Getting back to connectedness
An exploration of a team reflective practice group in a personality disorder service

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“We will meet; and there we may rehearse most obscenely and courageously”
(Shakespeare, 2008, 1.2.)

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ABSTRACT

Staff who work in emotionally challenging environments require time and space for team-based reflection to support their wellbeing and the standards of care they provide. This is particularly true for staff working with clients with a personality disorder diagnosis. These staff can experience powerful feelings and behaviours and respond with defensive practices and/or withdrawal. These reactions to the psychological disturbance encountered can manifest at an individual staff, team and organisational level.

Staff support groups (SSGs) are often employed to reduce staff distress and address team dynamics across a broad range of fields (including health, mental health, social care), however to date there is a paucity of research examining staff experiences of these groups. Using a constructivist grounded theory approach, a cooperative inquiry was undertaken with a team of 7 psychological therapists and 1 psychiatrist who attended a weekly, externally facilitated SSG as part of their work in an NHS personality disorder service.

A theory of 'connectedness' was developed through a systematic analysis of the data. Connectedness was derived through the emergence of 7 inter-related actions occurring within the SSG: (1) Security and danger (2) Emotional awareness and obscurity (3) Relational witnessing and turning away (4) Integrating and splitting (5) Belonging and isolation (6) Developing a therapeutic atmosphere (7) Energising and depleting. These actions are represented within a higher order model, delineating the processes that are included in each of these relational domains.

The findings are discussed in relation to the unconscious manifestations of attachment trauma at service-user, staff, team and organisation levels. These can be understood as a systemic propensity for disconnectedness as a means to manage overwhelming experience. It is proposed that an SSG provides a critically needed reflective space to re-introduce connectedness back into this disturbed relational context. The implications for group reflective practices that support staff to remain meaningfully engaged in their work are explored.

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1 INTRODUCTION

1.1 Setting the scene of the research focus: a personal account

As a Counselling Psychology and Psychotherapy trainee I landed myself a job as a trainee psychotherapist within an intensive, day-hospital treatment programme for clients with difficulties characteristic of a "personality disorder". Although motivated and keen, I was clinically inexperienced and found myself struggling to manage the emotionally charged relationships I encountered in the service. I spent most of my days (and nights) in an anxious state, preoccupied and afraid.

In contrast, I viewed the work of my colleagues in the team with awe. They were robust, honest and strong, and approached the clinical dilemmas they faced with openness, feeling and careful thought. They were a team. I was an outsider and clearly, I did not belong. Fantasies about their disappointment and irritation with me took shape, I began to lose my voice and avoided interactions wherever possible. I regarded my vulnerabilities as intolerable and weak and did my best to keep these hidden.

The stress of this grew, spreading through my mind and my body. My hopes of a career crumbled with the simultaneously comforting premise that this work was not for me. I urgently began to look for a way out.

"I've been wondering how you are doing Rachel?" a colleague asked me in our weekly staff support group (SSG). I desperately tried to stop the mask I had been hiding behind from slipping, but I could not. The tears began to fall. "I'm really struggling", I quivered, "being here is so hard. I don't think I can do it anymore".

After a period of silence, the team responded. Warmly and compassionately.

"I cried every day for about a year when I first started here";

"I still find it an incredibly difficult place to be";

“I’m sorry that I haven’t checked in with you more. Shall we make a time to meet and talk a bit more about how you are finding our group?”

“I think you’ve been doing really well. You bring an empathy that the clients really need”

“I’m so pleased you could say that and be vulnerable with us. It’s such an important part of what it takes to work here.”

The relief was immense. Through their responses I experienced a much-needed holding. I had allowed the team to see me and by doing so I had found a way in. I was not alone.

Over the coming months I utilised the SSG with zeal. In this unique collective space, the atrophy was halted, and I began to connect. With this I strengthened and grew. Meeting my colleagues in this way and allowing them to see me, I was able to meet my clients differently, with a developing balance of robustness and vulnerability. I did not disintegrate under attack, but neither was I unmoved. I was no longer paralysed by “threat”, “risk” and “anxiety”. The work took on new meaning; my passions and skills augmented.

8 years on, I still work in the service and continue to view the weekly SSG as the most important group of the week. Whilst our clinical work is supported by both individual and group supervision, this particular group responds to a need in us as a team, that only this collective, reflective space seems to meet. Looking outwardly, I notice that the emotional health of my colleagues in other mental health setting is not genuinely taken-up as the responsibility of their managers and organisations. Fellow trainees are overwhelmed with the volume and complexities they face in their early practice and the limitations of both their provision and their support. Teams within my organisation are consistently characterised by burnout, with overstretched and emotionally detached staff facing impossible demands, managed primarily through long-term sickness and long-term vacancies.

I cannot help but associate this to my early clinical experiences and the deterioration in my own wellbeing. Where are the spaces for my professional community, not to discuss their cases, but to acknowledge and digest the human impact of the distress, disturbance and death

that permeates the settings of their work? How and where do they work through the relational manifestations of this? Why are these critical needs so readily overlooked at the expense of both staff wellbeing and ultimately the quality of care for clients? Where are the SSGs?

What I have found in the Trust where I work is that there are not many SSGs. And those that are in operation are seemingly disparate and lack coherence in both their design and their aims. They have taken on an unspoken quality of being “musty” and out-dated. Mostly, they operate locally, quietly and behind-the-scenes. However, I have a different perspective, one which values the forum of an SSG and the critical role it plays within the emotional health of our team and therefore the quality of availability in our clinical relationships. I wanted to scrutinise this, understand it and articulate it better. I wanted to say something about it.

1.2 Reflective practice: a timely contribution for practitioner-research

Reflective practice can be viewed as the cornerstone of professional development; the vehicle by that which is learnt is put into practice. Reflective practice bridges the gap between theories of technique and real-life practices characterised by uniqueness, unexpectedness and conflicting values (Stedmon, Mitchell, Johnston & Staite, 2003). Requiring time and space for individuals to explore both the emotional and intellectual processes of their experiences, reflection ultimately leads to new insights, tacit knowledge (Boud, Keough & Walker, 1985; Kinsella, 2009) and the potential for “theorising action as it happens” (Bleakly, 1999: 328).

Given the distinctiveness and intersubjectivity of each therapeutic encounter, practice in the psychological therapies “continuously exposes the limitations of science” (Lavender, 2003: 11). The practical application of theoretically prescribed technique thus necessitates clinicians who are reflexive, adaptive and flexible. Reflective practices are therefore critical to honing therapeutic artistry, where theoretical limitations and uncertainty can be tolerated and utilised. Despite the centrality of reflective skills within the field of counselling psychology and psychotherapy, literature concerning reflective practice within the psychological therapies is disconcertingly scarce.

Whilst my interest in SSGs as a form of reflective practice has been locally derived and is positioned as ‘practitioner-research’, I locate my endeavour to examine, articulate and share the work of our SSG within the broader socio-political-economic climate that currently dominates the practice of counselling psychology and psychotherapy within the NHS today.

In particular, I view this research project as my own contribution to the calls being made for more practice-based evidence, in order to inform and annex the positivist discourse which currently dominates as knowledge-development within our field (Barkham, Styles, Lambert & Mellor-Clarke, 2010).

1.3 Epistemological divisions in the delivery of care

As an NHS practitioner, I am particularly enlightened to the ground-level impact of neoliberal, managerialist and pseudo-scientific influences upon the delivery of the psychological therapies and mental health care. Counting, measurements and standardisation have become organisational controls that threaten to remove the humanity out of the therapeutic encounter (Hoggett, 2018). This is the manifestation of an epistemological split, where the organisation's positivist values subsume perspectives of plurality, complexity, subjectivity and uncertainty that characterise good-practice on the clinical front line. These effects have been compounded in recent years by austerity, with an increase in "mental distress and marginalisation in the UK" (Cummins, 2018: 1). For those who remain there is an impossible pressure to do more and see more with far less. Clinicians are expected to manage increasingly risky and complex caseloads under conditions of limited resources, time and support.

Within this managerialist system, staff and service users are no longer related to as subjects to be cared about but objects to be acted upon in order to maintain the illusion of being efficient (Hoggett, 2018). This echoes an organisational defence against anxiety (Menzies Lyth, 1960); a "turning away from the realities of suffering, dependence and vulnerability and from the complexity of managing this" (Rizq, 2012: 9). In this climate of counting over caring, clinicians pay a high price. The challenging and emotionally demanding nature of their work is denied and split-off from the support structures put in place.

Governance increasingly formalises reflective practices in order to 'cover our backs'. Supervision notes must now account for decision-making, clinicians no longer feel they can be authentic in their process notes and there is an increasing disposition to standardise thinking about clinical practice (McGivern & Fischer, 2012). The result is an anxious malaise and the deterioration of the health and satisfaction of the NHS workforce who are burnt out, deskilled and emotionally detached (Imison, 2018). Ultimately this leads to poor outcomes for service users, as there is little or none of the containment necessary for clinicians to meaningfully acknowledge and engage with their distress.

1.4 Putting care back into care

To attend to the malaise, a reworking of staff support is desperately needed. One in which the emotional, reflective self of the clinician is rightfully returned to the organisational frame. Where feelings about the events that occur within our daily practice are viewed as intrinsic, important and necessary for caring about others and where relationships, whether professional, clinical or with the organisation, are seen as the primary driver through which practices can be explored and enhanced.

Clinical teams, such as mine, who have managed to preserve and prioritize spaces to think, in spite of the pressures they face, need to both examine and share their experiences. This will provide organisational leaders with meaningful and relevant tools to care for their staff, giving them the experiences that are necessary for them to provide meaningful and useful care for service users.

As my earlier reflections denote, I believe the SSG that takes place weekly within my service is an example of good-practice that rightfully belongs within this debate. It is my tentative assumption that this reflective space is where emotional material of both clinical encounters and the workings of the team are acknowledged, encouraged and explored in order that they can be used for the betterment of both individual and team practices. Not enough is known about SSGs; they remain a practice that is largely unformulated and unarticulated within the literature. The conditions of their use and the processes that underpin them have, until now, remained largely unexplored. Through the current research, it is my intention, to start to address these gaps and provide a coherent account of an SSG as it is experienced and examined by an NHS psychological therapies team.

2 LITERATURE REVIEW

My aim for this literature review is to clarify why a qualitative examination of an SSG is necessary for the service delivery of counselling psychology and psychotherapy within public health, and related fields. Until recently, reflective practices have been predominantly viewed as an individual learning endeavour, useful for enhancing one's theoretically driven clinical skills in the face of ambiguous and unpredictable real-life practice encounters. It is my intention to reposition reflective practice as a collective, organisational system that is far more than professional learning. By inviting the whole person of the practitioner into the organisational space, reflective practices can be seen as critically necessary for reaffirming the humanity of organisational life.

Reflective practices can be seen as a staff support tool that acknowledges the emotional valency and cost of caring for others in the human service professions and by doing so address the wellbeing of staff. This comes at a critical time; the impact of austerity, alongside managerialist defences that are dissociated from the quality of experiences for those on the front-line has rendered the health, wellbeing and satisfaction of NHS staff at an all-time low (Johnson, 2017). This is particularly true for staff working in mental health and personality disorder services, who require support systems that allow for the processing of the complex, challenging and disturbing communications that they receive. An SSG is a means to address these needs, however there is a paucity of research concerning their practice. This research project is therefore my attempt to address these gaps and consider the experiences of staff as they attend an SSG in a personality disorder service. In what ways, if any, do they derive benefit from using this collective, reflective space?

The following literature review is therefore structured as follows: firstly, I will set the scene by examining the theoretical literature concerning organisational reflective practices, arguing that they can be viewed as a means of staff support. Secondly, I will examine research concerning the impact upon staff who work within emotionally challenging environments, in particular those in mental health and personality disorder settings. Thirdly, I will examine the current literature concerning SSGs and identify the gaps in this work as it currently stands. Finally, I will introduce the reader to the team, myself (as researcher), the research context and the structure and process of the SSG that is to be the focus of this research.

2.1 Reflective practice

2.1.1 The need for an alternative epistemology of practice

Over the past 40 years, the notion of reflective practice has gained considerable influence across a broad range of clinical disciplines and is now widely viewed as a critical skill or competency for any human-service professional (Finlay, 2008; Hargreaves & Page, 2013). Reflective practice has become synonymous with 'virtuous' and 'good practice' (Smyth, 1992) and as such has been adopted into the realms of regulation and assessment for health service professionals' training and practice. Within the field of counselling psychology and psychotherapy alone, reflective practice is a core requirement in training programmes, professional registration (British Psychological Society, 2017; United Kingdom Council Psychotherapy, 2015) and job descriptions and guidelines for treatment (National Institute for Mental Health, 2003). This often results in the prescription of reflective practices in a non-reflective manner: "In many cases, reflection turns out to be synonymous with writing about practice situations as if recording and thinking about what happened had simply been renamed reflection." (Boud, 2010: 25).

This is a far cry from Donald Schön's (1983) original and encouraging introduction of a reflective practice to reinstate the artistry and nuance of professional judgements and actions. His motivations were to question and counter the dominance of a positivist, "technical rationality" in teaching about practice that often fell short in the unique and complex realities of real-life practice encounters. Schön's ideas can be located in Dewey's (1910) philosophical treatment of *thinking well,* with reflection defined as the "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it" (Dewey, 1910: 2). From this basis, Schön articulated that practitioners can fill 'theory-practice gaps' with reflection: enhancing and reconstructing their skills and knowledge through the review and appraisal of actual experiences in the field. His intention was to remind us how professional expertise were far more than an ability to adhere to standards and protocols. The fervent institutionalisation of reflective practice across a broad range of disciplines can be interpreted as an acceptance that purely positivist approaches to professional practice are insufficient in their real-world applications.

2.1.2 From simplicity to confusion: Schön's model and beyond

Schön's model of reflection is relatively simple and easy to digest. He specified two distinct domains of reflective thought that are useful as a response to those inevitable moments of doubt, perplexity and confusion that occur within practice. "Reflection-on-action", is the retrospective, critical analysis of an event after the fact; a conscious, purposeful reviewing of

past practice in order to influence and enhance future practice. Whereas “reflection-in-action” concerns the tacit, spontaneous and intuitive utilisation of past experiences and knowledge in order to adapt one’s approach in the face of clinical dilemmas and conflicts as they arise in the moment. Despite the seeming simplicity of these early ideas, Schön’s model captures a highly intricate and complex process, interweaving how skills, knowledge, experience and personhood come to be embodied in one’s professional practice.

As a demonstration of these intricacies, from Schön’s ideas has followed a colossal amount of development and repositioning of ‘reflection’ from a broad range of practice fields and theoretical perspectives. Although this acknowledges the richness and complexity of reflection, the over-intellectualisation of the concept has muddied the waters somewhat, obscuring Schön’s original clarity:

> *Authors and researchers define reflective practice from their own lenses, worldviews and experiences. In addition, various related concepts exist, such as action theory, critical social theory, praxis, problem solving and cognitive learning theory. This conceptual and methodological umbrella only serves to further mystify and blur a consensus of meaning*” (Ruth-Sahd, 2003: 488)

Consequently, practitioners must navigate their way through an overwhelming array of models of reflective practice. Reflection is represented in circles, depicting reflective practice as a cyclical iterative endeavour (Gibbs, 1988); hierarchies, representing reflection through stages or processes (Atkins & Murphy, 1993; typologies (Jay & Johnson, 2002); continuums (Finlay & Gough, 2008); loops; and through the answering of specific (yet different) questions (Rolfe, Freshwater & Jasper, 2001; Gibbs, 1988; Grushka, Hinde-McLeod & Reynolds, 2005). It is beyond the scope of this literature review to provide a thorough appraisal of these.

2.1.3 Common ground in the reflexive use of self

Despite these disparate perspectives, central and common components of reflection can be found across models (Boud, 2010; Finlay, 2008; Ruth-Sahd, 2003). Theoretical perspectives and research indicate the following core themes of reflective practice:

1. Learning through experience (Kolb, 1984)
2. Making sense of experience (Boud et al, 1985)
3. Gaining new understandings (Jaytilleke & Mackie, 2013)
4. Questioning assumptions and certainties (Heyler, 2015)

5. Becoming self-aware (Jaytilleke & Mackie, 2013)
6. Critically evaluating one's responses (Fook, White & Gardner, 2006)
7. Utilising the whole person of the practitioner (Urdang, 2010)
8. Improving practice (Liddiard, Sullivan & Chadwick, 2017)
9. Being situated in time and place (Finlay, 2008)
10. A feature of lifelong development and learning (Smith & Martin, 2014)

Of particular note is the critically reflexive use of self that is implied: reflection is an embodied action that incorporates the whole person of the practitioner in order to develop a deeper understanding of one's experience (Bager-Charleson, 2010; Boud, 2010; Finlay & Gough, 2008). The acknowledgement of the attitudes and emotions of the practitioner and an examination of the basis of these is therefore essential (Boud et al, 1985). This requires a commitment and vulnerability from practitioners to confront assumptions, blind spots and mistakes and locate these within one's socio-political histories and contexts. In this light, reflective processes strive to arrive at a "meeting point between historical and cultural forces and structuring processes, and struggles for agency, selfhood and integrity in a life" (West, 2010: 68). The critically reflexive use of self is a core skill in the field of counselling psychology and psychotherapy. Practice in this field has a longstanding history of reaching for deeper understandings of the therapist's experiences as they encounter the therapeutic relationship. This is both as a means to understanding psychopathology and as a factor of change.

