in the teams clearly described the need for some 'distance' to enable them to provide the type of reflective support psychologists offer. Clearly such external same profession peer support can assist any discipline in not being drawn into an enmeshed position in the middle of the team as represented in Figure 5(c). The position 'on the boundary' can facilitate most disciplines functioning (Roberts, 1994a) and it might be that the long term sick casualties to which participant 'Sam' refers might have also been assisted if they too had strong external same profession peer support. The dilemma is that such external support needs to assist return to the boundary rather than further alienation from the CMHT as is represented in Figure 5(b). In order to do this it seems important that the potential pitfalls of professional approaches are understood. A certain 'distancing' is necessary, but too much is counterproductive and in seeking to remedy a support problem within the CMHT it is important that professional peer support does not inadvertently justify and cement the instinctive response to withdraw when rejected. Peer support is essential, but to moderate the instinctive

and traditionally professionally justified position of moving towards Figure 5(b) when the psychologist identifies there are problems with supportive processes akin to the unsuccessful support cycle (Figure 4).

4.1.3 Recognise the emotional task and theoretical understanding of support processes within clinical training

In addition, the participants highlighted the gap between clinical training and their first jobs as sole clinical psychologists within CMHTs. They reflected that whilst formal training on supporting colleagues would not necessarily have helped, more experiential preparation in terms of exploring what it is to *be* a clinical psychologist and more training post-qualification to support those within CMHTs would have been beneficial. It may be that the underlying need for psychologists to be assisted with the emotional task of maintaining the human aspects of support in their work requires more recognition during training, as might some of the theoretical understandings about working within teams and the understanding and valuing other disciplines' perspectives, that this study has highlighted.

4.2 Limitations of study

This study has produced several theoretical ideas about supportive processes surrounding psychologists working within CMHTs. However there are several limitations within this work which need to be recognised. The research would have gained from more theoretical sampling involving additional data collection in the light of emerging theory. Time constraints prevented this and as a result the exploration of anomalies and exceptions to the emerging theory were limited. In particular it would have been valuable to have returned to participant 'Sue', who

was unusual in expressing positive experiences of CMHT support and to have explored in greater depth the experiences of the participant 'Sam', who described moving from a positive to a negative experience of CMHT support. This could have enabled further questioning about the apparent patterns of support and enabled emerging theory to have been confirmed or amended accordingly. It would have been interesting to have explored experiences of giving and receiving support, from the perspective of psychologists' colleagues, of all disciplines, working within and outside of their CMHT. Exploring and comparing different configurations of psychologist input to services would enable testing of theory generated by this study. This could include examining systems in which, psychologists are not core CMHT members, where external peer support is reduced or does not involve professional line-management.

5.0 Conclusions

This study challenges psychologists to reclaim the human aspects of their work with colleagues. It highlights that psychologists cannot function effectively in offering support solely as a technical exercise and that they need support from their psychology peers to assist them in holding onto human, rather than technical qualities of support.

The findings suggest that psychologists need to recognise the existence of their own needs as team members and that these will manifest themselves in disguise if unmet. In addition, it appears that where psychologists' own needs are hidden within their offers of support, this will undermine the very thing that is being offered, and is likely to fuel mutual experiences of rejection and lack of support.

The study indicates that professional peer support is important in supporting psychologists. However it suggests that such support is needed to assist psychologists in finding value in their colleagues and helping them move back to a position on the boundary of their team, rather than to reinforce instincts to withdraw.

Finally, the findings challenge experienced psychologists and clinical trainers to assist those who are nearly and newly qualified in understanding the complexities and potential pitfalls of working within CMHTs and to support them in developing positive experiences of giving and receiving support.

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Section 3: Critical Appraisal

Clinical Psychologists' experience of support – reflections on a qualitative study

Abstract

This paper reflects upon the process of researching CMHT clinical psychologists' experience of giving and receiving support at work. The researchers' experience of working clinically whilst researching and engaging with participants from within the same department are explored. The nature of qualitative research, the experience of developing understanding of this approach whilst clinically active but comparatively academically isolated is discussed. The limitations and methodological pitfalls of this approach are raised and lessons learned are outlined.

Key words:

Clinical Psychologist; qualitative research; clinical research

1.0 The journey as clinician

As a newly qualified community and clinical psychologist I left the familiarity and peer support of my training in Devon to enter a newly created post in adult mental health rehabilitation in Suffolk, where psychologists were few and relatively disparate. In this professionally isolated setting, I entered a steep learning curve in honing what I was about as a psychologist and what I had to offer. As part of my work I sought to offer a service to those clients within the large and active local voluntary sector.   I developed a range of input for staff in supported housing, mostly on a group basis, some involving staff support and team building, others focussing on psychological consultation. By the time I was working with four or five different teams, I began to consider that this might be an interesting area to study.

2.0 The journey as researcher

My undergraduate research had been a quantative study and my MSc research had been largely quantative, with some qualitative aspects. I had begun to appreciate the access to rich data and meaningful material that qualitative approaches offered. In clinical practice, I had also come to appreciate the complex and multi-dimensional aspects of human relationships and started to question how realistic it was to attempt or assume control of variables within a social area of study.

I was torn, as my previous beliefs about good quality research were based on traditional positivist thinking, using quantatitive approaches, but my clinical experience was challenging the meaningfulness of this style of research. Within this dynamic social context it felt that to hold certain assumptions and suggest variables were controlled was

game playing, appearing to nail some 'truth' and 'external reality', presenting results as being far simpler and more certain than they were when experienced in the field.

As I began to read more about other research paradigms where variables were recognised and complexities embraced (Denzin & Lincoln, 1994; Silverman, 1993; Smith, Harré & Van Langenhove, 1995), I became excited about the prospect of adopting research approaches which better fitted my clinical experience. It seemed to me that qualitative approaches offered a more 'mature' research approach to social and psychological investigation, in which social complexities are accepted, rather than 'controlled' or overlooked. I felt liberated in contemplating this approach, but also plagued by doubts. I asked myself, 'Would this be 'real research', valid, rigorous and 'proper'?' I had fantasies that my liberation would enable my clinical experience to be reflected, but uncertainties that I was purely indulging my own ideas and theory making, rather than engaging in an investigation that had legitimacy as being 'other' than me. I was beginning to consider that the objectivity sought within empirical study was more illusionary than 'reality' and I was aware that this was being discussed in 'hard sciences', such as quantum physics, let alone social sciences. Nevertheless, I still experienced some comfort in holding the positivist perspective and I felt unsure of letting go. In attempting to move forward from this point, I fell down several pits.