2.1.4 Non-reflective practice

Encouraging reflection is seen to enhance learning and practice and therefore reflective practices have been incorporated into methods for regulating and standardising professional training and organisational practices. There is something strikingly unreflective about the ways in which this is done, rendering reflection as another box to be ticked as 'complete'. This is disparaging for those who value reflection and has attracted a great deal of criticism: "such interventions are often antithetical when they turn reflective processes into procedures or attempt to assess them" (Zukas, Bradbury, Frost & Kilminster, 2010: 12).

This has resulted in reflection becoming increasingly imbedded within the discourse of power; utilised to establish how things stand rather than question it (Fook, 2010). It is therefore unsurprising that a demand for reflective practice is often viewed with scepticism and cynicism, engaged in with attitudes of reluctance and compliance (Hargreaves & Page, 2013; Knight, 2015). Subsequently it is now deemed necessary to distinguish reflective practice from "really

reflective practice" as a genuine attempt "to understand and challenge self, practice and received wisdom" (West, 2010: 70).

2.2 Reflection in the workplace: redefining reflection as a relational activity

Until recently, the predominant focus has been on reflective practice as an inward process, directed towards the self for the benefit of the individual's practice and development. Applications from this basis include the use of reflective journals as a course requirement for counselling psychology and psychotherapy trainees, or the critical examination of the clinical practice a psychological therapist might engage in with a supervisor. Such processes are likely to originate from an incomplete perspective that professional practice and development is an individual endeavour, somewhat separated from the contexts within which it takes place. An inadequate notion of reflection has followed suit, as Zukas et al (2010) explain: "the problems lie in the ways in which reflection is assumed to happen inside people's heads". However, contemporary perspectives illuminate how reflective practice is situated within the workplace, elucidating its intersubjective and relational proponents. With this has followed a 'new wave' or 'turn' of interest in reflective practice at work (Billet & Newton, 2010). Cressey, Boud & Docherty (2005) accentuate the following characteristics of modern practice within the workplace today:

1. Practice is contextual
2. Practice is embodied
3. Practice is collective rather than individual
4. Practice is multi/trans disciplinary in nature
5. Practice is co-produced with clients

What is emphasised in this picture is the inseparability of the practitioner, their subjectivity and the interaction of this with their organisations, teams and clients. From this perspective, notions of reflective practice inevitably shift towards its outward character and the relational frame within which it is intertwined. This has led to the "imperative that reflection in such settings cannot be an individual act if it is to influence work that takes place with others" (Boud, 2010: 32).

Definitions of reflective practice from an organisational or workplace perspective highlight reflection as a public, rather than private act (Raelin, 2008), focused on the collective rather

than the individual (Hoyrup & Bente, 2005) and linking learning and development with work experiences (Cressey et al, 2005). In addition, it is multidisciplinary in nature and enables the holding of changes over time (Cressey et al, 2005). Through reflective practices, the emotional experiences of the workforce are invited into organisational learning processes. Therefore, really reflective practice requires practitioners to be authentic with one another and expose their vulnerabilities. The implication here is that the workplace needs to invite the uniquely human qualities of practitioners into the organisational space by creating an atmosphere of safety and trust. However, systems psychodynamic perspectives illuminate that organisations are particularly prone to anxiety and this, if left unattended to, can pervade the practices, processes and relationships within them.

2.3 Organisational anxiety

2.3.1 Systems psychodynamics perspectives on organisations

Systems psychodynamics is an interdisciplinary field that utilises open systems, group relations and psychoanalytic theories to understand how organisations work. The ideas of systems psychodynamics were founded in the Tavistock method of studying experiential working groups. These ideas have then been applied to the potential forces that impact upon the processes and relationships embedded within organisational life. Consequently, systems psychodynamics has heavily influenced a psychosocial perspective on organisations and has had a longstanding influence in the field of organisational consultancy (Fraher, 2004).

Originating from Bion's (1961) ideas about groups, systems psychodynamics posits two 'systems' that run simultaneously in an organisation. The 'task' system concerns the operations required for the organisation to meet its aims. Specifically, the "nature and patterning" of the organisation's activities, processes, structures and roles (Gould, 2006: 2). Running alongside the task system is the 'basic assumption' system, which concerns the emotional atmosphere of the organisation, generated when groups of people relate and work together (Stacey, 2011). This is characterised by the unconscious management of primitive anxieties through social defence mechanisms (Jacques, 1955; Menzies Lyth, 1960), seen in group level manifestations of projection, splitting, fantasies, dependence, denial and idealisation. When the basic assumption system is operating in the background, with the task system at the fore, the organisation is viewed to be functioning optimally or in equilibrium. Akin to Klein's (1975) 'depressive position', this equilibrium capitalises on the potential benefits of anxiety, which fuel the organisation's creativity, adaptivity, diligence and insight (Stacey, 2011.

Problems occur when anxiety levels become too high, so that the basic assumption system floods the organisation and becomes the predominant operating system. In this state, organisations are thought to be reactive and fear-driven. Anxiety is passed around between sub-systems of the organisation, the relationships and dynamics toxify and ultimately the organisation cannot perform, learn or change effectively (Gould, 2006). One way the organisation can limit fall out from this and remain on task, is to create a subsystem that serves as a container for the anxiety.

2.3.2 Anxiety and defence in healthcare

Health care services are highly susceptible to anxiety, contamination and flooding by basic assumption systems. Firstly, they face pressure to be competitive, adaptable, time and cost effective and respond to power plays and relational dynamics typical of any organisation. These pressures are no doubt intensified by the current neoliberal socioeconomics and the impact of austerity, squeezing resources and increasing demands to unworkable ends (Cummins, 2018; Frost, 2009). Furthermore, they face the burden of being responsible for human life under duties of care and with these the seemingly inevitable angst embedded in risk management, accountability and harm-limitation. Finally, and perhaps most insidiously, their interactions are markedly emotional in nature, characterised by the inescapable human-suffering which accompanies disturbance, disease, dying and death (Rizq, 2014).

Menzies Lyth's (1960) classic examination of a nursing ward shed light on how organisational systems attempt to manage the primitive anxieties stirred up in staff working with the terminally ill. She postulated organisational defences against this anxiety were manifest in the practices of the team as a means to avoid the emotional burden of care-giving in this context. She cited depersonalisation of patients, staff detachment from their feelings, resorting to rigid task performance and avoiding change as some of the defensive processes she observed. This would appear to indicate an unconscious strategy to remove the 'humanness' out of the context so that unbearable feelings do not have to be shouldered. Indeed, more recently it has been argued that the national health service itself symbolises a place to put the unwell as a means for the rest of society to avoid having to look too closely at our own inevitable shortcomings (Rizq, 2014). If anxiety is not managed in the system, the dehumanised service user will inevitably experience an absence of care when at their most vulnerable. Furthermore, staff are also dehumanised by a systemic denial of that which they absorb on a daily basis, which is likely to be contributing to the stress, illness and burnout currently facing NHS staff.

2.4 Group reflective practices as a container for anxiety

Group reflective practices within an organisation can serve to contain the organisation's anxieties by providing a place where anxiety can be thought about and where one's experiences can be put into words, shared, negotiated and therefore made more tolerable and digestible. Reflective groups can operate as a subsystem, reclaiming the unconscious processes and restoring the task-functioning of the organisation. They do so by creating a systemic empathic holding of staff, where "people bring their work-related feelings to legitimate forums where they can be made available for examination in relation to the work rather than discharged" (Stacey, 2011: 137). However, this requires authenticity and a willingness to expose one's vulnerabilities, which can only occur through trust-building amongst colleagues. Reflective practices must be valued and encouraged throughout the organisation and not just treated as another box-ticking exercise.

Research indicates that prioritising the time, space and trust necessary for *really* reflective practice in healthcare organisations remains a significant challenge (Jayatilleke, 2013). Practitioners find it hard to prioritise reflection over other demands (Liddiard et al 2017), and the delivery of reflective practices can feel enforced and artificial (Knight, 2015). This can generate an overall mistrust and suspicion towards reflective practice (Knight, 2015), particularly when senior members do not include themselves as potential beneficiaries of reflective processes. This can be seen as an indictment of the managerialist culture proliferating health care organisations today. As Raelin (2008) suggests, we cannot continue on in this vein with no ill effects. The organisational provision of really reflective practices has the potential to offset managerialist and defensive processes by prioritising humanity and care-taking within their systems. Furthermore, they could engage the workforce in a meaningful desire to develop and improve (Billet & Newton, 2010), facilitating the necessary sense-making of complex experience. As Docherty, Boud and Cressey (2005) posit, reflective practice "unlocks creative forces in employees, and engages workers in new identities, meanings and communities inside work" (pg. 193). As such, the ultimate grounds for developing reflective practices within health care services is the overall improvement of the organisation in its functioning and its capacity to remain innovatively, meaningfully and creatively on-task.

2.5 Space to think: the need for reflective practice in work with clients diagnosed with a personality disorder

2.5.1 The emotional impact of mental health work

Work in mental health settings presents particular interpersonal stressors for staff, including contact with violent and aggressive patients (Dunn & Ritter 1995), increased chances of conflicts with patients, families and colleagues and the management of suicidal and self-harming patients (Cronin-Stubbs & Brophy 1985; Dawkins, Depp & Selzer, 1985; Sullivan, 1993; Travers & Firth Cozens, 1989). The impact of such challenges has predominantly been conceptualised in the research literature as 'burnout', a protective process of detaching from and depersonalising emotionally demanding work (Maslach, 1998). Quantitative measures of burnout have been associated with a range of negative outcomes; these include an increase in physical symptoms for staff (Kahill, 1988), impatient and intolerant approaches to patient care (Maslach & Pines, 1977), high staff turnover (Jackson, Schwab & Schuler, 1986), absenteeism (Firth & Britton, 1989) and diminished job performance (Maslach & Jackson, 1985). With Menzie Lyth's (1960) ideas still in mind, the phenomenon of "burnout" could be viewed as the manifestation of organisational defences against anxiety at the individual level. Research indicates that those who actively confront the emotional demands they face at work are less likely to develop burnout (Maslach, Schaufelli, & Leiter, 2001), this suggests reflective practices are important for supporting staff in acknowledging and expressing the emotions they experience at work.

2.5.2 The impact of working with patients diagnosed with a personality disorder

Work with patients diagnosed with a personality disorder is afforded a particular reputation due to the powerful emotional reactions that can be evoked in staff. Patient contact can be characterised by aggression, self-harm, dependency and a lack of responsibility taking. Consequently, clinicians may experience intense and raw emotional expression (Gabbard & Wilkinson, 1994: 2), which can lead to reactive responses in staff and the transgression of professional boundaries (Bateman & Fonagy, 2004; Gabbard & Wilkinson, 1994). Not only does this lead to stressful encounters for staff, but also a mismanagement of patients, too readily classified as 'challenging' and 'untreatable' (NIMH(E), 2003).

2.5.3 Clinical perspectives: co-created relational disturbance

Despite the diminishing influence of psychoanalytic practices within the NHS, it seems that psychoanalytic theories concerning the unconscious transmission of emotional material

between therapist and patient remains the dominant discourse for conceptualising the experiences of staff working with patients with a personality disorder. It has been argued that these have been transmuted into commonplace, everyday discourse, which often lacks any real understanding of the basis of these ideas and their clinical implications. They can be used with a particular patient-blaming quality, with claims that patients diagnosed with a personality disorder 'put' feelings into staff and 'split' teams (Green, 2018).

This discourse has its roots in the ideas of Melanie Klein (1975) concerning how the infant organises its primitive emotional experiences and relationships through a process of projection and introjection. Klein (1975) describes projection as a defence-mechanism, whereby intolerable 'bad' feelings are displaced into the caregiver. These are 'split-off' or separated from the 'good' feelings that arise from the 'good' caregiver, almost as if they were coming from two different people. This is coarsely applied in psychiatric settings today to imply that the emotional reactions of staff who work with clients with a personality disorder are purely a transmission of the patients' internal dynamics, where their intolerable states are pushed into those with whom they come into contact. Klein (1975) also advanced that projective identification is the process by which, under the unconscious pressures of persistent projection, the other begins to identify and act in accordance with the way that they have been characterised and related to. This is often used as an implicit means to explain and excuse the mistreatment of clients; the contribution of the staff member's internal dynamics and how these interact with their clients' is often left out of the equation.

However, Klein's (1975) ideas do serve as an incredibly useful means for understanding the unconscious relational dynamics characteristic of work with clients diagnosed with personality disorder. On both sides of the clinical relationships, clients and staff are exposed to the impact of emotional content that is often primitive and disowned. Given the early exposure to relational trauma that predominates in the aetiology of this group, this creates a relational atmosphere in treatment settings that is characterised by heightened affect:

> *They struggle with a range of fears and anxieties, notably fear of abandonment and chronic feelings of emptiness. These affect their behaviour and infect their relationships, which are typically intense and unstable, involving impulsive and unreliable behaviour with eruptions of intense anger* (Foster, 2019a: 3)

As it has already been proposed, Bion's (1961) concept of containment offers a means to protect both staff and clients from the potential harm that might be done if the emotional reactions of staff are not properly acknowledged, processed and understood. The process of

containment requires that emotions received in a primitive form are digested by the recipient through the process of thinking; that which is felt can then be put into words and returned in a tolerable form. This implicates a critical role for staff working with patients with a personality disorder to find ways in which their emotional responses can be understood, controlled and utilised to improve both staff and client outcomes.

Thinking about emotional responses to patients may therefore be an essential tool for working with patients diagnosed with a personality disorder. This is indicated in treatment guidelines for work in this area that frequently cite the necessity of reflective practices not only for the benefit of staff wellbeing but ultimately in order to provide effective treatment and support for patients (Bateman & Fonagy, 2004; National Institute for Clinical Excellence, 2009; NIMH(E), 2003). Whilst such perspectives are becoming increasingly established, it is important to consider their implications for professional practice. This requires that research concerning the experiences of staff working with patients diagnosed with personality disorders be considered.

2.5.4 Quantitative research on the experiences of staff who work with clients diagnosed with a personality disorder

The quantitative research concerning personality disordered patients confirms staff's difficulties in working with this clinical population. Surveys report that patients with personality disorders are viewed as 'more difficult' by psychiatric staff (Cleary, Siegfried, & Walter, 2002), and that they are approached with less sympathy and less optimism than those with depression or schizophrenia (Markham & Trower, 2003). In addition to the inevitable impact this will have on patient care, it also has negative implications for staff, who experience higher levels of burnout when working with suicidal and aggressive patients (Melchior, Bours, Schmitz & Wittich, 1997). However, studies examining staff and organisational relationships, in both forensic and community-based personality disorder services, found lower levels of burnout and increased job satisfaction when their services were viewed favourably by managers (Bowers et al, 2005) and when practice is supported by team work and effective leadership (Crawford, Adedeji, Price, & Rutter 2010).

2.5.5 Qualitative research concerning staff experiences

Qualitative research also suggests work in personality disorder services is particularly challenging. Staff in these settings describe their work as 'difficult', 'relentless' and 'draining' (Kurtz & Turner, 2007). Staff also experience fear during face to face contact with clients (Fortune et al, 2010), and describe patients with a personality disorder as "a powerful,

dangerous, unrelenting force" (Woollastan and Hixenbaugh, 2008: 705). Furthermore, community-based staff reported particular challenges in the management of their professional boundaries and a tendency for splitting amongst team members (Crawford et al. 2010).

Reid et al (1999a) highlighted staff concerns about the potential impact of close contact with disturbed patients, reporting "several staff described a tendency to mirror the mental state of clients with whom they worked, feeling depressed, miserable or helpless after a particularly difficult encounter" (Reid et al, 1999a: 304). Consequently, contact with patients was frequently viewed as a source of anxiety, distress and frustration. Currid's (2008) hermeneutic phenomenology of nurses in inpatient settings highlighted that a lack of opportunity to reflect upon distressing incidents at work led to rumination and anxiety about practices.

Indeed, whether staff can find their work rewarding seems to largely depend upon whether staff experience working as part of a cohesive team, where opportunities are provided for team members to come together, reflect upon the nature of their work and make collaborative decisions about practice (Crawford et al 2010; Fortune et al, 2010; Kurtz &Turner, 2007). Just as patients with a personality disorder require the containment of their emotions, so too do the staff who work with them. Across the board research points to the role of the team and relationships with colleagues in providing this containment. As Kurtz and Turner (2007) note, "the loss of well-being that resulted from isolation within the staff group was pronounced, leading to the threat of breakdown or madness" (pg. 427).

2.6 The indispensable team

It is increasingly evident from both the research and clinical literature that teams play a critically important role in supporting good and principled work with those whose difficulties are characteristic of a personality disorder. Teams provide an important containing function for individual team members, bolstering the work and making it manageable through support, camaraderie and perhaps most importantly a provider of alternative perspectives to the relational phenomena as they occur in the clinical relationship. As the African proverb reminds us, *it takes a village to raise a child*. We can use this as a metaphor for effective teamwork, which supports the therapeutic work much like an extended family or community triangulates and supports the parental dyad. The necessity of team work is reflected in the latest policy guidelines, which stipulate that specialist psychological therapy teams are the most appropriate provision of support and treatment for patients with such difficulties (NICE, 2009; NIMH(E), 2003).

Team characteristics and functioning are therefore critical features for managing challenging work environments (Sørgaard, Ryan, Hill & Dawson, 2007); Jenkins & Elliott, 2004; Nelson, Johnson & Bebbington, 2009). Qualitative studies indicate that the experiences of emotional stressors at work appear to centre upon staff relationships rather than relationships with patients, including inadequate supervision and the experience of working in dysfunctional teams (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000). Furthermore, poor relationships amongst team members has also been cited as the basis of negative experiences in mental health work (Currid, 2008).

Organisations have a responsibility to promote practices within services that support a culture of openness and safety amongst team members for team work to be valued and effective. This is particularly pertinent within personality disorder services as there is an additional threat of the psychological disturbance of the entire team (Kurtz, 2005; Milton & Davison, 1997; Novakovic, 2011; Thorndycraft & McCabe, 2008). It would seem that the emotional intensity of the environment is also reflected in the encounters between staff members, who can easily take up polarised perspectives on clients and treatment decisions. The team is thought to be 'split' when this happens. If such conflicts are not managed effectively then they can cause distress to staff members and limit the opportunity for coherent approaches to management and treatment. Although popular within the discourse concerning team work in personality disorder services, these ideas have yet to be examined empirically. Thus far the focus has exclusively remained on the range of ways in which individuals are impacted by their work.

2.6.1 Why individual supervision falls short

Hitherto the intention of this literature review has been to establish from the clinical and research literature whether there is a need for organisations to provide opportunities for team members to come together and reflect upon their emotional responses to their encounters with patients and one another. This containment may be particularly important when working with risky patients, whose crises need to be appreciated and manged (Hinshelwood, 2002). It might be assumed that supervision should be a sufficient support for staff to reflect on their practices, where thinking about the emotional material that characterises their work can take place. However, it has been argued that supervision can fall short in abating staff distress (Moynihan and Outlaw, 2014), possibly because its intrinsic focus is on patient wellbeing. In addition, the asymmetrical power dynamics within supervisory relationships may impede honest reflection. Furthermore, more recent managerialist influences are increasingly regulating, recording and measuring supervisory spaces (McGivern & Fischer, 2012). This

might make it risky to share difficult and uncomfortable, albeit expected, feelings about one's practice and team relationships.

Reflective groups, such as SSGs might provide a more open exchange due to their process focussed and unstructured style, founded in group psychology principles that view the 'group-as-a-whole' (Dawber & O'Brien, 2013). This might temporarily level existing power differences, particularly if they are externally facilitated, making it more possible to safely explore and unclog the emotional material of both individuals and the team. Furthermore, their group process orientation might serve to improve the quality of reflection in the team by providing a rare opportunity to reflect-in-action through making the group process experiences of team members explicit. This has the potential to annex the more common reflection-on-action that supervision typically accesses, with "a greater emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption" (Dawber & O'Brien, 2013: 2). SSGs are therefore indicated as having the potential to provide a unique and integral means of working with teams in emotionally challenging environments. It is to these groups that the focus of this literature review shall now turn.

2.7 Staff support groups

2.7.1 What are they?

SSGs are usually set up for healthcare teams working within emotionally stressful environments (Moynihan & Outlaw, 1984), in order to promote the atmosphere of enquiry and reflection necessary to foster a therapeutic environment (Scanlon, 2012). The SSGs provide an opportunity for staff to reflect upon the impact of their work, both on an individual and team level. The groups are theoretically underpinned by an integration of both group-analytic and systemic ideas and are characterised by "fuzziness" in the literature (Kennard & Hartley, 2009: 11). Consequently, there is a lack of clarity in defining what SSGs are and how they operate in practice. They can take on a variety of shapes and sizes (Kanas, 1986; Robertson & Davison, 1997), seen by some merely as an opportunity for the mutual sharing of experiences or support (Alexander, 1993; Scanlon, 2012) and by others as a complex blend of supervision, sensitivity, team development and reflective practice group (Kennard & Hartley, 2009; Thorndycraft & McCabe, 2008). It appears that psychology and psychotherapy staff departments are usually approached to establish and facilitate SSGs across a range of health settings when the distress in the team cannot be alleviated by other means (Bramley, 1990; Heneghan, Wright & Watson, 2014; Morante, 2005). Despite their relevance to the fields of

counselling psychology and psychotherapy as well as treatment regimes, there remains a dearth of literature concerning their practice.

2.7.2 Theoretical perspectives

It is a tricky task to discern a clear picture of the theoretical assumptions that underpin an SSG. If associated with any theory at all, references to SSGs predominantly draw upon group analytic theory, particularly the work of Bion (1961) and the function of a working group to contain primitive emotional experiences and transform these into managed and thoughtful form. This facilitates the uncovering of defensive practices developed to protect the individual or system from anxiety (Morante, 2005) and can therefore enable staff to use "the full range of their emotional responses in the service of their work", rather than protect themselves by shutting down (Kennard &Hartley 2009: 89). It has also been argued that effective SSGs espouse an essential secure base from which team members are safe enough to take the necessary emotional risks in their work (Carson and Dennison, 2008). However, such aims are not always achieved in practice and much of the literature warns of the perils of SSGs, where primitive anxieties may be acted out rather than contained (Milton & Davison, 1997; Morante, 2005). Indeed, the very establishment of an SSG may serve as a defensive practice to cover up management issues (Bramley, 1990). Consequently, the aims for establishing a group and the methods of operationalization are likely critical factors to their success.

Despite the absence of literature concerning SSGs, it appears that they are more prevalent than their weight in the literature would suggest. In their mixed-methods survey of all the groups taking place in a single psychiatric hospital, Robertson and Davison (1997) found that there were over 70 variances of SSGs in operation. In another survey it was found that between two and 10 SSGs are in operation in each mental health trust across England (Kennard and Hartley, 2009). Staff groups can also be found across a broad range of settings including psychiatric, medical, forensic, social services and education. Their high frequency and broad applicability makes SSGs an important yet so far mostly unchartered area for counselling psychology and psychotherapy research.

2.7.3 Quantitative research on SSGs

Quantitative research investigating SSGs has limited itself to the investigation of two questions: what are the different types of SSGs available and how useful do staff find them? Kanas (1986) reviewed a small amount of literature and found there was a variance in how effective SSGs were depending upon how the groups were operationalized. Effectiveness was

measured across a range of outcomes including stress, violence and staff communication. This led Kanas (1986) to conclude the following four conditions for an 'optimal' group: (1) goals of the group must be clearly defined; (2) feelings shared must be focused on the professional setting; (3) groups should have an active leader who is external to the staff team; (4) there should be a focus on group dynamics.

Thomas (1995) designed a small questionnaire to address the 'usefulness' of an SSG he facilitated, surveying 21 nurses who attended the group. He found the participants' overall view was that attendance to the group was seen as helpful, particularly for managing patient related concerns, coping with change and reducing stress. All of the respondents answered that there was a need for SSGs to be provided on an on-going basis, rather than short-term. This implies that staff think a reflective space is a continual requisite for working in a mental health setting. However, the applicability of these results must be taken with some caution due to significant methodological issues. In particular, both selection and response biases may have impacted on the findings as the questionnaires were completed by members of open groups, from a range of teams, where attendance to the group is voluntary. Given that participants were self-selected to attend the groups, they may have a had a vested interest in responding positively and the finding that SSGs were viewed as helpful is somewhat unsurprising. Furthermore, for a quantitative study 21 is a small sample size and the psychometric properties of his questionnaire were not examined or established. There was also no interrogation of team dynamics and how these were influenced by attending the groups.

Using a similar methodology Thomas (2003) investigated the impact of attendance to an SSG on two wards. He found that the majority of participants answered yes to questions concerning the group's helpfulness in improving communication amongst team members and facilitating debriefs about incidents. Eighty-four per cent of the 24 participants surveyed also affirmed that the dynamics within the team could be used as a diagnostic tool for understanding patient dynamics. However, this study also appears methodologically weak for the same reasons reported above. Furthermore, turnover in the groups was particularly high which leads to questions about the usefulness of the group for containing staff anxieties. Tommassini (1992) also explored the impact of attending an SSG for staff working in an acute inpatient unit and found that attendance to a short-term group resulted in improved Ward Environment Scale (Moos, 1974) scores concerning job clarity and perceived control. However, the group followed a structured format, led by a facilitator rather akin to a course, which is likely to have affected how freely participants used the reflective space.

Despite the methodological issues outlined, these studies do attempt to provide insight into attendees' views of team-based SSGs. However, it remains difficult to discern from this work the meaning participants ascribe to the potential benefits or difficulties of participating in an SSG and how attending is thought to support them in their challenging work. Indeed, participants' voices are distinctly lacking in this work, therefore, it is useful to consider the qualitative research to ascertain whether this discrepancy has been responded to. Unfortunately, qualitative research in this area is also minimal, with only three studies found.

2.7.4 Qualitative research on SSGs

Reid et al. (1999b) carried out semi structured interviews with 30 mental health professionals in an NHS trust to ascertain the ways in which they felt supported to carry out their work. Their study included participants from both community and inpatient settings and covered a range of disciplines within the field. Whilst discussion with colleagues was the most popularly cited source of support, SSGs were held with anxious and ambivalent regard and over half of the interviewees reported that they found attending an SSG unhelpful. Participants cited several reasons for their negative experiences stemming largely from operational issues, including being unclear about the groups' purpose. Attendance was characterised by inconsistency and avoidance and the majority of groups discussed lacked the support of a facilitator. Hierarchical dynamics also appeared to obstruct the groups, with managers reporting that they felt it inappropriate and unsafe to display their vulnerabilities in front of less senior staff. These findings are supported by Robertson and Davison (1997), who followed up survey respondents with semi-structured interviews to gain their perspectives on SSGs. Staff viewed SSGs as an 'object of fear' where aims are unclear and attendance is avoided, particularly by senior staff (Robertson and Davison, 1997).

However, when participants found SSGs helpful they expanded with reports that they could be used to facilitate a sense of being part of a team, discuss the impact of patients freely and share their difficulties and concerns (Reid et al, 1999b). Unfortunately, this research concerned a range of support systems in place for staff and therefore insufficient detail was gathered about the nature and operationalization of the groups in questions.

More recently, in a mixed-methods study of 73 group facilitators in psychiatric settings, Heneghan et al (2014) interviewed a sub-sample of six, and the interviews were thematically analysed. Results highlighted the difficulties in running groups particularly due to engagement, group dynamics and a lack of management support. They also found that the pervasive organisational culture of 'doing' in health care clashed with the aims of the groups to pause

and reflect. However, this research focussed solely on the experiences of group facilitators, there was no examination of the participants' experiences of attending these groups.

3 RESEARCH AIMS AND QUESTIONS

In summary, the research concerning SSGs is sparse and in the main is limited in its use to practitioners in the field who might wish to enhance their understanding of this practice. Those extant studies suggest a relationship between how SSGs are set up and whether they can be 'effective' at encouraging real reflection. In addition, facilitation, team leadership and boundaries concerning both structure and process of the group are tentatively implicated as factors affecting their efficacy. Much of what is assumed about why an SSG might be useful or not appears to be anecdotal, such as their role in establishing team cohesion and providing an individual and/or team with an experience of containment. These ideas are nevertheless held in people's minds as fact, as if the research evidence exists, when actually it doesn't. As will be outlined in greater detail below, to date there has been no robust examination of SSG members' experiences of attending an SSG. Furthermore, there has been no examination of an SSG in a personality disorder setting. Given the particular emotional challenges and the importance of working relationally with this client group, research examining SSGs in this clinical field is particularly warranted.

SSGs are a feature of reflective practice within a range of health care environments, espoused to provide staff with a supportive and reflective space to explore their emotional responses to the challenging events they face at work. However, to date there appears to be a significant lack of detail concerning what is actually happening in an SSG that perhaps supports, or not, the work of a clinical team. Managers, facilitators and staff could benefit from research-based knowledge concerning SSGs in order to inform their understanding of this practice and to consider its potential relevance to their own work. The aim of this research has been borne from the realisation that there is a significant deficit in the SSG knowledge-base, and a wish to provide a rigorous account of what takes place in an SSG from the perspective of participating health-care staff. Through an exploration of the experiences of staff, this research aims to develop a conceptual framework of an SSG and its processes.

In order to meet the above aim, this research is designed to answer the following research questions:

1. How do team members participating in an SSG understand what is happening in the group?
2. What are the processes they feel they are in engaged in?
3. In what ways do the staff experience the impact of SSG upon team functioning?

4. In what ways do the staff experience the impact of SSG upon their emotional engagement in a challenging environment?
5. How do the staff understand the rationale for their participation in an SSG in their setting?
6. What supports the functioning of an SSG?

Before I provide an account of how this project was designed to answer these questions, it is necessary to introduce the reader to the research context to gain an understanding of the service, team, SSG and researcher that are to be the protagonists of this study.

4 THE RESEARCH CONTEXT

4.1 The personality disorder treatment service

This research took place with a team of practitioners working in an NHS personality disorder service. The setting provides intensive psychological therapies in a day-hospital for clients whose social and relational functioning are characteristic of the diagnosis. These difficulties are often accompanied with acts of deliberate self-harm, suicidality and regular episodes of emotional crises. Clients are offered treatment for up to two years and are required to attend the day service between three and five days per week between the hours of 9:00 a.m. and 4:30 p.m.

The service offers an integrative relational treatment model underpinned by the principles of attachment theory, therapeutic community and mentalisation-based approaches. As well as weekly individual therapy, clients are also invited to attend twice-weekly small-group therapy, daily large/community group meetings, psychodrama, occupational therapy, family therapy, Cognitive Behavioural Therapy (CBT) and a range of informal activities. As such, the team represent a broad range of therapeutic backgrounds including psychodynamic, Cognitive Analytical Therapy (CAT), psychodrama, occupational therapy, systemic and integrative. The leadership team is made up of a consultant psychiatrist and a group psychotherapist both of whom have extensive experience of working with this client group in similar settings to the current one.

The primary aims of the treatment model are to support the development of healthy, authentic attachments (with therapists and fellow clients) in a safe space where the experience of these relationships can be openly explored and where maladaptive patterns of relating can be recognised, challenged and adapted. This sits upon a central premise that it is within the domain of relationships that both dysfunction and change are manifest.

Given the complexity of the clinical work and the relational intensity of the treatment programme, the programme structure includes a range of supervision and support opportunities for the team. Staff attend weekly individual supervision with a senior member of the team, externally facilitated community supervision, monthly external supervisions with specialist focus, such as psychodrama, family therapy and CAT. The whole team are also required to attend the externally facilitated weekly SSG that is to be the focus of this study. The clinical work of the service is very much seen as a collaborative endeavour, it is ‘the team’

that holds the treatment for each client. This depends upon a collaborative and non-defensive inquiry about how the team is relating to clients and one another.

4.2 The SSG

The SSG takes place weekly for 1 hour and is viewed as an integral group for the functioning of the service. Punctual attendance to the group is expected for all members of the team. Absence from the group for training or meetings needs to be negotiated with managers and the team, there is a strong ethos that clinical work should not interfere with attendance unless in exceptional circumstances. The group is facilitated by an external supervisor whose background is in group analysis. She holds the space with firm boundaries around the structure and content of the group. This includes an expectation that everybody contributes by talking in the group, that the focus is on exploring affect, and that the focus of the group should remain on the staff rather than the clients. All members are clear about these objectives.

The aim of the group is to provide the team with an opportunity to explore feelings that might impact on one another and potentially interfere with the clinical work. This is predominantly covered by six main domains of exploration:

1. Exploring dynamics of current team working, particularly where this may have recently broken down
2. Sharing concerns, questions or observations about one's own or each other's practice and the motivations behind particular clinical events
3. The critical appraisal of circumstances surrounding significantly challenging events
4. Sharing elements of one's personal life stressors, current or historical, that might be impacting upon the relationships within the service
5. Exploring and marking changes, endings and experiences of team membership
6. Exploring the experience of the team's relationship to the wider organisation

The group utilises an unstructured format. Members are expected to bring what is foremost in their minds at the time of the group. There is a collectively held narrative within the team that the group is not a therapy group and whilst certain experiences might derive therapeutic benefit for individuals, the focus of the group should always be relevant to the work and functioning of the service.

4.3 Socio-political influences at the time of the research

The early ideas for the current study emerged at a point of stability and familiarity. The service was headed by a longstanding leadership team: a service manager with 20 years of service and a consultant psychiatrist of 13 years. This partnership had facilitated a healthy and stable team, evidenced by low staff turnover and low sickness: I was still the 'newest' member of the team after having worked there for over 4 years. This stability had enabled a coherent framework for the therapeutic work of the service, underpinned by the provision of spaces for staff to come together and reflect upon their clinical work and its impact. At the commencement and during the course of the study proper the service was experiencing an unprecedented time of change, loss and uncertainty for the team.

As the study design began to take shape and submissions were being readied for ethical approval, the team was reeling from the retirement of both the service lead and consultant. The newly appointed leadership team were in conflict with one another about how to work together and reach an agreement on the principles of the treatment model. This seemed to throw the team into chaos and turmoil, as the firmly held principles and ways-of-working were questioned and under threat. The dynamics were fraught at this time, characterised by conflict and a wish to make it work. This resulted in what seemed a confusing mix of wanting to both accept and reject each other's ideas and coincided with an articulated sense of grief and loss for the existing team.