3.0 Initial attempts at a qualitative study

I decided to embark on some research examining this process of attempting to offer support to staff. However, as is often the case for clinicians, I had distant academic support and no field or peer support. Such peer backup is important in encouraging all forms of research, but is particularly important in supporting qualitative approaches,

especially for inexperienced researchers. I therefore battled alone with my researcher identity crises and attempted to placate my anxieties in ways that compromised aspects of the research.

I planned to investigate the process of offering support to a staff group using qualitative approaches. I wanted to embrace the complexities of the subject area, but decided to seek to study a group which had recently approached me, with which I had no previous contact so that I could carry out base measurements, followed by my intervention and follow-up measures. I planned to use both qualitative and quantitive approaches, in 'before and after' interviews with participants and to qualitatively examine the process of my intervention. The number of participants was small and so quantitative analysis was going to have little statistical strength, but I felt that it gave the study 'legitimacy' and quelled my anxieties to some degree.

Towards the end of several of the base-line interviews, I was surprised to hear participants comment that they felt supported by the base-line interview itself!
I began to realise the nonsense of what I was trying to do, and that my 'ABA' design was farcical. My plan had been that I would 'intervene' in attempting to offer input that was supportive, after I had base measures, but of course the act of spending time individually with participants, discussing their experience of stress and support was an intervention in its own right.

I then went on to conduct qualitative examination of the process of facilitating a team-building day and follow-up team sessions. In negotiating this research with participants I had attempted to be as collaborative as possible, I explained that I wanted to research the

process of the work, and that this was often aided through making audio recordings, but that it was of course the participants' choice as to whether we used this approach. In wanting to embrace the freedoms of exploring what I experienced clinically, I wanted to ensure that the methods did not get in the way, however I was naïve in 'throwing caution to the wind' and not properly considering that the quality of data recorded would inevitably greatly influence the study. With my understanding that the form of data collection did not really matter, it is not surprisingly that most participants opted not to be recorded, but gave permission for me to make detailed field notes following the sessions. I was embarking on a study where I was explicitly observer (researcher) and participant (clinician). In wanting to acknowledge the presence of dual observer/participant positions, rather than trying to assume it is possible to eliminate or deny this configuration, I fell into making a different set of assumptions. These included an implicit assumption that research rigour could be loosened, so that method could take second place to the substance of what is being investigated and that my closeness to the subject material should not impact on the methods adopted. Ironically, these pitfalls were the exact issues that my positivist self criticised in my new found approach.

I carried within me polarised and epistemologically confused positions – an evangelical, but immature understanding of qualitative approaches and an anxious and compromised positivism. With no peer group with which to work through this conflict, I found myself often burdened and paralysed by the research process. Coupled with this was the nature of what I was exploring.

I have noted in my practice, the strong emotions the process of attempting to offer support to colleagues can engender in me. Back then, I was just beginning to understand this and

the process of acting as researcher in making detailed field notes seemed to magnify this experience. I found that at times my emotional reactions affected my ability to perform as researcher. It was much more difficult to settle down immediately after a session and write notes if my emotional reaction had been one of experiencing rejection, than if, for example, I had received validation or gratitude. I also found tensions between my researcher and clinical roles.

At the end of the team-building day, I discussed with the team what they would like to do following this day. Within my research role – particularly with my 'positivist hat', I thought that following up the team day with six further sessions would be a 'neat intervention'. As a clinician, I would have had far less personal investment in the teams' decision, and far more focus on what the team would find most helpful, rather than on what would give me a good data set. On reflection, I definitely feel my 'researcher's hat' predominated and I feel I sought opportunity to encourage the group to meet for follow-up sessions. This impacted upon the follow-up sessions. I am sure some of my experiences of disappointment and rejection following my efforts to 'support' in these sessions, were a consequence of my disguised needs within my offers of help.

Not surprisingly, the end result was that this research was never completed.

4.0 An epistemological crisis

The confusion in my epistemological position was central to the 'errors' I recount. Through attempting to satisfy several incompatible positions at once, I ended up with an

incoherent approach, unclear research questions and a deleterious effect on methodology, analysis and interpretation of results (Madill, Jordan & Shirley, 2000).

As an undergraduate, I had held a traditional positivist epistemology, concerned with deducing objective, truth. During my MSc research, I maintained this position but began to consider the use of qualitative methods. Following this research I began to make a shift into post-positivist thinking. This included taking a scientific realist position in terms of seeking to gain insight into true representations of the world through scientific inductive enquiry, but also some critical realist thinking in embracing the inherent subjectivity in seeking understanding of social phenomena, where perceptions and belief influence what is determined. I was also beginning to consider contextual constructionism, in terms of knowledge being determined by the context, understanding and ascribed cultural meaning of participant(s) and researcher.

This mixture of post-positivist coupled with my remnants of positivist thinking led to an incoherent mix of research design, methodology and analysis. I ended up hoping to analyse using grounded theory, where the field data simply was not dense enough for this approach. I also ended up with small sets of quantative data, which could only provide descriptive information rather than any statistical significance.

In addition, I seemed to be confused about differentiating clinical analysis from research analysis. As a clinician, I was practised in constantly 'eye balling' data, quickly filtering information and attempting to derive formulations to test and reappraise. As a qualitative researcher one of the tasks is to add methodological rigour to this process, to note carefully thoughts on the research, to systematically collect and analyse data, to note the

development of ideas and emerging theory and to allow an intertwining of data collection and analysis whilst maintaining fidelity to the method so that the process of analysis is transparent and can be audited. As I began to analyse the data I found not only that I could not use my chosen analysis, but also I struggled between approaching the analysis using my instinctive clinical interpretation and feeling anxious that I was not doing the research 'properly'.