Once approval for the study had been finalised and we entered the data collection phase, the impact of financial cuts had finally reached, and the team were in the process of merging with another personality disorder service. Key members of the team had lost their jobs and those that remained were in the process of forming a new service with the other team, whilst also trying to provide treatment to current clients with as minimal impact as possible. The consultant psychiatrist resigned, so alongside the still relatively new resident service lead, the team were led by a consultant who only attended one day per week and otherwise led remotely from the other team. The situation was exacerbated by limited presence or input from senior managers during this time.

There was a sense of being left with the impossibly complex and challenging task of ending established services, joining two teams together and creating a new service, whilst trying to provide a containing, thoughtful and coherent treatment to clients. Overall, there seemed a profound sense of injury for the team, of being disregarded by the decisions of the wider

organisation and then being left to get on with making it work. There was also a palpable sense of threat that followed. Everyone and everything could be annihilated by those who were experienced as cold, unthoughtful and distant from the work of the team and the impact of their decisions. Whilst it seemed there was a good intention to get on board with the changes and enter a creative and hopeful space about developing a new service, the team also appeared thwarted by undercurrents of anger and futility.

Throughout these monumental changes for the team, the SSG maintained a stable feature, the weekly provision of a space where an attempt could be made to share and digest some of what was happening. As always it became an important place in which the team could work out a collective narrative for their experience of these major changes and their impact. The facilitator, with a 13-year history of working with this team, became a significant witness to the process. Conducting a research project about this group at this particular time took on a new meaning. The study became a means to articulate and stand up for a model of practice that felt under threat, it became a way of defending values and ways of working. The study meetings felt like a place where cohesion could be achieved amongst team members because there was a shared agreement in the value of the SSG. This served as a relief for the team as the merger was causing tensions and strong feelings. However, the contextual needs to defend the established values and practices of the team and to be in agreement with one another about something may have compromised the space for really challenging and grappling with the previously held beliefs about the SSG.

4.4 The team

This project concerns the experience of the clinical team who practiced in the service at the point at which the data was collected. At this point, the team consisted of: a service lead, who managed the service and co-facilitated several groups in the service; a deputy service lead who was also a psychodrama and occupational therapy group facilitator; a team of 4 psychotherapists representing a range of modalities who practiced as individual therapists, group therapists and care co-ordinators for the clients; and a trainee psychiatrist (SHO) who was on a 6 month rotation with the team. There was a vacancy in the team for a consultant psychiatrist whose position was filled but they would not be joining the team until the merger of the two services took place and therefore was not included in the study. One psychotherapist was also on maternity leave during the data collection phase.

4.5 The researcher

I am an integrative psychotherapist whose primary motivation for conducting this research is to gain a doctorate in counselling psychology and psychotherapy. I have worked in the personality disorder service under investigation for 8 years, starting in a trainee psychotherapist position and then being promoted to psychotherapist once I gained my UKCP registration 4 years later. Unsurprisingly, my development as a psychological therapist has been heavily influenced by my experience of working in this team and I have internalised many of its values and practices, particularly those around authentic relating with staff and clients and taking a position as a benign authority in relation to destructive and harmful behaviours. I have become incredibly attached to the team over the years and it felt like an important, worthy and timely endeavour to research the practice of this team and attempt to articulate the ways in which our experience of the SSG supports our work.

Conducting the study felt particularly significant because of the changes that the team were facing. The impact of this had left me jaded and bereaved. I wondered what energy I had for merging and making uncomfortable compromises about the type of therapy I could provide. However, I was also becoming emotionally distanced somewhat as a result of being pregnant with my second child; cushioned by the personal creativity, hope and dreaming that this experience afforded me. This would mean taking a year's break from the team at its most fragile time, which was a comfortable, albeit not entirely guilt-free prospect. Supporting my colleagues and I to lay claim to our work and the principles underpinning our use of the SSG became an important feature of my ending a significant chapter of my professional life in this team and the service as I had come to understand it over the years.

There are several key personal pieces about me that might be pertinent to provide a sense of the lens through which I have interpreted this research. I am a 38-year-old mother of two young boys, and I am in a stable and loving relationship. I classify myself mostly as white-British, but in fact I come from a mixed heritage as my mother is Norwegian: my apparent white-British-ness can often make invisible significant cultural differences through which my identity has been formed. I grew up in a multicultural urban city with two sisters and a mother and father who shared socialist and liberalist values which they pursued professionally in nursing, social work and psychotherapy. When I was a young child my parents separated and eventually divorced, and I understand this to be a result of my father coming out as a gay man. My parents worked hard to stay close in spite of their split and remain good friends to this day. I understand my upbringing to have taken place in a context of multiple perspectives and differences which were celebrated and enjoyed for bringing richness and interest to our lives.

These have crystallised into the values I encompass as a woman and therapist today. From this basis it is probably unsurprising that I chose to train and practice as a psychological therapist using an integrative modality and that this research has been formed from a social-constructionist basis.

5 METHODOLOGY

5.1 Introduction

A first step in choosing a methodology is to define its epistemological and ontological basis (McLeod, 2011; Willig, 2013). Methodological choices should then fall logically from this. In the development of my research methodology I have embraced the spirit of plurality within the field that posits any "meaningful question admits a variety of responses" (Rescher, 1993: 79). It is therefore with the spirit of a 'bricoleur' that I have developed this research project (Denzin & Lincoln, 2000; McLeod, 2011), with an intention to balance and hold tensions within my methodological choices rather than simply attempt to resolve or disregard them. This spirit has been applied to the project whilst prioritising the timely contribution I intend to make: highlighting the practice of SSGs in an attempt to keep the debate around non-standardised forms of reflective practices within the NHS alive.

By accounting for the social constructionist and pragmatic underpinnings of my methodology, I intend to portray the nature of knowledge(s) this project aimed to produce. I will demonstrate how I found Charmaz's (Bryant & Charmaz, 2010; Charmaz, 2006) social constructivist grounded theory a fitting methodology for achieving this. I will then provide an account of how this was applied in the data collection and analysis stages of the research. It is also my intention throughout this chapter to capture how the development of this project has been influenced by my nascent identity as a practitioner-researcher and the 're-working' of early messages I received about what constitutes 'good-science' as an undergraduate.

5.2 Philosophical underpinnings

5.2.1 Sociological philosophies– the common pool

I view my position as a varied grouping of ideas drawn from a 'common pool' of sociological philosophies. I do not think that positivist approaches sufficiently illuminate the complexity and richness of social life required for research and its application in the social sciences. It certainly has its place in contributing to the generation of psychological knowledge, but I reside in the movement in psychology and psychotherapy research that is refusing to *prioritise* measurements over subjectivity (Charmaz & Henwood, 2017) The social construction in 'knowing' is therefore a distinguishing feature of this research.

5.2.2 Social knowing

I believe that knowledge can be socially situated and "an active, cooperative enterprise" (Gergen, 1985: 267). The acquisition and development of knowledge is collaborative because we 'come to know' through the process of interaction (Vygotsky, 1978). This active, co-constructed process is shaped by social, cultural, historical and situational factors. Consequently, whilst I intend to make some claims about the practice of SSGs through the process of this research, I do this tentatively, with an understanding that knowledge is fluid, contingent and incomplete.

The limitless shades of human subjectivity and individual differences are critically repositioned from an irritation to be minimised in positivism, to the primary concern. Getting to the heart of how people make sense or attribute meaning to their worlds and experiences is the focus of study. I see the process of meaning-making as the intrinsic link between people and their culture, shared and manifested in language and social actions (Bruner, 1990). This research aims to enhance 'verstehen' or 'understanding', but more than this, I aim to ask *how* the experience of an SSG is understood and conceptualized by its' members (O' Connor, 2014).

5.2.3 Reality as fluid

If knowledge is developed through intrapsychic, interpersonal and contextual interactions then the case for viewing truth and reality as multiple and changeable is clear. An important example of this in my lifetime is the repositioning of homosexuality as a 'mental disorder' (American Psychiatric Association, 1952) to an equality and human rights agenda, now upheld in law by the Civil Partnership Act (2004).

However, I am wary of the nihilistic potential of relativist ontologies, rendering that "nothing is real, nothing is true, and nothing is important" (Holland, 2000: 3). Whilst some aspects of social life might indeed be truth-relative, in line with critical-realists I believe that social understanding responds to something *real* (Bhaksar, 1989). However, it is impossible to separate the object from the seer and as such we only view this reality indirectly, through our own unique personal lens. This lends itself to the possibility of nuanced and multiple realities and truths, interpreted into meaning and then shared between persons and cultures via language, artifacts and behaviours.

5.2.4 Reality as stable

Over time, I believe that social routines, habits and discourses institutionalize subjective meaning into social fact and that this development ranges from common sense realities right through to concretized pillars of society such as law, education and medicine, experienced and related to as objective truths. Therefore, I can make legitimate claims about the practice of SSGs, whilst situating these in context, time and place.

5.2.5 Positioning the researcher

It is impossible to disentangle the relationship between the 'knower' and the 'known' or capture a value-free and objective account of reality. This repositions the researcher from inconsequential witness to a central influence: the inseparable nature of researcher and researched (Lincoln, Lynham & Guba, 2011). This demands the need to reflect upon one's own position in relation to the phenomenon and tease out how this interaction has influenced the research process (Willig, 2013). Therefore, I locate my own experience of participating in an SSG as a "legitimate source" (Etherington, 2016: 4). I aim to explore the SSG from the "instrumentality" of both mine and my fellow group members' experiences (Heron, 1996: 11). This will be done as faithfully as possible (Charmaz, 2000).

5.2.6 Pragmatic influence

Whilst locating this research within a social constructionist framework, I find myself resisting the inherent schoolism and inaccessibility too commonly associated within these 'big' philosophical debates. I believe that the pragmatic focus upon practices and actions people encounter in their real-worlds operates as a middle ground between absolutist and nihilistic positions (Evans, 2007). This has also been referred to as a "truth that makes a difference" (McLeod, 2011: 5). Therefore, I aim to generate knowledge that is relevant to my daily life and stands up to what I view as pertinent questions: does this work and is this useful in practice? (Polkinghorne, 1992).

As a practitioner-researcher I place a particular importance on the examination of psychological therapy as it happens in the field; that which facilitates the linking of theory to practice. This "credits local stakeholders with the richness of experience and reflective possibilities that long experience living in complex situations brings with it". (Greenwood & Levin, 2007:1). Much can be learnt from the work of the specialist team whose reflective work in an NHS personality disorder service is the focus of this study. Worthwhile research is also that which "embraces action" (Lincoln et al 2011). This is a political issue, where the historical

power imbalances of traditional research can be redressed. In addition to honouring their voices it is my aim to make the research accessible, valuable and transformative for the study participants (Sallee and Flood, 2012).

5.2.7 Epistemological tensions within the research context

It is important to acknowledge that this research sits within the wider context of the NHS, which is predominantly operationalised from a positivist basis. Quantitative statements are utilised as a verification of truth and proof, and thus form the basis of service delivery and treatment protocols. This positivist discourse is both persuasive and influential, despite its limitations in providing a nuanced or complex account of human experience. Perhaps the best example of the force of positivism within the NHS is the somewhat awkward superimposing of a medical model to psychiatric understanding. This biological approach often reduces the causes of mental 'illness' to the structure and function of the brain, rather than offering a more holistic, systemic and relationally informed understanding of a person's psychological distress. This creates a tension between the epistemological and ontological stance of this research and the positivist discourse of the wider research context, which declares that the only valid knowledge is scientific. It might have been more prudent to have developed a more quantitively informed research design, for example, measuring the impact of the SSG against a range of outcomes, and possibly including a comparison group. Such a study might hold more sway in influencing key stakeholders on account of being more adept at speaking their language.

Having said that, the aim of this research is to develop a conceptual framework of an SSG and its processes. This is a response to the gaps in the literature and the needs of the clinical team to understand what is actually happening in an SSG and what processes are in operation when a team utilises this form of reflective practice. The aim is to provide something useful to those for whom the practice of SSGs is of relevance and interest. These aims demand an experience-near enquiry that I believe a positivist informed approach could not provide at this point in time. Furthermore, reflective practice itself was developed to annex what was seen to be the incomplete, positivist driven application of science to human encounters and this research follows suit. This is by no means with a wish to eradicate the valuable contribution that positivist approaches to the human sciences have made, but with an acknowledgement that solely positivist perspectives do not provide us with the entire picture. Indeed, the acknowledgement of expertise and knowledge that is derived from lived-experience is currently gaining more influence. An example of this is the increasing use of 'expert by experience' perspectives in the field of medicine today. Such dialogue between paradigms, perspectives and standards from which knowledge might be claimed needs to continue:

"practitioners and researchers need to value multiple paradigms which, together, can provide a more robust knowledge-base for the psychological therapies" (Barkham & Mellor-Clark (2003: 320). So, whilst the epistemological stance of this research does provide a point of difference or tension with the predominant stance of the wider research context, this tension is embraced with the spirit of plurality that characterises the field of Counselling Psychology today. This comes with a belief that the voices of this staff team and their longstanding experience of participating in an SSG should be included in the knowledge base that concerns SSGs and team based reflective practices.

I shall now set out why a social constructivist grounded theory (SCGT) approach was the natural methodological choice given this philosophical basis.

5.3 Choosing a methodology

Methodology and philosophy are inextricably linked, and any methodological choice should logically follow the philosophical foundations. It was therefore clear that I needed to use a qualitative design. This enabled me to capture the "quality and texture" of the interactive and contextually complex process of the SSG and how they ascribe meanings to this (Willig, 2013: 7). Five core approaches dominate the literature on qualitative research methodologies: Ethnography, Case Studies, Interpretative Phenomenological Analysis (IPA), Narrative Inquiry and Grounded Theory (Creswell, 2007; Stainton-Rogers, 2011; Willig, 2013). To a 'new kid on the block' these seemed like a good place to start. I shall briefly outline my consideration of these approaches before settling on SCGT.

5.3.1 Ethnography and Case Study

An ethnographic study requires the complete immersion of the researcher in order to provide a detailed description of a culture. An ethnographic account of the team, with its' capacity to identify the cultural and social interactions of the SSG would be an interesting approach. The concept of immersion initially appeared to suit my close relationship to the research as participant-observer (Creswell, 2007). However, immersion and reflexivity seem to be means to a different end, aimed at acquiring an objective account of the social context (Lichtman, 2017). I could not position myself as an observer who *describes* with *detachment* nor align myself with the realist ontology underpinning this. I faced a similar predicament when I considered examining the SSG from a case study perspective. A case-study design offers a detailed, close-up examination of an individual, organisation or action within its specific

context. An in-depth analysis of the multifaceted contextual layers of the SSG could support my aims for developing a theoretical understanding because “it is at the level of the case that the operation of different factors can best be observed” (McLeod, 2010: 3). However, I could not marry with the realist characteristics of aiming for objectivity and causality inherent within their design (Yin, 2014).

5.3.2 Narrative Inquiries and Interpretative Phenomenological Analysis (IPA)

Narrative Inquiries and IPA both emphasise multiple meanings and hermeneutics so offered relativist alternatives to ethnography and case studies (Creswell, 2007). A narrative inquiry would have established the ‘storied lives’ of the staff group (Clandinin, 2006), specifically the words used and accounts given of their experiences and the meanings behind these (Lichtman, 2017). Similarly, with its philosophically informed focus on the ‘lived experience’ of participants (Heidegger, 2004), an IPA would have been an interesting and fitting way to approach the research. In particular, the idea that I could reduce the ‘essences’ of reflecting on practice from staff experiences within this context, appealed. This would have gone some way to fill the gaps in the literature. However, I found the positioning of these approaches did not quite fit. I wanted to utilise an approach with something more of a ‘middle-ground’ ontology so that the critical-realist basis of the research could be met. Furthermore, I wanted to go beyond a deep description and begin to identify the dynamic, co-constructed nature of experiences within this unique practice context (van Wright, 1971; Willig, 2013). This married with my aims to uncover the multiple-truths of the team’s experience and how these manifest in consensus and collective meanings.

5.3.3 Social Constructivist Grounded Theory (SCGT)

I needed an approach that could answer the open questions I had about the actions of reflecting in a staff team, the meaning of these actions for its members and to support a contextually based understanding of *how* this meaning is generated. I wanted to search for a possible ‘emerging theory’ of the social process of group reflection, grounded in the intrapersonal, interpersonal and contextual worlds of the participants (Lichtman, 2017). I also needed a methodology that would utilise my embedded relationship to the research as a strength and legitimate source. Charmaz’s (2006; 2010) SCGT posits a ‘middle-ground’ interpretative ontology, demanding a ‘faithful’ account of participants and contexts, whilst simultaneously acknowledging that discovery is inextricably woven to the researcher’s interaction with data. This, and its aims of driving theoretical understanding from the analysis of social experience, meant that SCGT was the most suitable choice.