Following this experience, I eventually moved towards a different understanding of using qualitative approaches. I learnt that qualitative approaches do add meaning to social research and that they can also utilise the kind of skills developed within clinical practice. However I also came to appreciate that methodological rigour is vital in maintaining the process of research and defining the research process as being different from clinical or instinctual analysis or descriptive accounts of experience. I came to appreciate that my clinical skills added to the research analysis, but that their presence meant that I needed to acknowledge my intuitive analytic style (Madill *et al.*, 2000) and that I could compliment this by attending to systematic serial aspects in my analysis, particularly in its early stages. This meant being more disciplined in staying close to the data and not relying on intuitive interpretations to the extent I might within busy clinical practice. I also learnt the importance of good quality data recording, which enabled me to participate (for example by engaging in an interview process), rather than attempting to participate and simultaneously record data. I also came to appreciate the need to own and gain some understanding of my epistemological position. I recognise that I currently adopt a critical realist stance, which incorporates aspects of contextual constructionism (Parker, 1996 cited by Madill *et al.,* 2000). That is, I recognise that context and cultural meaning is ascribed by researcher and participant and this guides interpretation and understanding,

whilst considering that underlying social practice can be discovered within grounded discursive accounts.

5.0 My recent journey as clinician

My interest in offering support to staff groups has continued over the years. I also have become increasingly interested in understanding organisations and systems having spent most of my career aiming to help clients survive and extrapolate themselves from psychiatric institutions and having to steer a course for myself within such systems. I had become aware of my own needs in working with others within teams and the reciprocal nature of support. Certainly my experience of working with and within staff teams appeared less than straight forward and as I began to look for what others had written about the area, I was struck by some insights and theoretical understanding that I had not encountered in clinical training and which might have spared me a sometimes torturous route of discovery post-qualifying. I was also surprised by the lack of literature specifically relating to clinical psychology and this type of work. This was in spite of my anecdotal experience of psychologists appearing to accept offering support to colleagues as an intrinsic part of their role. I therefore decided that I would revisit this area of study.

6.0 The Current study

Throughout the process of this research I kept a research diary from which the following account is drawn.

6.1 Planning the research

A little wiser concerning research methodology and focused on attempting to successfully conduct and complete my Doctorate in Clinical Psychology, I decided to examine clinical psychologists' experiences of giving and receiving support from colleagues. I wanted to allow consideration of 'care givers' experiences of receiving and I was also interested in the difference in giving and receiving from within and outside of a team. I therefore decided to focus on community mental health team (CMHT), clinical psychologists. I decided to approach colleagues from within the locality. All participants were employed within the same trust as myself and we shared the same line-manager and membership of the large (60 or more) department of psychological therapies.

6.2 Ethics Committee Approval

The application for research registration, ethics committee approval and indemnity was a lengthy process. Initially I was advised by the ethics administrator that as my participants were employees not service-users, formal approval was not necessary. Later clarification established that this was not the case and I began the formal process, finally receiving the approval necessary. Locally there is considerable debate about whether the extremely lengthy process might hinder rather than support good quality clinical research and certainly it was an anxiety provoking experience despite my relatively uncontroversial study. The main ethical issue was ensuring confidentiality of participants and of third parties to whom they might refer, particularly in the light of participants working locally. I addressed this, to the satisfaction of the committee, through the process of giving transcripts to participants, further amending and returning again until they were satisfied that all identifiable information had been sufficiently disguised. Interestingly some of the committee did not seem to understand that issues of support giving and receiving often

involved the relationship between clinical psychologists and other disciplines, rather than referring only to clinical psychologists' experiences with each other. This seemed to echo the lack of recognition I had observed within the literature concerning this aspect of clinical psychologists' work.

6.3 The research process

The issue of the participants working within the same locality as each other and as myself, is important to appraise. Firstly it is important to recognise that there is always the factor of prior relationship to consider within research, as non-acquaintance as well as acquaintance will influence the structure and content of the interaction between researcher and participant (Burman, 1994).

In considering the prior relationship between myself and the participants, I had not worked closely with any participant, although we had participated together within monthly adult mental health psychology meetings and we shared the same line manager, the director of psychological therapies. Although my relationship with the participants was limited, I felt positively towards each of them and felt curious about their experiences within and outside of their teams. Practically, having local participants aided the progress of the research, which I was conducting whilst working full-time as a consultant clinical psychologist. I also felt that the interviews very quickly accessed some deep and poignant accounts of experience.

It could be argued that my prior and anticipated future relationships with participants hindered what was discussed due to participants being aware that our relationship would continue beyond the scope of the research. Participants might have unconsciously made

false assumptions about our shared understanding and omitted some valuable explanations of their experience. They might also have displayed bias in their disclosure, for example, by choosing not to raise sensitive information which might increase future vulnerability or selecting information highlighting a positive aspect of self, in a way they might not if there was no ongoing relationship in which to invest. Having no prior relationships, might have afforded participants greater freedom to respond without such bias, but paradoxically it could also increase caution and reluctance to disclose. For example, participants' might experience disquiet about voicing criticism of the service to someone they do not know, from outside of the organisation. They might also avoid areas requiring lots of background explanation, or spent much interview time providing background explanation, inadvertently limiting the depth and range of disclosure. Each applicant offered informal positive feedback about the interview process. This feed back could be biased for the reasons outlined above, however potential participants were made aware of the research procedure and my involvement as researcher and interviewer prior to offering to participate within the study. Therefore their willingness to engage in such interviews with me would have been part of this self-selection. This makes it more likely that participants' previous experience of me would have been positive or at least neutral to have decided to engage in the research. This could have enhanced the likelihood of the prior relationship being beneficial in terms of participants feeling safe in disclosing information. Indeed this effect of prior relationships between researcher and participants potentially facilitating greater disclosure and more self-reflection has previously been noted (Burman, 1994).

Positive relationships and the desire to maintain these might also predispose the interview to collusion where the interviewer is less probing and questioning of what is described. I

observed that within the interviews, participants did not appear to have to do lots of preparative work to set the scene before discussing their experience as they might have with an interviewer completely new to them. This might have provided a greater quantity of in depth interview material, but also might have increased the likelihood of some misunderstanding due to false assumptions that we all shared the same account and perception of background information. My experience was that the participants were very frank and revealing about problems and perceived failings within their team work and possibly this might have been hindered if, for example, I had come from a neighbouring department.

It is impossible to be certain about the effect of the dynamic between myself and the participants, I was aware of the issues outlined above and this conscious awareness might have lessened collusion, and false assumptions. Within the interviews I also regularly sort clarification of half described issues and asked for confirmation that my emerging understanding throughout the course of the interviews was in accordance with what had been meant by the participant. In addition, the outside perspectives of my field research peer and academic supervisor assisted me in balancing my observer/participant position.

Much of what participants described concurred with my own experiences of offering support to colleagues. I particularly recognised their confusion in experiencing rejection when offering something believed to be helpful. Most appeared to fret and question themselves about this rejection, but I was surprised by one participant appearing far more philosophical about this experience and less questioning of themselves than I had been. I was also surprised by the extent that participants' own needs were hidden in their accounts of working with the team. As an observer of the participants' accounts, even

though I shared the same professional background and I recognised I shared aspects of their stories, I found myself surprised they sometimes appeared unaware of what seemed apparent to me as observer. For example, on several occasions during the interview I found myself reflecting that, 'Of course certain efforts to help would inflame relations with team colleagues, because they seemed to be motivated by the participants' own needs'. The experience of observing in this way was both encouraging and disconcerting. It illustrated to me that I was able to step away from totally identifying with the participants, but also in doing so I experienced the uncomfortableness of being critical of my own profession, colleagues and indeed my own practice. Overall, I found the interview process very stimulating and interesting and it is the words of the participants that have helped motivate me and captured my interest throughout this study.

6.4 Analysis

The fact that as a practising clinical psychologist I am well versed in quickly appraising an array of information and formulating, testing and reformulating, can enhance research analysis, but also can lead to similar issues of false assumptions and inferences beyond the text. Balancing the advantages and difficulties of bringing clinical skills to a research task had previously caused me considerable confusion and anxiety. In entering this study I realised that the discipline of careful and systematic analysis was important. My wider experiences of the background and current discussion amongst local psychologists highlighted the importance for me in staying close to the actual words of the participants, and not taking short cuts in interpretation, through adopting the discipline of line-by-line coding. I found that this detailed process increased my knowledge of the transcripts and made me ponder in great detail the words of the participants. I made slight adjustments to the approach following discussion with my field research peer who had independently

line-by-line coded, 10 pages from the first interviews. We noted that the main difference in our coding was that I coded every line, whereas she sometimes coded more than one line at a time. We discussed the reasons for this and agreed the style of speech by the participant meant that meaning was often not apparent within a single line but clearer within slightly more than a line. We acknowledged what was gained in the analysis through the rigour of line-by-line coding, but also recognised the importance of the coding being meaningful. We agreed that I would continue to line-by-line code, but allow slightly more than a line and mark the text accordingly, if necessary, to preserve meaning. This approach has been described by Rennie, Phillips and Quartaro (1998) who use 'meaning units' of individual concepts as their analytic unit. They commented that they found this approach more workable than literally line-by-line coding and emphasised the importance of researchers clearly describing and consistently using their chosen analytic unit. I therefore adapted my line-by-line coding, so that I coded the smallest meaningful units as close to line-by-line as possible. We also discussed whether to move to focused-coding after having line-by-line coded several interviews, but following discussion with my academic supervisor, for the reasons I outlined above, I decided to continue with the amended line-by-line coding of all interviews.

The effect of my prior knowledge of participants and of the services they discussed will have had an effect on my analysis and interpretations. Such effects could include me making false assumptions about background issues and me drawing upon more than the information available within the transcripts to make interpretations and derive theory. To varying degrees the issues of false assumptions and inferences made from beyond the data can and do occur in any research process, although they might often go unacknowledged. The conscious acknowledgement of these issues is important in mediating their effects, as

was the discussions with my field research peer and academic supervisors, and comparing my coding with independent coding of the same text and the demonstration of the analysis paper trail.   Certainly I am aware that during the course of my research, some of the very things that participants raised were then debated within the department culminating in the Director of Psychological Therapies presenting a paper to the Clinical Director of Mental Health Services proposing a different working configuration for some CMHT psychologists, with them no longer being integral members of CMHTs, but offering their services to the CMHTs from the department of psychological therapies. It is unclear whether this research and the process of interviewing had a role in the articulation and discussions within the department about CMHT psychologists, but I was certainly aware of this development as I analysed and interpreted the data.

As the analysis progressed, I drew upon my instinctive analytical style of taking a dynamic, rather than linear, approach in examining emerging categories, identifying how they might relate to each other and considering different ways this could be conceptualised.   It was a rewarding process, gaining dynamic perspectives on categories rooted in the detailed coding of the text.

The discipline of remaining close to the text within the analysis helped maintain my motivation. It was very demanding to carrying out this research whilst working full-time and being occupied mothering my two year old. In particular, it was difficult to perform the latter stages of analysis on a part-time basis, as many strands of information need to be compared and contrasted. I therefore negotiated some study leave and took annual leave to give me a block of time to dedicate to the analysis.

During the analysis I was aware that further data collection would be helpful in providing richer exploration of some aspects of emerging theory. In particular, further examination of the patterns of support identified by questioning participants 'Sue, Jan and Sam' about their specific examples of being within or moving between different patterns of support. However, the time constraints that I had in completing the doctorate and working full-time meant that this was beyond the scope of this study. Although this 'macro level' theoretical sampling was not possible, within the analysis theoretical sampling at a micro level was conducted in terms of seeking out examples of difference and re-examining the text surrounding these differences. Indeed this 'micro' theoretical sampling highlighted the different patterns of support processes for 'Sue, Jan and Sam'. However in the absence of 'macro level' theoretical sampling, the processes suggested by this latter stages of analysis were dependant on limited examples which definitely require further exploration to add richness and robustness to the analysis. Although saturation was not achieved in the processes which emerged within latter stages of analysis, generally the emergence of new categories lessened as the analysis progressed and for the last couple of transcripts established categories were built upon rather than new categories being created. This pattern indicated that saturation was beginning and this might have been confirmed if further theoretical sampling had been possible.

6.5 Writing up

Anecdotally, I am aware that those in clinical practice often struggle to write-up research and I echo that experience, though doctorate deadlines helped keep me to task. As I honed and reworked the analysis, the structure of the write-up fell into place and gave direction to the rest of the writing. The literature surrounding the subject was more discursive than research based and initial drafts of the literature review reflected this. In

rewrites I attempted to regain a more critical perspective. In rewrites I also attempted to add clarity to the complex and involved analysis.