5.4 Grounded Theory

When you have not yet had the experience of 'living through' a 'qualitative project it can be hard to feel confident about your choices in this boundaryless realm. This is particularly true of a student whose prior exposure to psychology research has been strictly from a positivist perspective (Cox, 2012). Grounded theory provided a "reassuring and genuinely useful" bridge into qualitative researching (Henwood & Pidgeon 2003: 133). Furthermore, I appreciated the power-shift inherent in the method. Grounded theory offered an invitation to stimulate my own "theoretical imagination" and claim an authority about my world, its inhabitants and practices (Charmaz & Henwood, 2017: 244).

5.4.1 History of grounded theory

Glaser and Strauss (1967) have successfully met their original aim to provide an alternative to the hypothetico-deductive reasoning so predominant in sociological research. Their introduction of the grounded theory methodology to the field marked an important 'turn' in the utilisation and acceptance of qualitative methods (Denzin & Lincoln, 1994; Charmaz, 2000). In their original works, Glaser & Strauss (1967) provided little explicit detail about the philosophical positioning of their method. However, positivist leanings were implied through what they claimed was grounded theory's capacity to achieve objectivity and truth through systematic and rigorous analysis of qualitative data. These positivist roots have no doubt influenced its popularity today, applying rigour and logic to 'unruly' qualitative data. Indeed, it was very much these tones that originally appealed to me because they brought together the original lessons I received about what constitutes 'good science' with an emerging understanding of complex and nuanced social life.

5.4.2 Universal principles of grounded theory methodology

Numerous strands of grounded theory have since developed. These differences have been primarily concerned with the philosophical repositioning of grounded theory from its positivist roots to philosophical ideas more in keeping with qualitative research. However, the method for inquiry has remained mostly consistent with what Glaser & Strauss (1967) originally proposed.

The principle task of the researcher in a grounded theory study is to organise qualitative data into increasingly abstract and analytical concepts. These concepts are defined and refined into a theory through the iterative and simultaneous process of coding, constant comparison and theoretical sampling. The result of these processes is to arrive at a theoretical integration of the data that 'fits' and 'works':

> *by fit we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by work we mean that they must be meaningfully relevant to and be able to explain the behaviour under study* (Glaser & Strauss, 1967:3)

5.4.2.1 Coding

In order to achieve increasingly abstract concepts, data is subjected to up to 3 levels of coding during analysis. Initial or descriptive codes organise the raw data into descriptive categories. These are then compared with one another. Patterns and relationships are identified and the most important of these form the more analytical 'focused' codes. This is seen as both a creative and a technical endeavour. There is the option of then theoretically coding the focussed codes and identifying a core category thereby capturing, in just a few words, an explanation of what the entire research is about (Strauss & Corbin, 1998). This is the central point at which all of the categories and concepts of the grounded theory are integrated (Saldaña, 2013) and where the 'theoretical story' of the research is told (Charmaz, 2006). A key task for the researcher throughout the coding process is to refrain from sorting the data into predetermined or preconceived categories or themes. In this way, the process of coding serves as the pivotal link between data collection and theory (Charmaz, 2006)

5.4.2.2 Constant-comparison

Coding in grounded theory is inextricably woven with the method of constant comparison. This is the process of moving back and forth between codes and categories to establish similarities and differences so that all instances of variation are captured by the emerging theories. As Charmaz and Henwood (2017) explain, "we compare datum with datum, datum with code, code with code, code with category and category with category" (p. 241). Constant comparison occurs throughout the research process and is what gives grounded theory its synchronous and iterative nature. Defining and refining the coding process in this way is a distinguishing feature of grounded theory (Holton, 2007).

5.4.2.3 Theoretical sampling

Typically, research sampling is concerned with generalizability to a wider population and is normally decided upon prior to data collection. However, in grounded theory the sampling process is more 'strategic' and 'systematic' (Charmaz, 2006). Initial data is collected and analysed according to the principles of constant comparison, this will then indicate avenues for further sampling and data collection, either to elaborate concepts and categories or to account for gaps in these (Holton, 2007). Data collection is therefore "controlled by the emerging theory" (Glaser and Strauss, 1967: 45). Theoretical sampling stops when theoretical saturation is reached. This is the point at which no new properties or variances of categories can be found.

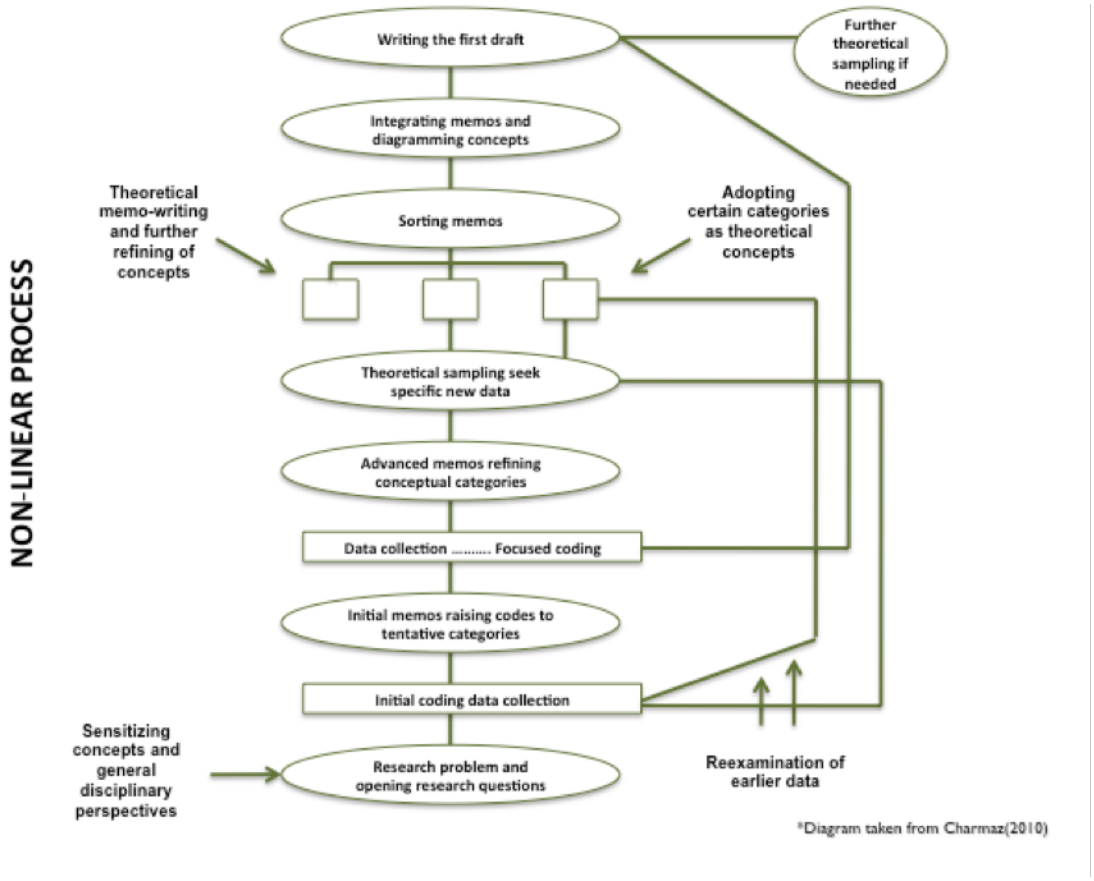
5.4.2.4 Memoing

The theoretical notes the researcher makes to capture ideas about the development of categories is known as memoing and occurs simultaneous to coding. Memoing is seen as the 'engine' of grounded theory (Gordon-Finlayson, 2010: 164), prompting the advice to stop immediately and write a memo if anything significant comes to mind during analysis (Saldaña, 2013). Memo-writing supports raising the analytical level of coding and the development of the complex properties of categories. Like codes and categories, these must be 'sorted' and integrated by the researcher.

5.4.2.5 Overall process

The process of data collection and coding takes place in a continuous, cyclical and iterative fashion, as such, they "blur and intertwine continually" (Glaser and Strauss, 1967: 43). Fig 5.41 represents this, depicting the process of grounded theory as a whole.

Figure 5.4-1 The grounded theory process



Researchers are required to move back and forth along the process, defining and refining their questions and theories as they go. Knowing how and when to move between grounded theory processes requires confidence and experience. This includes responding to the moments of confusion and surprise with imagination and intuition. This appears to capture both the chaos and order of the methodology: tolerating uncertainty and being available for what emerges, whilst adhering to grounded theory principles and practices (Holton, 2007). It is the rather poetic combination of rigour and system in the method, with flexibility and an openness to allow for the materialisation of ideas which are grounded in the experiences of participants that appealed. This married well with my nascent identity as a qualitative researcher whose knowledge up to this point had been formed within solely positivist institutions and ideals.

5.4.3 The philosophical repositioning of grounded theory

Despite these commonalities, there is much contention in the field about grounded theories and the manner in which they should be conducted. These technical differences (and criticisms) are manifestations of the divergent philosophical foundations upon which these variations rest. I shall briefly summarise my understanding of the three main strands of

grounded theory to evidence why Charmaz's SCGT is the version that fits best with the philosophical placement of this research.

5.4.3.1 Glaser and classical grounded theory

Once the field demanded Glaser and Strauss to make explicit the epistemological and ontological claims of grounded theory, their differences became apparent and in the end were irreconcilable. Glaser remains with classical grounded theorists, who claim their method transcends philosophy. They posit the methodology can "accommodate any type of data" through "any epistemological lens" (Holton, 2007: 268). However, classical grounded theory clearly beckons a *neutral* and *objective* researcher who *discovers* theory (or truth) (Charmaz, 2014; 2006). These positivist leanings significantly undermine any claims of their philosophical neutrality.

5.4.3.2 Strauss and Corbin and Straussian grounded theory

Following his departure from Glaser, Strauss teamed up with Juliet Corbin and developed a strand of grounded theory supposedly philosophically rooted in pragmatic and symbolic-interactionist ideas (Strauss and Corbin, 1994). However, in their method they posit the need for detailed coding paradigms in order to develop theories that "closely approximate the reality it represents" (Strauss & Corbin, 1990: 57). Their aims of achieving verification and impartiality reveal some confusion about the ontological basis of their method, particularly in terms of their positioning of the researcher within the process (Charmaz, 2000).

5.4.3.3 Charmaz and constructivist grounded theory

Charmaz clearly positions her version of grounded theory in a social constructivist paradigm:

> my approach explicitly assumes that any theoretical rendering offers an interpretive portrayal of the studied world, not an exact picture of it. Research participants' implicit meanings, experiential views and researchers finished grounded theories are constructions of reality (Charmaz, 2014: 17).

This marries with my constructivist perspective, centralising social life in the development of knowledge. Furthermore, Charmaz does not disavow the researcher's influence upon the process, arguing that theories are generated through the researcher's interaction with the data. However, SCGT is moderately interpretative, making a claim about the world whilst

acknowledging the inevitable influence of the researcher in this (Pidgeon and Henwood, 1997). Consequently, it was Charmaz's SCGT which most influenced my choice of methodologies.

5.5 Methodological issues faced in this research

5.5.1 Literature review

In traditional grounded theory the literature review was seen as a barrier to the task of preserving researcher objectivity. Prior knowledge or assumptions concerning the subject of study could obscure a pure emergence of theory from the data. Delaying the literature review until after the data has been analysed remains an important conduct within classical grounded theory today. However, the interpretative shift in SCGT acknowledges the unlikelihood of grounded theorists having no prior theoretical knowledge of their subject areas. Therefore, advice is to approach the existing literature with a view that nothing is 'knowable' (Henwood and Pidgeon, 2003). This means to view the literature with a critical and reflexive stance so that one can remain open to what the data is telling you. As Charmaz states, "the trick is to use it without letting it stifle your creativity or strangle your theory" (Charmaz, 2014: 308).

Areas of the literature review in this study were conducted prior to analysing the data in order to develop a case for both programme and ethical approval. However, the literature review concerning SSGs revealed scant prior work and limited theoretical conceptualisations. Indeed, I was more concerned about how my personal experiences of the SSG had already informed a working model in my mind about the practice of this group and how this might influence my honouring of the data.

5.5.2 Insider-outsider position

I am both a member of the team and the SSG that is the focus of the study. This qualifies my relationship to the research as one of a 'total insider', specifically, I share many identities and experiences with the research area (Ross, 2017). The category of 'total-insider' sits within a broader definition of insider-outsider researchers, where researchers straddle the dual identities as both insiders immersed within the groups they study and outsiders by virtue of being a researcher looking in. There is much debate in the literature about the strengths and weaknesses of this relationship (Corbin Dwyer & Buckle, 2009).

In many ways I view my closeness to the research area as a potential strength of the study, I believe it can afford insights that an outsider could not achieve. The longstanding nature of my relationships to the participants and of the participants with each other can facilitate a swift moving into a familiar and yet challenging nature of one another that could lead to mutual growth and discovery during the inquiry (Ross, 2017). Furthermore, I have a deep understanding of the social, political and historical context of the service, team and SSG due to my insider position, allowing me to "project a more truthful, authentic understanding" (Merriam et al, 2001: 411).

There appear to be two main criticisms of insider-outsider researchers. Firstly, there are the ethical dilemmas that this scenario might raise (Ross, 2017). Informed consent is not straightforward, specifically, my existing relationship to the team might mean group members feared disappointing me or letting me down if they wished to decline from participating. My espoused position is one of supporting informed consent and withdrawal from the project with no repercussions but a withdrawal from one of my close colleagues might indeed trigger feelings of anger and resentment. Furthermore, confidentiality might be compromised due to the longstanding nature of our relationships and close-working arrangements. How easy will it be to discern which pieces of whom I present have only been informed by a discrete data collection scenario?

Secondly, there are questions about the validity and quality of the data which has been collected and analysed by an insider-outsider. There are concerns that total insider status complicates the reflexive task of "establishing and maintaining an appropriate degree of both social and emotional distance" (Greene, 2014: 9). In practice, this could mean that the data collection and analysis might be shaped and guided by my own experiences rather than the group members (Corbin Dwyer & Buckle, 2009). Furthermore, my closeness to the research area could inhibit me from challenging the status quo. However, feminist perspectives are rightfully trying to move us from the intentional drawing of boundaries that demarcate 'researcher' from 'researched' towards understanding that each person has a different and changeable relationship to the research process as it develops (Llloyd, Enis & Alkinson, 1994). As I hope it has been made clear, my intention was not to provide an 'objective' account about the practice of this SSG, but rather one whose validity is supported by authenticity and critical reflexivity.

In this way we can see how it is overly simplistic to perceive insider-outsider as a fixed dichotomy. Merriam et al (2001) highlight the shifting of power, positionality (vis a vis culture, race, ethnicity, class etc) and representation that will be negotiated throughout the course of

an inquiry. It is perhaps more accurate to understand the dialectics of similarities and differences as they move through the relationships that are established and re-established throughout the duration of a project. It was therefore important to weave into the project design some mechanisms to attend to these issues and navigate my way through these shifting sands of closeness and distance, similarities and differences and power.

5.5.2.1 Strategies

The strategies I chose for attending to the outsider-insider issues were as follows. Firstly, I kept a journal record throughout the research process in order to make visible my thoughts, feelings, experiences and opinions. This enabled me to be transparent about decisions made and any salient issues pertaining to my insider-outsider status. It also recruited a steering group of two expert and credible members of the field to act as 'consultants' to the process. The steering group convened twice during the data collection process to provide advice and troubleshoot where necessary. Finally, I also recruited a critical research friend with experience in conducting qualitative research to interview me prior to collecting data to establish some of the perspectives I held. She also provided an outside perspective on my coding and theory generation in the data analysis stage. The journal entries and transcripts from the steering group meetings and interview would be revisited in my analysis of the cooperative inquiry group transcripts.

5.5.3 Collecting data through an adapted cooperative inquiry

Having established constructivist grounded theory as the methodological framework, I needed to decide upon the methods I would use to generate data for the study. Within qualitative research, the possibilities for data collection are vast. Interviews, field notes, poems, art, music and journal entries are some of the potential strategies used for capturing subjectively derived information. Initially I considered using individual interviews to inquire about participants' experiences and understandings of their SSG membership. This is a widely used practice for generating grounded theory data and generates rich and detailed descriptions of group members' experiences of attending the SSG. However, as the focus of the study is group practice, I thought it would be incongruent to disband the group and engage with participants at an individual level. I needed a data collection method which was coherent with group participation and process. Therefore, I thought the data should arise from the collective, living interaction and inquiry that characterises the nature of reflection in the SSG itself. As a result, I considered cooperative inquiry as a data collection strategy because this would allow for the group to share in examining the SSG in an open, creative and spontaneous form. However,

this process would be “contained within the disciplinary framework of CGT” (O’Connor, 2014: 51).

Stemming from the broader school of action research, Reason and Heron’s cooperative inquiry is a group-based approach that examines real-life practices and experiences. Although cooperative inquiry is a research methodology in and of itself, my research aims better suited combining it with grounded theory. This would enable me to generate a theory about how the SSG is experienced by members through a collaborative inquiry process. The ease with which grounded theory can be combined with other methods is often cited as one of its strengths (Charmaz and Henwood, 2017; Dick, 2007). “All is data”, after all (Glaser, 2001: 145). In particular, the combining of action research (including cooperative inquiry) and grounded theory methods can reconcile weaknesses in both approaches. Action research needs to more cogently address the issue of theory development, whilst grounded theory needs to engage in methods which involve participants and researchers more directly in the research process (Dick, 2007). Utilising a cooperative inquiry as a data collection method for grounded theory has been successfully achieved in other studies, generating theoretical models which have been built from the ground of an interactive and group-based inquiry process (Andrews, Williams, Vandecreek & Allen, 2009: Dick, 2007; O’ Connor, 2014; Peelo, 2016).