6.6 Supervision and Doctorate completion

My research journey has been long and intertwined with my clinical experience. Following my MSc research I entered a wilderness in my own research identity and as for many in clinical practice my research support in terms of supervision and peer contact was very limited. I initially embarked on a part time PhD and although I was supported at distance by a supportive supervisor, I soon decided against this route and pursued registration for a top-up Doctorate in Clinical Psychology. I hoped the scope of this would be more manageable, not fully appreciating the extent of work that would be involved.   Unfortunately, I did not receive any academic supervision for the majority of the registration period, due to my supervisor's long-term sickness. I continued in my 'research wilderness' and made the errors I described prior to this study. Then in the final year I was given a new supervisor who I met with to review my progress. We decided that I needed to address my mistakes, by essentially beginning a new study in the same subject area. I gained an extension to enable me to gather the new data, with the much needed support from my academic supervisor. Around the same time, I gained regular support from another clinical psychologist experienced in qualitative research. Previously, she had worked as a CMHT psychologist, within the same department of psychological services, however she had since moved jobs to work locally, but in a specialism outside of my psychology department. She acted as my research peer and field support throughout the research. We acknowledged her previous connections with the subject area and department, although her current work and research focus was in a different area and this appeared to give her some distance from my research and

experience. I also gained from joining with University of Leicester clinical psychology trainees on a qualitative research training day. I am grateful to my academic supervisor for organising my access to this day. This opportunity to meet and study along side other research students was an invaluable experience and one that has been rare given my studying at a distance form the University.

During the analysis I discussed emerging theory within a local supervisor's forum and consultancy special interest group which included several of the participants from this study. The feedback I received within these discussions assisted me in furthering my understanding of the analysis and was confirming of many of my emerging theoretical ideas. Within these discussions I raised general themes emerging from the research, but not specific examples. I viewed these discussions as opportunities to further explore the general themes of the research rather than as requests for participant validation to ratify my findings. This approach has been described by Smith (1996) and acknowledges that .attempts to validate findings through participant feedback is not without problems. He highlights that it could be difficult for participants to disagree with interpretations due to the inevitable perception of the researcher being more powerful and suggests that rather than attempting to seek 'absolute truth', discussions with participants can add richness to latter stages of analysis.

Following completing the analysis, I gave all participants a written account of the findings and presented them to the adult mental health psychology meeting. I considered issues of how the findings were dispersed as the analysis write up contained emotionally charged quotations. Although participants had given consent for transcripts to be published and had agreed texts were sufficiently anonomised, I was mindful that within the locality

quoted material might still be recognisable by individuals who knew participants well, including participants recognising each other. I therefore used summary information within feedback. The process of providing feedback is furthering discussion about my findings and bringing them into the wider debate about psychologists' relationships with CMHTs with adult mental health services. I also intend to publish and present the research at conferences.

7.0 Learning points and future direction

In drawing to the completion of this study, I feel that I am now less anxious and confused by clinical research. I am aware that my journey as researcher and clinician is ongoing and that I have much more to learn and understand, particularly concerning issues such as epistemology. Whereas once I did not understand its relevance, at least now I recognise the importance of considering my epistemological stance and the consequences for the whole process of research. I feel that now I can embark on further research with more confidence.

I have learnt more about psychologists' experience of giving and receiving support within CMHTs, particularly with respect to understanding more about successful and unsuccessful patterns of support and the possible significance of systemic positioning within relevant sub-systems. If I had known when I began working with colleagues what I understand now, I think I might have avoided quite a few pitfalls and had a better understanding of the difficulties encountered.

I now realise that in some respects I have learnt the hard way, both as a clinician in working with colleagues and, as a researcher. Even though my journey of discovery has

sometimes been painful, I do feel that my understanding has gained depth from my experience. Although experience is invaluable, I hope that this study might further others' interest in the theory and practice of psychologists in teams and I would like to encourage those in training to explore these issues. In addition to publishing the study, in the next year I shall be teaching on a local Clinical Psychology Doctorate Course regarding 'Working in systems' and I plan to incorporate some of the issues raised within this study within this teaching. I also plan to continue meeting with my field research peer, so that we can support each other in further clinical research using qualitative approaches. We have discussed using this peer support regarding qualitative research to encourage trainees and others interested in carrying out qualitative research within a clinical setting. In these ways, I hope that this study can contribute towards others' preparation for and work within CMHTs and their qualitative research as clinicians.

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Appendices

Appendix 1. Notes for contributors – Journal of Mental Health

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form. **Evaluation Criteria of Qualitative Research Papers**.

Manuscripts should be sent to Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. Electronic submission is also welcomed using the *Journal of Mental Health* e-mail address: **jmh@iop.kcl.ac.uk.** It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process.

To expedite assessment, three complete copies of each manuscript should be submitted along with an electronic version on disk. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

All books for reviewing should be sent directly to **Martin Guha**, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed on one side of paper, double-spaced (including references), with margins of at least 2.5cm (1 inch). Good quality printouts with a font size of 12 or 10 pt are required. The first page should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts . The second page should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords. Authors should include up to five key words with their article, selected from the American Psychological Association (APA) list of index descriptors, unless otherwise agreed with the editor.

Text . Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. Manuscripts should not exceed 6,000 words unless previously agreed with the editor. Language should be in the style of the APA (see *Publication Manual of the American Psychological Association* , Fifth Edition, 2001).

Style and References . Manuscripts should be carefully prepared using the aforementioned *Publication Manual of the American Psychological Association* , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes *et al* ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of *all* authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should *not* be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging, 18* , 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should *not* be inserted in the text. Three copies of each should be provided separately, numbered on the back with the figure number and the title of the article. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 4). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate sheets and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Accepted papers . If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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Appendix 2. Notes for contributors – Journal of Community and Applied Social

Psychology

Instructions to Authors

Initial Manuscript Submission. Submit three copies of the manuscript (including copies of tables and illustrations) to Sandra Schruijer, Faculty of Social Sciences, Tilburg University, P.O. Box 90153, 5000 Le Tilburg, The Netherlands.

Authors **must** also supply:

an electronic copy of the final version (see section below),
a Copyright Transfer Agreement with original signature(s) - without this we are unable to accept the submission, and
permission grants - if the manuscript contains extracts, including illustrations, from other copyright works (including material from on-line or intranet sources) it is the author's responsibility to obtain written permission from the owners of the publishing rights to reproduce such extracts using the Wiley Permission Request Form. Permission grants should be submitted with the manuscript.