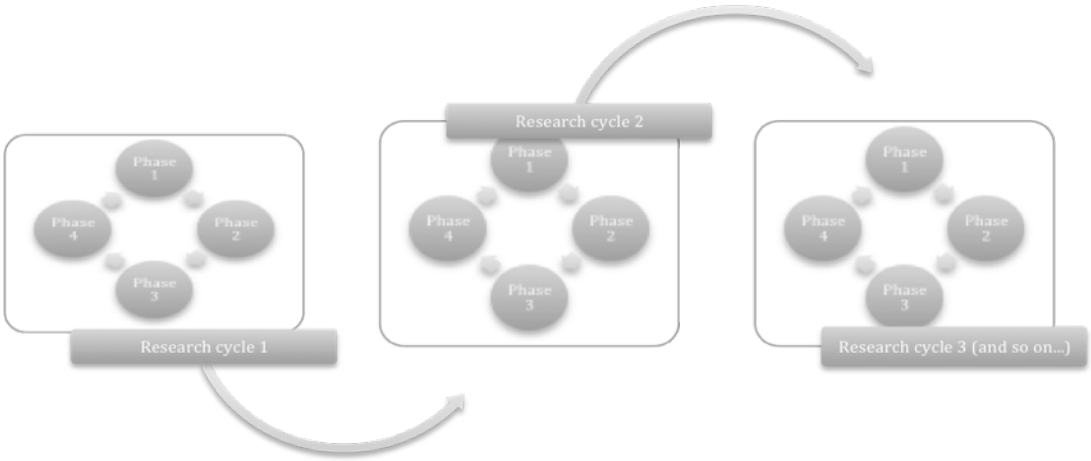
5.5.3.1 Cooperative inquiry

The foundational premise of a cooperative inquiry stems from the emancipatory principles of action research, described by Heron and Reason as, “research *with* people rather than *on* people” (Heron and Reason, 2001: 179). Thus, in a cooperative inquiry, researchers and participants are repositioned to ‘co-researchers’ and ‘co-subjects*’*. The inquiry process is designed to encourage an “intentional interplay between reflection and making sense on the one hand, and experience and action on the other*”* (Heron, 1996: 36). This interplay occurs through a systematic means of ‘research cycling’, designed to establish experiential, presentational, propositional and practical domains of knowing (Heron, 1996). Cooperative Inquiry intends to move knowledge development out of academia and into the real world, making it a fitting choice for practice-based research. This is much in line with the directionality of theory development in grounded theory, moving from local interest to theoretical models.

5.5.3.2 Research cycles and phases

The cooperative inquiry process entails inquiry group members moving through a number of research cycles (see figure 5.5-1). Each research cycle contains four discrete phases.

Figure 5.5-1The cooperative inquiry process



Phase 1: This phase concerns the coming together of the group to reflect upon a shared area of interest, agree upon a focus for the inquiry and establish questions or propositions to explore. This allows access to participants' propositional knowing, what they understand through ideas and theories "knowing through ideas and theories" (Reason & Heron, 1996: 4)

Phase 2: The group take their decided upon actions into their everyday work, observing and recording their experiences as they go, lightly holding their original ideas and assessing their fit with actual experiences. This phase accesses and develops participants' practical knowledge, specifically, knowing 'how to' do something

Phase 3 – Group members become fully immersed in their actions and experiences, deepening their awareness and opening up for new understandings through surprise and creativity. This stage corresponds to experiential knowing, in particular, a more non-verbal domain of knowing through feelings and intonations.

Phase 4 (and phase 1 of the next stage) – The group members reassemble to share their learning from their experiences of the prior phases. This corresponds to presentational knowing, specifically, the first forms of expressions, including imagery, stories and art. There is also a reconsidering of original ideas, revising and replacing them following their learning. Decisions are then remade about what and how to explore in the next research cycle and thus the process starts again. This cycling continues until participants agree that the knowledge(s) acquired are sufficiently complete.

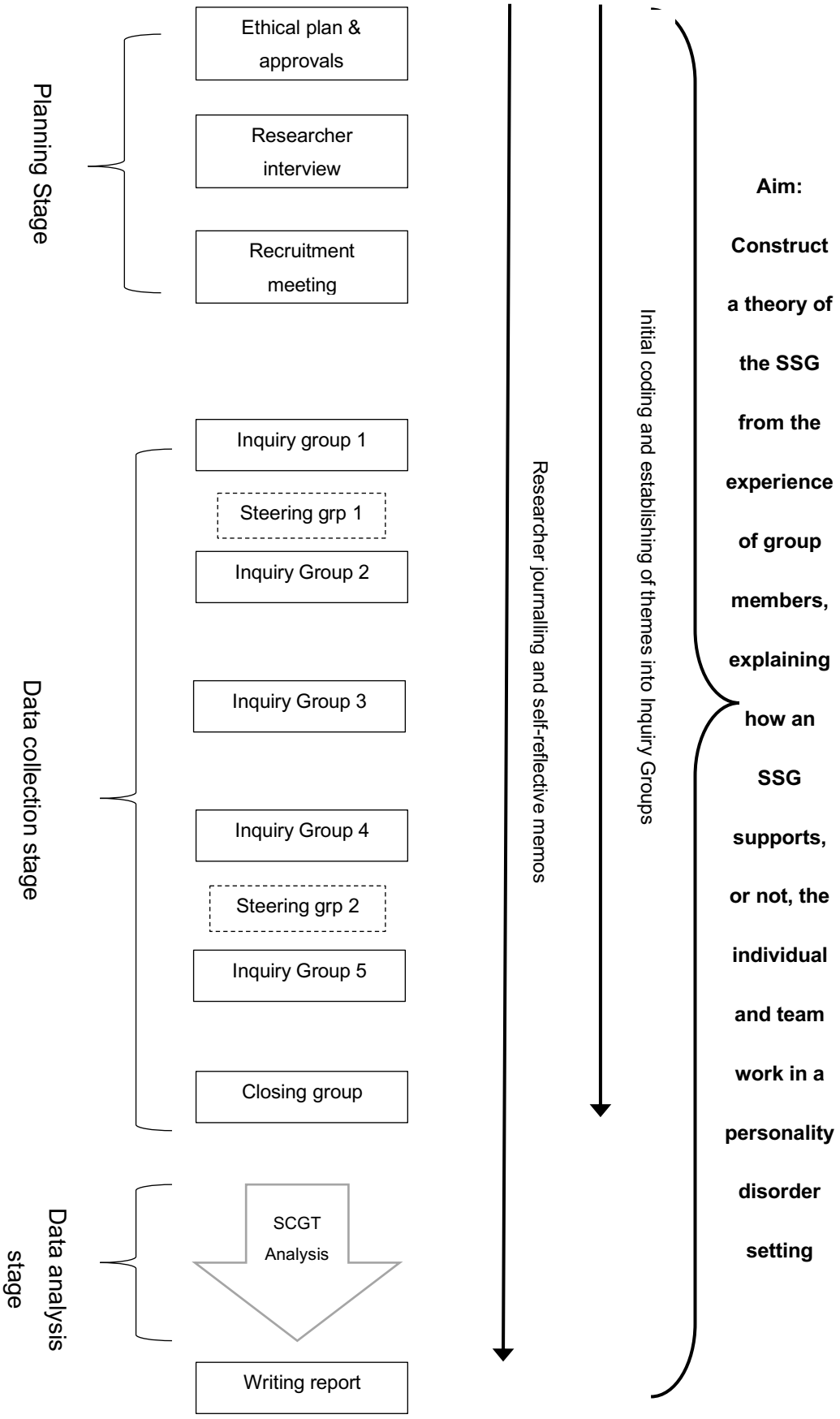
5.5.3.3 Adapting the cooperative inquiry

It is important to reiterate that a cooperative inquiry is a full research methodology in and of itself. The process typically arises out of a shared need amongst a group of people to engage in a deeper understanding of their world and practices to establish ideas and suggestions for change in the field. These aims are met through the research-cycling process. However, the research questions that have been generated from this study did not arise from the team and the team were not, at that time, expressing a need or desire to change their practices. We could not escape the issue that 'ownership' of the project needed to remain with me to meet my aims of gaining a doctorate. In light of these particulars the aim was to 'bind' the cooperative inquiry discretely within the 'data collection' phase of the research. This would mean preserving the use of research-cycling to generate ideas and systematically explore experiences of the SSG from the collective. This marries well with the grounded theory principles of theoretical sampling, returning to the field to develop and refine categories. It would also mean preserving, within the data collection phase, the collective responsibility-taking for deciding upon the avenues and means for this exploration. However, it was decided that once the cooperative inquiry had generated sufficient data, the project would return to me for analysis and writing-up.

5.6 Research design and implementation

The research design consisted of three phases: (a) planning and development, (b) data collection and (c) data analysis (see figure 5.6-1). The planning and development stage started with a researcher-interview conducted with me by a personal acquaintance who has significant experience as a qualitative researcher outside of the field of counselling psychology and psychotherapy. I also established the 'expert' steering group, approaching two outsiders of the service who work as psychological therapists in the NHS. They have experience of attending SSGs in the past and both have worked in a personality disorder service previously. I also conducted a recruitment meeting for my team members, to introduce them more formally to the research aims and methods (please see below for further information). The cooperative inquiry process followed, consisting of a total of 5 research cycles. I met with the steering group twice during this phase, once after the second inquiry group had taken place and again between the fifth inquiry group and the closing group. During the data collection phase some initial coding took place and early themes were fed into the inquiry process to develop and refine potential categories. Following the closing inquiry group, the 'ownership' of the project returned to me to continue a more thorough data analysis following Charmaz's (2006; 2010; 2014) coding principles for a systematic theory development.

Figure 5.6-1 The research process



As a group we decided not to invite the external group facilitator to take part in the research. It was felt that the boundary she held as an external member of the group was critical to the functioning of the SSG. We did not want to risk changing the dynamic of our relationship by inviting her into another group context. This prompted a concern that hers might be a 'missing voice' in the research. However, attending the SSG which she facilitates would be included in the experiential phases of the research process. In this way her voice would be a part of the study, but only in our interpretation and exploration of the SSGs when we returned to reflect on our experiences.

5.6.1 Ethical planning

Ethical approval for the project was sought and granted from a number of sources: the Metanoia Institute Ethics Committee; The Health Care Authority; and the local Research and Development Office of the research site (Appendix A). As a member of the BPS and the UKCP I was also bound to their codes of ethics (BPS, 2018; UKCP 2009). Despite gaining the green light from these various institutions it was important to utilise the ethics of caring and professional morality as superior guiding-principles for the project (Marks-Maran, 1999). This meant that I was committed to taking care of my participants throughout the life of the project including keeping them in mind, considering any impact the study might have on them, remaining transparent, and providing informed choices. However, I was also aware that there might be a conflict of interest in my needs to complete academic requirements and my responsibility to my participants. I saw two particular areas that would require attention before commencing with the project, these were concerned with the complexities around consent and confidentiality.

5.6.2 Ethical planning

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responsibility to my participants. I saw two particular areas that would require attention before commencing with the project, these were concerned with the complexities around consent and confidentiality.

5.6.2.1 Consent

Written consent needed to be sought prior to commencing the study and participants needed to be free to decline and withdraw. However, I was aware of the unknown qualities of participating in a study that used a cooperative inquiry method to collect data. What would my participants be consenting to? I knew it was not possible to establish this from the outset and therefore the 'informed' aspect of seeking consent was always going to be limited. Furthermore, as I have touched upon already, I was aware that my close relationship to team members would impact upon decisions taken to consent or withdraw. I believed our close bonds with one another might negatively impact upon potential participants' freedom to decline if they so wished, because of the possible feelings that this might arouse between us. However, I thought that the pre-existing nature of our relationships would give the consent process an atmosphere of care, trust and direct communication, which reassured me that any potential harm would not go unnoticed or unspoken about. Finally, I observed that there were also power dynamics at play, with senior members of the team clearly endorsing the project. How might this affect one's ability to decline?

5.6.2.2 Confidentiality

I was aware that my ability to assure the confidentiality and anonymity of participants would also be limited. The data collection would adopt a group format, which meant confidentiality could not solely be my responsibility. The group would need to establish an agreement of confidentiality amongst each other. Reassuringly, this was an already established culture in the team with confidentiality of the team being held within the service. There was also an issue around ownership of stories. As team members, our stories about our team-work would inevitably involve each other, therefore the material that is shared in the process one's experiences or actions might not be solely an individual's choice. Furthermore, due to the unique, team setting and its specialism, it might be possible that the team could be identified during the publication and dissemination of this work.

I grappled with the ethical and moral complexities of consent in research supervision and in discussions with research colleagues and friends. I needed to maintain participants' autonomy in the process (Tee and Lathlean, 2004). This meant utilising the following guidelines:

1. Emphasising the right to withdraw (and making explicit my awareness of the pressures to consent)
2. Transparent consent procedures (including my concerns over consent and confidentiality)
3. Striking a balance between autonomy and paternalism (relating to the team as capable and robust enough to make choices and attend to any difficulties should they arise)

It therefore felt appropriate to plan a 'recruitment meeting' with the team to be explicit about these ethical complexities and for us to discuss some of these together. I also decided to make some of these issues explicit on the written consent forms and participant information sheets that would be issued during the meeting. I was reassured about the structures that were already in place to support the team in grappling with the emotional complexities of our work together and engaging in collaborative decision-making processes. There was an established culture of honouring divergent perspectives and the vocalising of these and I thought this would support the raising of any differences, doubts or concerns should they arise.

5.6.3 Addressing quality and trustworthiness

I considered a number of measures in the development and implementation of this study in order to ensure quality and trustworthiness. Lincoln et al (2014) provide some criteria for qualitative researchers, which they offer as equivalents to the validity standards found in quantitative research. In addition, I thought it was important to judge the design of the project in accordance with the paradigm from which the study had been designed (Merriam, 1995). I therefore included some criteria from Morrow (2005), which addresses quality issues unique to a constructivist frame.

5.6.3.1 Credibility

In order to attend to the 'truth value' of this research I made the following decisions, as per Devers' (1999) advice:

1. To collect sufficient information to provide thorough and 'thick' descriptions of the participants' experiences and the contexts out of which these occurred

2. To carry out a prolonged engagement with the team (this was granted by virtue of my being a team-member also)
3. To utilise the support of 'peer researchers' throughout the course of the project: a 'critical research friend' and an expert 'steering group', all of whom were external to the inquiry process
4. To engage in negative-case analyses, through discussions with steering group and by adopting a 'devil's advocate' method within inquiry groups
5. To allow for member checking of early codes and final analysis

5.6.3.2 Transferability

I hope that, as well as being of value to my participants, the study findings might have a wider application. I have attempted to make explicit the potential and broader contributions of this research throughout this report. However, readers need to ascertain for themselves which aspects of the study are more broadly applicable and which are not. In order to support the reader, I took steps to gather sufficient information about myself, the research context and the nature of my relationships with participants throughout the course of the research and I have also endeavoured to make these explicit.

5.6.3.3 Dependability

I made sure to document the decision-making processes entailed throughout, in order that I could provide sufficient information about the development and implementation for the study to be replicated (Devers, 1999). Having said that, I will have brought a unique influence to this study and it is also uniquely situated in time and place. It was important to consider these influences from the outset and I have endeavoured to make these explicit in this report.

5.6.3.4 Confirmability

In order to maintain the integrity of this research, I took steps to ensure that the findings have been derived from participants' perspectives, rather than a mere reproduction of my own biases and expectations. I made the decision to keep a reflective journal from the outset to justify, account for and manage my own responses (to the extent that this is possible). I also established a community of practice (Rallis and Rossman, 2003) with peer researchers (as above) to support me to engage in critical discussions throughout various stages of the research.

5.6.3.5 Reflexivity

I planned to maintain a stance of critical reflexivity to ensure the 'contextual grounding' of this research and how the meaning has been constructed by myself and the participants (Morrow, 2005). This includes the aforementioned tasks of journaling and critical discussions with research peers. However, the reflexive piece within this research has also been a "constant and evolving endeavour to take personal, internal responsibility" for the quality of this research (Morse et al, 2002:10).

5.6.4 Recruiting participants

5.6.4.1 Recruitment meeting

The recruitment process was relatively straightforward, given that group members were colleagues of mine, who were involved from the formative stages of the project. In the early days, before the project had any real shape, I shared my interest in researching the SSG with my team. The response was positive, and the team said they would like to participate. This gave me the necessary impetus and permission to go off and create the project. Our monthly business meetings provided a forum for me to provide regular updates about my progress, checking out my ideas with them and informing them of the status of the project when required (namely receiving programme and ethical approval). Once the plan had been finalised and approval had been gained, I conducted a 'recruitment meeting' with the team to detail the research plan. This included a presentation on the process of cooperative inquiry and providing handouts (Appendix B). The team were able to ask questions about the research process. At the end of the meeting I issued participant information sheets (Appendix C) and consent forms (Appendix D) for the team to take away and reflect upon before signing. I invited them to discuss with me privately also if they wished. In addition, there was a collective decision to discuss any issues with individual supervisors or in the SSG if people needed to. I am unaware of any discussions taking place and by the end of the week all forms had been signed and returned to me.

5.6.4.2 Participants

A total of eight participants took part in the study (figure 5.6-2). Six of these identified themselves as female and two as males. The participants were mostly White British, with one participant identifying as Black Caribbean and one as White Irish.

Figure 5.6-2 Table of participants

Participant (pseudonym)	Age	Ethnicity	Gender	Position	Years in service	Modality	No.of grps attended
Rebecca	37	White British	Female	Psychotherapist	7	Integrative relational	6
Sarah	42	White British	Female	Deputy Lead	13	Psychodrama and OT	5
Amelia	64	White British	Female	Lead	1.5	Group Analysis	5
Grace	69	Black Caribbean	Female	Psychotherapist	20 +	Psychodrama	4
John	39	White British	Male	Psychotherapist	9	Psychodrama and OT	5
Siobhan	50	White Irish	Female	Psychotherapist	20 + years	CAT	5
Claire	63	White British	Female	Psychotherapist	20 + years	CAT	5
Paul		White British	Male	Psychiatrist	6 months	Medic	4

The participants consisted mostly of psychotherapists in the service with a broad range of specialisms. There was also one psychiatrist who was on his rotation as a core trainee (level 3) who took part. Due to unforeseen circumstances most participants were unable to attend every inquiry group session, however the majority of groups were attended by all participants.

5.6.5 Data collection: cooperative inquiry process

The first meeting initiated the inquiry process. Following this a total of 5 cycles of action and reflection were carried out. We ended the process with a closing group at the sixth meeting. The groups lasted between 75 minutes in duration. We met in the group therapy room of the service, which is also where we meet for our SSG. This room is large and white, with client artwork on the walls and a mixture of pink and blue armchairs that form a circle around the edges of the room. I arrived early before each group to set up the room, placing the chairs in a tight circle around a small table holding the recording equipment and water.

5.6.5.1 Cooperative inquiry group 1: initiating the process

The first research cycle was initiated by an inquiry group to brainstorm aims for the inquiry and early propositions about the SSG process. I briefly introduced the session, reminding members of the cooperative inquiry process. Introductions were not required as all members were familiar with one another.

The aim of the initial group was to initiate members into a collaborative process of inquiry (Reason &Heron 1996). We agreed upon the need for each and every member to explicitly state their agreement for any actions or decisions made in order to establish a collaborative process. Important decisions needed to be made about the research process in the first session. These were agreed upon by each member of the group:

1. Ground rules around confidentiality and active participation were established
2. A schedule of meeting weekly for 90 minutes and a commitment to attending as many sessions as possible
3. We agreed to meet for a total of six inquiry groups
4. The boundaries of discussion contents were clarified (distinguishing between talking about moments that had occurred in the SSG's and engaging in misplaced processing of team material during the inquiry groups themselves).
5. All meetings would be tape recorded and transcribed by myself
6. One member of the group nominated themselves to member check transcripts on behalf of the group. It was agreed that he could raise any issues with the group in the inquiry process. This role was open to other member's if they wished to member-check at a later stage
7. I would carry out an initial analysis of the themes raised in the first group. These would then be reflected upon more deeply in the subsequent research cycles, with the aim of deepening one or two themes roughly per cycle.
8. To support the linking of reflection and action, members could journal during experiential phases if they wished
9. Groups to follow a conversational, free flowing format
10. Members were free to raise any issues concerning these agreements at any point in the process for a collaborative review
11. Collective responsibility for maintain these guidelines

I am aware that this might present itself as rather an unproblematic list. The atmosphere of this discussion was one of 'agreeableness', nobody seemed to raise many objections, and decisions were made with apparent ease. I wondered if this was related to the therapeutic community influences on our work together as a team, as we were well versed in the art of collective decision-making about roles and responsibilities. There was an energy, including from me, of wanting to get through this swiftly and get down to the 'nitty gritty' of talking about our SSG. I think on the whole these agreements were easy to make because many of the guidelines decided upon were of a similar vein to other groups in the service that we

participated in together. Fortunately, these initial agreements served as well, no real dilemmas were posed and so they remained in the background of the rest of the inquiry process.

The group were unanimously clear that they did not wish to use the process as a means to change aspects of how the group was functioning. This seemed to be not so much as a 'if it ain't broke' mentality, but more a reflection of the upcoming merger and not wanting 'any more changes'. The SSG had served as a dependable and important space to attempt to process some of the monumental impact of the merger and it seemed that now was not the time to meddle with this. Instead it was agreed that the aims of the inquiry would be to deepen our understanding of the process of the SSG and to see how our espoused ideas about the group mapped onto our experiences. This suited my aims of using our experiences to provide a deeper conceptualisation of the SSG and its impact upon our work. I pointed out that as result of understanding the group more deeply some change might be inevitable. This led into a brief discussion about the difference between setting out with an intention to change and a more organic process of change borne through new understanding. I felt apprehensive, a burden lay quietly on my shoulders as I led the group into a process of which none of us could know the outcome, at a time when the team was at its most vulnerable.

Decisions having been made, the group settled into a free-flowing discussion about the SSG. This resulted in the group identifying some propositions to explore in the subsequent action and experience phase. These were noted on a flipchart and I later typed these and emailed them to the team (Appendix E). I carried out an initial analysis of the themes raised in the first group. These were then be reflected upon more deeply in the subsequent research cycles, with the aim of developing one or two themes roughly per cycle.

Groups 2-6

The following four research cycles followed a similar structure; namely meeting with an emphasis on bringing the experiential, from the previous week, into an articulated form of reflection. This was married with my bringing in some early, tentative categories that had emerged from the discussions of the first group. These were presented each meeting on a paper handout that was issued to each member of the group and much of the discussions arose out of a consideration of these (Appendix F). This handout sometimes served as a 'red-thread' for us to follow when we felt that we had lost our way (Thompson, 2018). It also contributed to the process of theoretical sampling and constant comparison whereby we attempted to define and refine our early ideas.

The meetings were alive in their nature. The group seemed genuinely motivated and engaged with the task of exploring their thoughts and experiences of the SSG. There was a nice range of people within the group, with older, more established members of the group who had experienced the SSG for several years weaving in the history of the group and its changes over time. This was married with the newer members bringing in the issue of 'joining' a well-established culture in the SSG and who were more able to offer outsider perspectives. The group supported each other to return to examples of experiences that also covered more recently attended SSG groups, so that the group in its present form was examined through the inquiry process. There was a spontaneous, devil's advocate style of challenge brought into some of the discussions. At times, each member of the group challenged what they thought were assumptions, too much certainty or providing disconfirming accounts. There was mutual participation and engagement demonstrating that this was a group that were well established in the process of openly reflecting with one another. A narrative began to establish that the research process was a 'refreshing' and 'creative' experience. This was a relief and a contrast to other meetings we were attending concerning cuts and the merger with another service. I struggled with guilty feelings that I was imposing further demands on an already stretched team. I was reminded by the team and the steering group that this research would not solely benefit me but was of value to the team also.

There was a co-created difficulty in establishing a truly collaborative process that ratified the group as 'co-researchers'. On the one hand the group were reluctant to take up too much responsibility or control for the sessions, the impression was that they were happy to attend and explore their experiences akin to a more typical research participant role. Similarly, with my internalised version of the 'doctoral requirements' I struggled to let go of my role as guide and initiator. There was a pressing need to get 'good' data about their experiences of the SSG as efficiently as possible and this may have compromised my ability to support the group to establish an exemplary cooperative inquiry process. This stirred up challenging feelings of both anger and anxiety in me: "we're not doing what we are supposed to be doing and my research will be compromised as a result!". Relief came during the many moments when the quality of discussion and exploration transcended the 'research project' in a free-flowing exchange of experiences and ideas that in and of themselves were challenging, affirming and meaningful for all of us.

During the process of research cycling we established Heron and Reason's (2001) four domains of knowledge. Propositional knowledge was established by the group's attendance to the espoused theories they had about the SSG. I would also be establishing the propositional further when I approached the analysis and the building of theory that was

grounded in our discussions. Presentational knowledge was achieved through the exchange of stories and memories about experiences in the group and their impact upon both individuals and the team. Experiential knowledge was established through the 'action' phases of the research cycles, with the inquiry process serving as a means to reconsider their experiences and ideas in a more visceral and embodied way. Finally, practical knowledge was also established through the ways in which the learning generated changes and in how members used the group, such as inquiring more actively when they noticed their uncertainty about another's state of mind. The team also realised an urgent need to include in the SSG the members of the other team who we would be merging with. This meant the first ever rescheduling of the SSG to a new day and time in order that the teams could begin merging in this group, prior to the official merger proper.

5.6.6 Data analysis and theory building

I transcribed the discussions from the inquiry group meetings and these were analysed using the principles of grounded theory coding. I found that the coding process was not a linear process, but instead I moved iteratively backwards and forwards between the levels of abstraction delineated through initial coding, focussed coding and the development of themes.

Initial coding was carried out in the form of line by line coding, which enabled me to interrogate the data closely. This facilitated my moving from the contextual pieces embedded in the transcripts to look at smaller units of meaning. As a result, hidden and unexpected communications in the participants' words were revealed. I used gerund verbs and in vivo coding to capture the actions and the voices of my participants. At times I felt myself lost in a sea of codes as I tried to capture every nuance of meaning I could in order to stay as close to the data as I could. However, as the analysis progressed I became more familiar with the codes that were forming and the process became more efficient. However, on the whole, line by line coding was time consuming and laborious, not the "speed and spontaneity" that Charmaz encourages (2006: 48).

Initial codes began to group together in what were my developing focussed codes, making my codes more inclusive of the initial codes and increasingly more analytic. As this happened, I followed the "analytic directions" they encouraged (Charmaz, 2006: 57), which took me back to the initial codes and forwards into potential categories which encompassed larger amounts of data. I found both the methods of constant comparison and memo-writing, a natural, almost automatic part of the process. Tentative categories were developed, amended, retitled and regrouped as I incorporated more of the initial codes within them. My memos moved from one

or two sentences into more complex perspectives on what I thought the data was capturing. A theoretical code emerged from this process in an ‘aha’ moment, as I considered a piece of data I had seen repeatedly in my coding process. Although I had not been striving for a theoretical code it was clear that I had stumbled upon an integrating point that brought together the focussed codes I had developed.

Data analysis was conducted using a combination of NVivo Software (QSR International, 2014) and hand sorting. I found the software invaluable in allowing me to navigate my way quickly through vast quantities of data. Codes could be easily linked to text and memos. A commonly cited criticism of utilising software is that it interferes with the creative and fluid process of analysis (Holton, 2007). This was not my experience: in fact, my creativity and intuition felt enhanced as the software held large volumes of data for me to play with. I did find there were times when I needed to ‘touch the data’, however. I listened to the recordings of the transcripts repeatedly throughout the process as this provided far more depth and richness than the words merely typed onto a page. I also printed off my initial codes in order to play with them and their potential groupings. Once organised, I was able to apply these new categories back to the software and link these to the original transcripts. I also hand-sorted my memos and journal in a similar way. The results of this process shall now be discussed in more detail in the following chapter.

6 Findings

6.1 Introduction

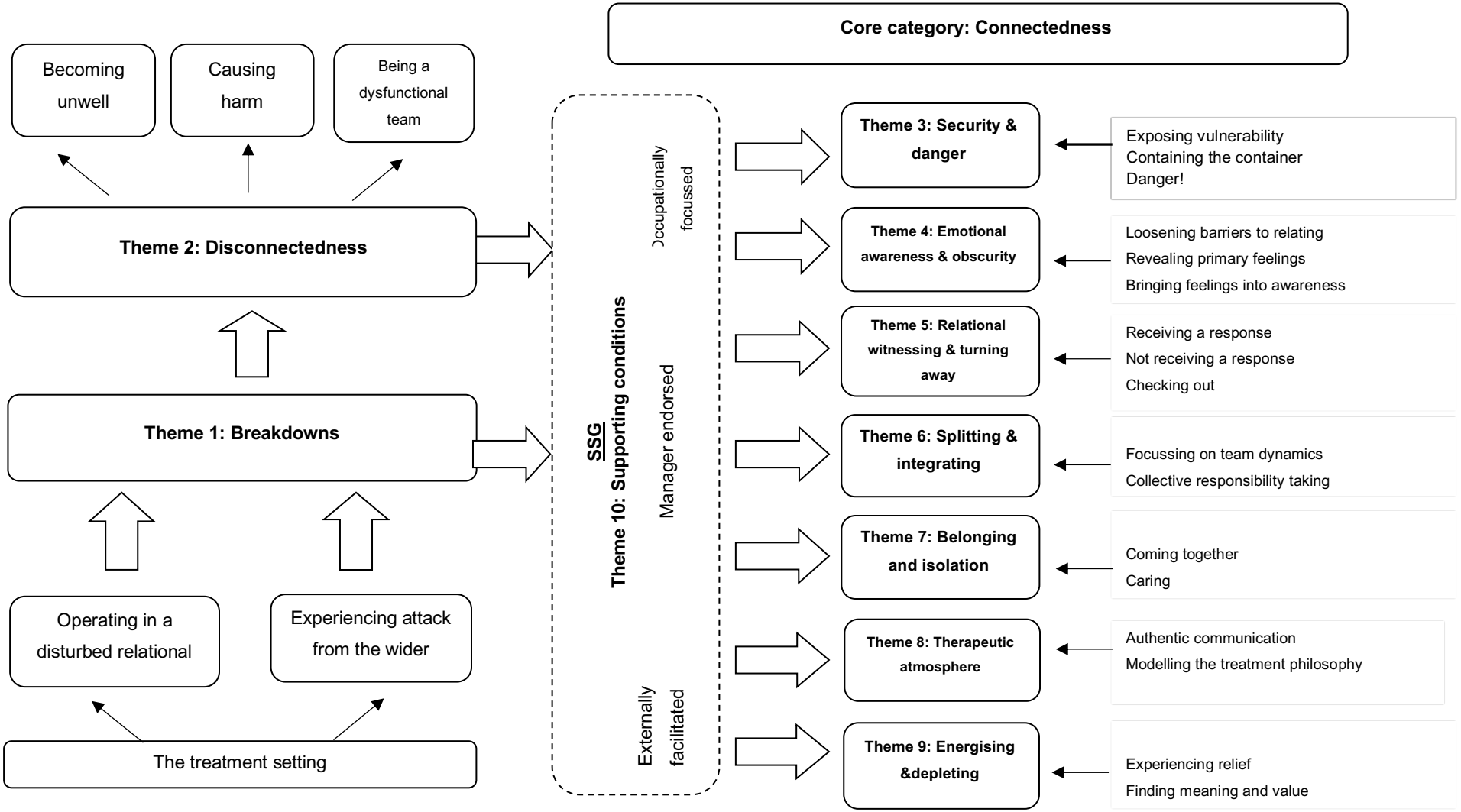
The cooperative inquiry process led to the staff team discussing their experiences of working in a personality disorder setting, how this impacted upon their team relationships and what they thought the SSGs function was in all of this. These discussions were transcribed and analysed according to constructivist grounded theory principles. The analysis led to the development of a model of the SSG that centres upon the core category of *connectedness* (see figure 6.1-1). Through the process of engaging in the SSG, team members experienced a restoration of their capacity to connect with their experiences and this state of connectedness had implications for both their experience of team relationships and their clinical work.

The model of connectedness incorporates a total of 10 themes. Firstly, the model indicates a rationale for offering staff an SSG within the treatment setting. Staff encounter regular and significant emotional and psychological pressures to dissociate and disconnect within this environment. These are experienced as interruptions to their capacity to remain available for the use-of-self that is required for the relationally based treatment model. These were identified through the first two themes: (1) Breakdowns and (2) Disconnectedness.

The model of connectedness also incorporates a further 7 inter-related themes which appear to capture the nature of staff experiences that elucidate *how* the SSG group works in its capacity to restore connectedness:

3. Security and danger
4. Emotional awareness and obscurity
5. Relational witnessing and turning away
6. Integrating and splitting
7. Belonging and isolation
8. Developing a therapeutic atmosphere
9. Energising and depleting

Figure 6.1-1 Higher order model of connectedness



By encountering these processes in the SSG, the clinical team experience a ‘restoration’ of connectedness. However, in examining their experiences, the findings also identified that the staff team do not think this is always the case. This led to the development of a further theme (10) Supporting conditions, to capture what is required to make the process ‘work’ for team members. The theme of supporting conditions contains three subthemes or qualities: ‘externally facilitated’; ‘manager endorsed’ and ‘occupationally focussed’.