Submitted manuscripts should not have been previously published and should not be submitted for publication elsewhere while they are under consideration by Wiley. Submitted material will not be returned to the author unless specifically requested.

Electronic submission. The electronic copy of the final, revised manuscript should be sent to the Editor **together with** the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect [and TeX or one of its derivatives].

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in **TIFF** or **EPS** format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

Manuscript style. The language of the journal is English. All submissions including book reviews must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. They should not normally exceed 7,000 words in length, or equivalent in text, references and tables, and should include a word count where possible. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

The **title page** must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page, as the *Journal of Community & Applied Social Psychology* operates a 'blind' reviewing system.
Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
Supply an **abstract** of up to 200 words for all articles, except book reviews. An **abstract** is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
Include up to ten **key words** that describe your paper for indexing purposes.

Short Papers of no more than 2,000 words in length [or equivalent in text, references and tables] are encouraged. Research papers, Innovations in practice and Communication and commentary are all welcome in the Short Paper section. Submissions will be reviewed in the usual way but it is anticipated that the reviewing and publication process will be of shorter than average duration than for longer papers. Abstracts for Short Papers should be of around 50 words.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year.

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al*. (meaning "and others").

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al*., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al*. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)

Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)

List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

Murzynski, J., & Degelman, D. (1996). Body language of women and judgments of vulnerability to sexual assault. *Journal of Applied Social Psychology, 26*, 1617-1626.

Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean*. Hartford, CT: University of Hartford Press.
Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press. and so on.
The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the inital citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials*. Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website:
http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion*. Retrieved August 3, 2001, from http://www.psywww.com/psyrelig/psyrelpr.htm

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence, 15*, 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology, 20*, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

Article or Chapter in an Edited Book

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

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Appendix 3. Methodology background information

Qualitative research – background and epistemological issues

Qualitative research is generally undertaken in a naturalistic setting (Guba, 1981), often involving gathering non-numerical data such as interview scripts or written texts (Henwood & Pidgeon, 1995), with the researcher taking a central role in determining meaning and making sense of the subject of investigation (Parker, 1994).

Where quantitative methodology tends to subscribe to the positivist or experimental paradigm, qualitative methodology usually adopts the interpretive or constructivist paradigm (Henwood and Pidgeon, 1994). The positivist paradigm holds a realist stance, assuming an objective truth within the world. This is challenged by the interpretive paradigm which suggests that knowledge is influenced by issues such as context and that 'realities' are constructed (Elliot, Fischer & Rennie, 1999). It is important to recognise that both qualitative and quantitative methodologies can be used within positivist or interpretative paradigms (Parker, 1994). The choice of methodology depends on the aims of the research (Silverman, 1993) and neither approach should be viewed as intrinsically valid (Henwood and Pidgeon, 1992).

It is however important to recognise the epistemological position taken, and understand the research aims and choice of methodology in the light of this stance. Although each paradigm might employ both qualitative and quantitative methodologies, qualitative methodologies can be especially valuable if embracing an interpretative paradigm. The interpretative paradigm, acknowledges the gap between what is studied and how it is represented and the bridging role of

interpretation (Parker, 1994). Qualitative methodologies accommodate this through acknowledging that a researcher is not divorced from the subject matter, that total objectivity is not possible (Denzin and Lincoln, 1994), hence the interpretive role of the researcher is embraced whilst managing researcher bias through mechanisms such as explicit reflexive practice (Henwood & Pidgeon, 1994).

In acknowledging the interpretive role of the researcher, qualitative research is vulnerable to the criticism that it simply reproduces and reflects the researcher's own views (Schwandt, 1994). The application of systematic and rigorous methods in the collection and analysis of the data is a major way in which such criticisms can be countered. Grounded theory is one qualitative methodology which is systematic and grounds the findings within the data, enabling the reader to assess the fit between the emergent theory and the raw data (Charmaz, 1995).

Grounded Theory – summary of background and characteristics

Grounded theory was developed by Glaser and Strauss (1967) as a qualitative approach, which uses data to develop theory, through the systematic application of comparative analysis. Within this approach, there is repeated comparison of data, and the grouping of data within commonalities of progressively higher levels of abstraction. The overall aim is to develop theoretical understanding surrounding the core categories which emerge through this process of constant data comparison which ideally continues until a point of theoretical saturation in which no new categories emerge (Rennie, 1998). In this way data is used to induce, rather than to test theory (Charmaz, 1995).

In order to further assist in developing and validating the emerging theory, a process of theoretical sampling is employed (Glaser and Strauss, 1967). This involves searching the data for examples which could add depth and understanding to the emergent theory. One important aspect of theoretical sampling is negative case analysis which involves exploring cases in which the emergent theory does not hold and examining these further in order to challenge early assumptions and refine theoretical understanding (Pidgeon, 1996).

Grounded theory is also characterised by the parallel collection and analysis of data. This enables the researcher to guide data collection to explore and focus upon emerging theory (Charmaz, 1995). As the researcher notes emerging themes they can develop a theoretical sensitivity, in which they can use their understanding of pertinent aspects of the data to guide their exploration (Strauss and Corbin, 1990). This creative process is assisted and recorded through making analytical notes or memos. The inductive process is further assisted by the researcher delaying the literature review until the analysis is well developed (Charmaz, 1990).

This interpretive use of researcher highlights the constructionist epistemological position within grounded theory (Henwood and Pidgeon, 1994). Whilst Strauss and Glaser's early accounts of grounded theory emphasised positivist assumptions that categories will emerge independently (Charmaz, 1990), with some recognition of the constructionist stance in acknowledging the significance of researchers' perspective within the analysis (Rennie, 1998), later they differed with Glaser retaining a post-positivist position and Strauss moving further towards a

constructionist position (Stern, 1984). Other researchers in this field argue for a revision of grounded theory, to fully acknowledge the constructionist position (Charmaz, 1990; Henwood and Pigeon, 1995).

Interviewing - Background issues

Within qualitative research, the interview is often used as a method of gathering the main body of research data (Denzin and Lincoln, 1994). The research aims and epistemological position determines the way interview data is analysed and understood.

The positivistic position seeks to access generalisable facts about the world, and therefore focuses on standardising questions and ensuring their validity and reliability (Silverman, 1993). This approach has been criticised for overlooking the complexities of the social interaction within the interview process (Mischler, 1979).

The interactionist position acknowledges these complexities and considers the data and its analysis as constructing an understanding bound within social context (Silverman, 1993). From this perspective, the interview process enables the researcher and participant to move back and forth in time, reconstructing the past and interpreting representations of the present and future (Lincoln & Guba, 1985). In this approach interviews are more open and flexible, allowing development in questions beyond the initial schedule in order to add depth to the interview. This pursuit of deeper understanding, seeking clarity and exploring anomalies provides the basis for the validity of this research approach (Reason & Rowan, 1981).

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Appendix 4. Table3. Demographic Information

		Participants					
		Jon	**Sue**	**Eve**	**Lyn**	**Jan**	**Sam**
D e m o g r a p i c s	**Gender**	Male	Female	Female	Female	Female	Male
	Qualified (Yrs)	11½	11½	14	1½	14	7½
	Specialisms Worked within	AMH -Psych Dept/ Primary care -CMHT	AMH CMHT	AMH - Hospital/ Community - CMHT	AMH CMHT	AMH -Psych Dept -CMHT -Substance misuse	AMH CMHT
	Post-Qualifying training	Supervision and CBT training (not externally accredited)	Person-centred art therapy	MSc Psycho-therapy	Starting Gestalt therapy training	MSc Integrative Psycho-therapy	-Psycho-therapy training -Group therapy training
	Therapeutic orientation	- Eclectic - Humanis-tic - Psycho-dynamic - Learning theory	- Humanistic - Person-centred - Psycho-dynamic - Cognitive behavioural	- Psycho-dynamic - Community and life experience informs clinical work	-Gestalt -Humanis-tic -Focus on therapeutic relationship -Cognitive behavioural -Psycho-dynamic -Socio-logical perspective	-Psycho-dynamic -Process/ relationship focused -Cognitive psychology	-Psycho-dynamic -Critical psychology -Cognitive and behavioural therapy

Appendix 5. Ethics Committee Letter of approval

Shropshire & Staffordshire Strategic Health Authority

NHS

Ms R Lucas
Consultant Clinical Psychologist
Adult Mental Health (Rehabilitation)
Shropshire County PCT
Shelton Hospital - Wroxeter Ward
Bicton Heath
Shrewsbury SY3 8DN

Shropshire Local Research Ethics Committee
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL

Telephone: 01743 261300
Facsimile: 01743 261303

24th May 2004

Dear Ms Lucas

Full title of study: A study examining Clinical Psychologists' experiences of offering support to colleagues within the Health Service
REC Reference No: 04/27/RJH

The Shropshire Research Ethics Committee reviewed the above application at the meeting held on 20th May 2004. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion to the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the following research site:

Site: Shropshire County NHS Primary Care Trust
                        Shelton Hospital
                        Bicton Heath
                        Shrewsbury

Principal Investigator: Ms R Lucas, Consultant Clinical Psychologist, Adult Mental
                              Health

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

- Application Form
- Protocol
- R&D Approval letter Dr A Tinkler
- Proposed Research Questions
- Consent Form

- Flow diagram of Procedure
- CV – N Robertson
- CV – Ms R Lucas
- Participant Information Sheet

Management approval

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed below.

Notification of other bodies

We shall notify the research the host organisation that the study has a favourable ethical opinion.

Statement of compliance (from 1 May 2004)

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 04/27/RJH   Please quote this number on all correspondence

Yours sincerely,

Julie Ramsey
Shropshire Committee Administrator

Enclosures:

Standard approval conditions SL-AC2

List of names of members who were present at the meeting:
Mrs J Grime (Chair)
Dr G Clements (Vice-Chair)
Dr R Terry
Mr R Rainford
Mr D Adams
Dr D Elcock
Mr R Law
Mr R Skews
Ms M Parker
Mrs J Ramsey (Administrator)

Letters/2004/lucas1
An advisory committee to Shropshire and Staffordshire Strategic Health Authority

Appendix 6. Participant Information Sheet

(PCT headed paper

Researcher's name,

address and contact

number)

Participant Information Sheet

A study examining clinical psychologists' experiences of offering support to colleagues

Thank you for your interest in participating in this study.

I am writing to give you some basic information about the study and the procedure for those participating to assist you in deciding whether you would like to participate. Please let me know if you would like any further information or clarification.

As I previously explained, I am interested in understanding community mental health team, clinical psychologists' experiences of offering 'support' to health worker colleagues.

Background to study

It has been recognised by observers of the profession that clinical psychologists more than other health professionals are active in offering support to colleagues in terms of clinical supervision, facilitated support groups, training, consultation and advice (MAS, 1989). It appears that this area of clinical psychologists' work, particularly 'informal' psychological support of colleagues, is often invisible and given little consideration in training and supervision. It therefore seems of value to investigate the experiences of clinical psychologists in offering support to colleagues. As this phenomenon appears to be multi-layered with explicit and less explicit aspects and I am seeking to further understanding of this subject, a qualitative approach appears the most appropriate way of investigating this subject.

Procedure for study

I am planning to interview 6 or more clinical psychologists. Each interview will be semi-structured, lasting 45-60 minutes. I will be asking participants' permission to audio tape the interview. Confidentiality will be preserved by coding participants' name within the written transcript of the tape and altering identifying features of participants and any individuals to whom reference is made. Each participant will be offered a copy of the transcript of his/her own interview. Any feedback from participants requesting further amendment of identifying features will be addressed until participants are satisfied confidentiality has been maintained. I shall also ask participants to read and sign a consent form before we begin the interview. I attach a copy of this form for your reference. Within the consent form I will also be asking for permission for transcripts to be analysed as part of my Doctorate in Clinical Psychology at the University of Leicester and for the transcripts to be made available to those involved in the Doctorate of Clinical Psychology and subsequently in University Library Archives.

The audio tapes and codes for names will be kept in a locked file and destroyed following submission of Doctorate and publication in professional journals. It is anticipated that the process of the study to publication will be 18 months- 2 years.

Each participant will be given a written copy of research findings as submitted in main research paper.

Verbal feedback of research findings will be given at the Adult Mental Health Clinical Psychologists' Meeting and makes available written copies of research findings.

As stated within the consent form, if you agree to participate in this study you can withdraw that consent at any point.

Please let me know if you would like to discuss anything further.

After having read and considered this information, if you are willing to participate within the study, please let me know and we can arrange a time for the interview.

Yours sincerely

Rachel Lucas

Appendix 7. Participant Consent Form

(PCT headed paper

Researcher's name, address and contact number)

CONSENT FORM

Title of Project: A study examining clinical psychologists' experiences of offering support to colleagues

Name of Researcher: Rachel Lucas   **Please initial box**

1. I confirm that I have read and understand the information sheet ☐
   for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to ☐
   withdraw at any time, without giving any reason.

3. I agree to participate within this research project through audio-taped, ☐
   semi-structured interview(s).

4. The subject area and procedure has been satisfactorily explained ☐
   to me and I am aware of and satisfied by the arrangements to
   maintain confidentiality.

5. I consent to transcripts being made available to those involved ☐
   with the Doctorate of Clinical Psychology and subsequently within
   library archives.

…………………………..   …………..   ……………………

Name of Participant   **Date**   **Signature**

…………………………..   …………..   ……………………

Researcher   **Date**   **Signature**

1 for participant; 1 for researcher

Appendix 8. Semi-structured research schedule

Initial semi-structured research schedule

Demographic Information

(i) Please could you tell me how long you have been qualified as a clinical psychologist?

(ii) In what specialisms and settings have you worked since qualification?

(iii) What, if any, post-qualification training have you undertaken?

(iv) How do you describe the way in which you work (ie therapeutic orientation)?

Main interview questions

I am interested in understanding clinical psychologists' experience of offering 'support' to colleagues.

(1) What is your understanding of the term 'support' within your working relationships with colleagues?

(2) What have been your experiences of offering and/or providing support to colleagues?

   Prompts
      Is there a difference between offering support to colleagues within
      and outside of your own multi-disciplinary team?

      Do you adopt the role of 'supporting' and attempt to develop it in
      your work or do you find it is others who are asking or expecting
      you to carry it out?

      Do you have a sense of what is successful support and if so how
      do you recognise it?

(3) I would like you to consider for a moment what dilemmas have you faced in offering and providing support to colleagues?

Prompts
>> Could you give an example?

>> Do you feel the role of offering support is appropriate? Why is that?

(4) What has been your experience of receiving support from colleagues?

>> *Prompt*
>> Have you actively sought support or has it been offered?

(5) What training have you received to prepare you for offering support to colleagues?

>> *Prompts*
>> Within clinical training?

>> Post/pre-clinical training?

>> Does this preparation feel appropriate, helpful, sufficient? Why is that?

>> What in effect has best prepared you for this task?

>> What does this discussion lead you to think about clinical training?

>> What if anything did you need differently in training?

(6) What sustains you in offering support to others?

>> *Prompts*
>> Supervision/peer support etc?

>> Is this appropriate, helpful, sufficient? In what way?

>> What is it that you need?

Appendix 9. Example of transcript, initial coding and memo

Line by line Coding and corresponding Memo – Transcript of interview with 'Eve'

306 345. I think, I think sometimes be about playing the game/and - *Game playing*

307   actually, about scoring points, or something that I can get into/, -*Get into point scoring*

308   that I think is about **my** need to look supportive/or show that I – *Focus on own need to*
                                                                                        be supportive

309   can support somebody junior against somebody senior./- *Exert professional power by*
                                                                                        'supporting' junior over senior

310   RL. Yes.

311 345. That sort of thing. That it feels, mmm, I'm doing it, at the time I

312   feel like I'm doing it with the best of intentions/ and there are – *Feel doing right thing*
                                                                                        at time

313   things that are with the best intentions but I know that there is – *Afterwards question*

314   something, afterward,/ I thought, 'Yes, what was my, what was

315   my bit in that, really/,   - *Recognise own needs*

Memo :
        Recognises own needs
        ?? Masquerading as supporting others ?
        Exercising power – battling with other powerful figure in team indirectly by attempting to
        strengthen another colleagues' position – made look as if 'support', but using process to further
        own power struggle
        Aware of this process on reflection

Link – *consider 'Sue'. – where she describes own needs attended to by colleague*
        Filling her in on problem, day after it had happened.

    Example of false support – doesn't work
    'Outer shell' – explicit 'support' – inner process not really support

Appendix 10. Example of initial and focused coding being collapsed into categories

Line-by- line, focused and category coding – Transcript 'E, 306-315

Line coding	Focused coding	Category	Core Category
306 Game playing	Own needs priority	I need support too	
307 Get into point scoring	Own needs priority	I need support too	
308 Focus on own need to be supportive	Own need present but hidden	I need support too	own needs hidden within attempts to support
309 Exert professional power by 'supporting' junior over senior	Hidden attempt to influence system	Support part of job	
312 Feel doing right thing at time	Intention to help	Support part of job	
313 Afterwards question	Motivation mixed	I need support too	
315 Recognise own needs	Recognise own needs	I need support too	

Appendix 11. Example of Field Supervision memo

Memo – Field Supervision notes (12/09/03)

Met with Rachel C to discuss line-by-line coding and compare her coding of 10 page section from first interview with my coding.

Broad agreement in substance of coding. Identified there was a difference in coding due to me coding literally every line and Rachel missing some lines. Discussed the problem that as participants' style was to repeat parts of sentences, trying to code each line irrespective of this meant that some of my coding were not meaningful. Debated value of the discipline of ascribing a code to every line against the need for coding to be meaningful. Agreed that line-by-line coding is an important discipline to follow, particularly given my clinical background and interest in the area and the danger of appraising the data and making interpretations that are not rooted in the text. Also agreed need to ensure coding is a meaningful process. Decided that I would mark beginning and end of the smallest meaningful chunk of text with '/' and code accordingly, attempting to make this each line or less, but allowing more that a line if less would lose meaning. Debated whether to line-by –line code all interviews, or whether to move to focused coding for last few transcripts. I fed back discussion with academic supervisor, Noelle where we had considered this and agreed that for similar reasons as those above, following the discipline of line-by-line coding for all texts would be preferable. Noted, I have indeed found it a powerful discipline to examine the text in such detail and I feel it will assist in helping me to stay 'close to the text' during the analysis…