Core category: *Connectedness*

This core category uses the in-vivo terms ‘connected’ and ‘connectedness’. These emerged during the final cooperative inquiry group, as the team reworked some of the narratives about the function and purpose of the SSG within a personality disorder service. It was an important moment for the collective understanding of the group when Sarah said the following:

> Sarah: I think it's about, I think it's about the relational process. I think it's about that, fundamentally we hold a philosophy and view that it is in relationships that people grow, heal and develop. As well as become damaged, and all of that. And that actually, what we are doing, what the patients are attacking, when we talk about an ‘attack on thinking’, I am not sure it is an attack on thinking that happens. I think it’s about attacking connection. I think it’s about attacking connectedness. And when they attack us, our wish is to withdraw, in all sorts of ways actually. And I think that the purpose of the staff group is to get back to a place where we have a wish and a desire to connect with them on a relational level.
>
> Which is you know, I think what we were struggling with, about the Trust’s attack on the psychodynamic model. You know it’s a relational model, not a technique-based model, which is what the Trust are trying to throw at us all the time. We are just so under attack about the fact that we think you know, that relationships are the way to heal things, fundamentally.
>
> You know people are not here because of their symptoms, are they? They are the consequence of their problems in relationships. Which is kinda stating the bleeding obvious to us but actually, we lose sight of that don’t we? And in the staff group we are saying it’s that, that is what we are trying to stay in touch with. It’s that need to connect and be vulnerable. You can only connect if you’re vulnerable. And there’s something about us being in that staff group together and being vulnerable. And I think that is a massive part of, because we need to be able to do that with our patients and I don’t think you can do that if you can’t stay connected.

Connectedness is seen as the key mechanism, which drives the relational practice of the team, both in terms of understanding the patient’s difficulties and how to address these issues

creatively and spontaneously within the therapeutic relationship. This requires an awareness of how staff are thinking and feeling, particularly around their vulnerabilities. This is seen to be essential in re-establishing the will and desire to stay engaged with clients and their treatment. Connectedness protects against defensive practices, enabling clinicians to continue to respond benevolently to psychic attacks and the manifestations of earlier damage and trauma as they arise in the relationships. Moreover, connectedness captures the availability for establishing meaningful and authentic attachments at work in the face of dynamics that are characterised by fragmentation, disruption and dissociation.

It is understood by the team that the relational disturbance of the treatment setting is one which impacts upon clinicians' capacity to remain connected with patient's, one another and themselves. The SSG provides the space where the breakdowns in relational connectedness are re-established and repaired.

> Rebecca: If you are out there and you are getting all these experiences that do attack your ability to kind of connect then you need to go somewhere where you switch those lights back on. It's almost like going to recharge a 'connecting-battery', you know, going to the staff group.

The SSG thus becomes a re-integrating space, a point in the week where team members can reconnect with themselves and with each other about what they have been experiencing. This accentuates the intrapsychic dimension of connectedness; how one can return to a state of recognition and experiencing of that which is happening within.

> Rebecca: I was thinking about self-integration in terms of like how helpful it can be to come - and it's good that it's sort of towards the end of the week - you kind of sit and go, "How have I been feeling this week?" - "What have I not – Wh - what am I still with this week?" You know, 'cause you have all these, um, experiences, don't you, that are often highly, um, impactful, one way or another, as a team and as a clinician, and, you know, in your groups and yet you just have to keep on going, holding sessions, facilitating groups, attending meetings. The SSG kind of allows you to kind of draw all that in. So, what do I need to say about this week that's kind of topmost? I think that's quite sort of integrating as well, isn't it?

The SSG is understood as a replication of a healthy developmental-model: a mirroring of parents, coming together at the end of the day to reconnect with each other, to re-establish the parental and adult relationship so that the capacity and wish to remain connected with the child is restored and maintained.

> Sarah: It's quite a difficult thing to articulate, but what I'm trying to say is that actually I think it's a very ordinary thing, to sit, if you're trying to work with relationships as a means of something growing and developing, which we would with our kids. You sit and you talk together. There are ways that you need to process stuff together to get back to a place of understanding and attunement and connectedness. Which is what we are saying our patients need to get better, isn't it? Fundamentally?

In this way the state of connectedness between team members is essential for providing clients with an experience of attunement and attachment. This spells out the interpersonal dimension of connectedness and its importance in team work.

6.2 Theme 1: Breakdowns

It felt important for members to establish a rationale for the group, particularly given the current context of threat to the model imposed by senior management and the wider Trust. This led to the development of the category ‘breakdowns’, which identifies staff experiences of disruptions to connectedness in this setting via two processes: (1) operating in a disturbed relational context; and (2) experiencing attack from the wider system.

6.2.1 Operating in a disturbed relational context

Due to the relational dynamics that are characteristic of working with clients with a diagnosis of personality disorder, the service constitutes a ‘disturbed relational frame’. This exposes the team to highly charged relational events that are extreme and regular. These include a range of anti-therapy behaviours that undermine the treatment progress and provoke withdrawal: suicidal and self-harm acts; chronic depression and hopelessness; anger and rage towards staff, other clients and the external world; and stories of sexual and physical abuse. These events are stressful and destabilising and interrupt both intrapsychic and the interpersonal dimensions of connectedness.

> Amelia: And yesterday, like in - that (therapy group) - just felt, "God, what a day. All these groups are so deep and dark and hopeless." You know, and that (therapy) group is so hopeless, and thinking, "God”. You've got to have a team around you to survive it and to ha- or you’ll lose sight of - "Have we done anything? Was it all just a pissing waste of time? They haven't got anything?" You know, just slumped. You know [laughs] And feeling like, "Oh God!" you know, "Have I wasted all my life in this stuff?" [Laughs]

Grace: I would talk about my experiences with the patients, who were extremely aggressive, and some of the things that we - we exper - we encountered with them that, you know, the facilitator didn't even take seriously - or not so much didn't take seriously. They were quite, um, what's the word when somebody's unbelieving and they're, um - incredulous. The incredulity was there.

However, it is not just major, more obvious incidents, which cause a breakdown in connectedness for team members. On analysis of the data I began to recognise the pernicious impact of the day-to-day relational exchanges that could almost be missed.

Rebecca: And I remember her (client) asking me what size my feet were and whether I'd like to try on her boots. And for a brief moment I was absolutely terrified, frozen, you know that, er, er, extreme rush of adrenaline, my heart was pounding and I just said, "no thanks" and carried on to the office. (Laughs). I don't think I'd ever even remembered that 'til now.

John: There can be degrees of aggression. Direct or indirect. It could be people being- saying nothing. It could just be sometimes a presence in the room. Doesn't have to be verbal.
Amelia: Can be in the down time - like flirting you know that sort of thing. Like (Client) and how he comes with the, " Did you miss me over the weekend?" You know and I'm like "yeah!" - it's like is that a good response? You know. It's like can I even bring that back to the group? Why did I say that? Or the likes of (female client) and how you (John) are idealised and it can be hard to/
John: Think or speak/you get paranoid
Amelia: Challenge that
Siobhan: Yeah. It is very difficult, isn't it? I think sometimes it's easy to kind of, I don't know if, kind of avoid or wanna forget. Or kind of just, you know, collude or just make a joke about

These encounters on a surface level could be misinterpreted as minor or innocuous. However, they trigger a profound and visceral response that indicates a disintegration of self. Any connection to self is momentarily lost, evidenced by an inability to think or respond authentically to the encounter.

6.2.2 Experiencing attack from the wider system

The wider organisation is experienced as a non-reflective and reactive system, which is experienced as an attack on connectedness. This attack is experienced as deliberate, as if the emotional needs of the team are intolerable. Staff experience a split, where the team's relational values and practices are dehumanised by the Trust's need for standardisation and measurement. Both experience each other as a threat. This was particularly acute during the

data collection phase of the research as the team were simultaneously trying to piece-back-together the organisation's annihilation of the service and its longstanding model in the proposed merger.

> Amelia: They've suddenly discovered that there is such a thing as a reflective space! But I remember, I remember at that event there were loads and loads of nurses there who are obviously desperate for some sort of reflective thought, thinking, support and their manager stands up and says, "say you gave staff a space and all they did was moan". Like that couldn't possibly be allowed to happen! "Yeah, they'll just moan". Like there was no sense that it could help someone to be able to start with a moan and then it goes somewhere. You know, you just don't wanna hear about the moan, so "shut up. Stay quiet". And that to me just sums it up, you know. If that's what they think, "We're just moaning," how are you gonna get through that, you know?

> Amelia: Especially in this climate. As you say - where things like the TC model, or any sort of parallel process or psychodynamic thinking is just not wanted
> Paul: You gotta justify things in a numerical way
> Siobhan: Yes. "Where's the evidence?!"

> Rebecca: Like, our, now, our new appraisal system.
> Amelia: Oh God.
> Rebecca: Do you know what I mean? It's now actually preferable that you don't even dialogue with each other.
> Sarah: It's incredible.
> Amelia: Yeah, "cut out the dialogue and sit in front of a computer".

The team experience a twofold pressure to disconnect and detach both from inside and outside the service. These are pressures pushing the team not to see, speak, think or feel at work. This is a striking contrast to the treatment model which prioritises relatedness and healing through relationship and dialogue. The team also described their anxiety about the personal and professional fall out of remaining in a state of disconnectedness. It is the fears associated with disconnectedness, to which we turn in the next category.

6.3 Theme 2 : Disconnectedness

The impact of remaining dissociated from one's experiences at work is perceived as potentially damaging to staff, clients and the overall effectiveness of the team. In the team's experience it is this category that establishes a rationale for structures in psychiatric services that address

issues of connectedness and disconnectedness. Three core processes were identified within the experience of disconnectedness: (1) becoming unwell; (2) causing harm; and (3) being a dysfunctional team.

6.3.1 Becoming unwell

Staff describe states of paranoia, fear, anxiety, sadness, despair and anger in response to their clinical work. They describe coping with these heightened emotions through dissociating or disconnecting from their experiences. This relates to experiencing isolation and withdrawal, which they see as a significant feature in psychological and physical breakdowns.

> John: and I think there's a fear of going mad. I've sometimes thought, "God, I'm going mad here" and that - and this work can generate that fear. And that's generally in psychiatry, "Am I gonna go mad if I, if I'm gonna be working in it"?
> Amelia: Or if I go near my feelings about this. I suppose if you do feel like you're vulnerable and there there's all this madness around you, like it, I think you probably do go into coping mode don't you? The thought of exposing it would be terrifying…unless there's safety
> Siobhan: I think in some places it might be easier to differentiate yourself/
> Amelia: That's true. Yeah/
> Siobhan: like if you're working with someone who is floridly psychotic then you can be the one whose/
> Rebecca: Not!/
> Siobhan: reasonably together! Whereas in this kind of work, with personalities, it can be much more "what's mine?", "what's theirs?" [Laughs]. You know?
> Amelia: Yes. The clients are always picking up on your issues/
> Chris: yes, and your vulnerabilities/
> Group: Yeah. Yeah/
> John: and your Achilles heels.
> Siobhan: It feels much closer, to, you know, potential, your own potential to expose your own personality disorder [laughs]
> John: Yeah, you can't hide here can you?
> Siobhan: Its hard isn't it…that feels much more…harder
> John: yeah risky. Frightening?
> Siobhan: yeah. Frightening. You're vulnerable.

> John: I think it's arguable that doesn't happen (talking about one's fears at work), then people become isolated; I think people could then become unwell. And I think that leads to staff sickness…that leads to staff mistreating patients or leaving the service…and yeah, that affects retention, recruitment, sickness. Probably hard to evidence but it's kind of striking I guess in this, probably this team and maybe in (other local P.D service which attends a similar

group), they're the services that have had the staff that's been there the longest, that probably have lower levels of sickness. You compare that to a psychiatric inpatient ward or community mental health team there's high levels of sickness, high levels of recruitment and, er, difficulties in getting people in posts. It makes sense.

The team view isolation as a threat to wellbeing as the disturbances in their minds are removed from the normalising, protective and integrating experiences that are made available through connecting with one another.

6.3.2 Causing harm

The team were preoccupied with their potential to cause harm if they did not attend to the quality of connectedness in their clinical relationships. Being consistently related to as someone with malignant intentions takes its toll on staff, as such there is a fear that this could manifest in the 'acting-out' of feelings that have not been acknowledged, expressed or remain out of awareness in the relationship.

Staff utilise psychoanalytic ideas to understand their potential to damage clients if they do not attend to managing their disconnectedness at work. In particular, the concept of projective identification supports their understanding of the potential risks of taking on the qualities of the abusive caregiver. They view this as an unconscious provocation to re-enact and repeat past relational traumas.

Amelia: But I suppose it's also, I feel like I'm trying to juggle so many different positions, that I can never take a position. You know, it's like, how do you get to the point where, you know, you can just take a position as well? And not be worried that it's a neg - a pathological one or based on acting out, rather than thought or, you know. Like that's why the whole thing with X (Client) has been so tricky, I think. 'Cause there's so much being rammed into us, that could lead us to act out, you know. And the thought about how do we think when we're under so much pressure, and not just either give in, 'cause it's easier - or hold firm with this decision - and then the experience is punitive, but is there a sadistic element, because she is pissing us off? Or you know, blah-blah-blah-blah-blah
Rebecca: There is so much literature out there at the moment on the vicarious traumatisation of therapists who work with extremely damaged clients. And actually, and again, the vehicle is the relationship, but whilst the relationship is one that can, um, 'heal' – I can't think of a better word for it right now/
Sarah: But it can also traumatise/
Rebecca: it can also traumatise/
Sarah: Yeah, absolutely
Rebecca: the therapists –

Sarah: Oh, I was thinking it was where it can actually traumatise/
Rebecca and Sarah: the clients.
Rebecca: Well yeah, but it can come back to the therapist. The therapist gets stressed out, the therapist can't sleep, the therapist becomes preoccupied. What is that that happens to us, you know, when we are working with someone? And the dangers are that we disconnect, we withdraw, we breakdown, we leave, we can't hack it anymore [laughs]
Sarah: Well, um, also it's a process; I mean psychoanalytically its projective identification isn't it? We then start to act-out the very, you know, the uncaring, the aggressive or the abusive caregiver, inadvertently. By withholding, by challenging, by shaming, or, you know, whatever it is.

Staff are particularly mindful of the power they hold in their clinical relationships and how the domain of clinical decision-making is a likely arena for potential harm to take place. This highlights the significance for the team in managing the interpersonal dimensions of the connectedness-disconnectedness dialectic as a duty of care to clients.

6.3.3 Being a dysfunctional team

The service is a stressful and fast-paced environment, where the interactions are emotionally intense. One area of concern for the team is the impact this could have on the overall functioning and effectiveness of the team.

Rebecca: It was that sort of primitive deep process that we're in where we are all sort of sitting in a room trying to get on with a task, and actually -
Amelia: Yes, there's all these primitive feelings going on. Fuck the task!
Group: [laughs]

Staff utilise the psychodynamic concept of 'splitting' as means for understanding elements of dysfunctional team dynamics. This captures their experiences of taking up rigidly different polarised, or incomplete clinical positions. The team hold the view that splitting can occur as a result of disintegrated self-states of clients and their relational manifestations and as a result of unexpressed feelings within the team. Without a team-based appreciation of these, useful information for understanding and formulating clients' difficulties and team dynamics is thought to be lost. Splitting is thought to lead to an incohesive and inconsistent treatment model, which is viewed as the ultimate failing for clients.

John: Because there was a problem. There was a breakdown in our communication wasn't there? Because as a result of us discussing that issue that you just described in the staff

group, I remember subsequently coming to you after and being much more clearer about what was said, about what (client) said and you are right I had missed bits out.
Sarah: And what (facilitator) would say is that your feelings somehow got in the way of you being transparent and honest with Grace. You weren't adequately informed in a way that then really impacted on your-- the way you handled your relationship with that patient. So, therefore clinically, it was a problem. I think that's an example of where, actually, if you are not talking about your feelings towards each other
Amelia: Or you're not so aware
Sarah: Or yeah, if you are not aware of them, you know, then then then, then it impacts upon the clinical work with the clients
Rebecca: So, it's about the feelings we have towards one another and how, how that impacts on a sort of inability to think openly about a client in a way that, that is clinically helpful.

We can see how the team is concerned about the potential for breakdowns on multiple levels, whether that is staff members who breakdown, therapeutic relationships which breakdown or team functioning which breaks-down. There is an implied relationship, with each level of breakdown likely to impact upon the other. Staff wellbeing did feature as a concern, but the team were far more preoccupied with the quality of team dynamics and functioning. Personal gains did not matter as much as their duty of care to clients and heir capacity to serve as emotionally available, benign objects holding severe levels of disturbance through a cohesive and stable team.

6.4 Connectedness

The first two themes suggest the need for supports to be in place for the team to maintain their engagement in their work and with each other in order to offer something relationally useful and meaningful to clients. The SSG is viewed by the team as a vital point in the week where this can happen.

Claire: For me, it is part of the fabric of the program, that it is absolutely essential that we have one

Sarah: "It's the - it's the most important thing that we do is come together and be authentic with each other, in the face of everything."

But what is it that happens in the SSG that addresses issues of connectedness for the team? What are the processes through which this takes place? The data led me to 7 discrete but interrelated themes of experience that make explicit *how* the SSG works. These were: (3)

security and danger; (4) emotional awareness and obscurity; (5) relational witnessing and turning away; (6) integrating and splitting; (7) belonging and isolation; (8) developing a therapeutic atmosphere; and (9) energising and depleting. Each of these themes incorporates a number of processes that illuminate how the SSG is operating in order to restore the connectedness of the team. These themes and their related processes shall now be illustrated.

6.4.1 Theme 3: Security and danger

The SSG is experienced by the team as a safe space; a reliable point in the week where they can reflect on the experiences and emotions that are the most in need of attention. Although other meetings are held, this space is particular because the focus is not on the clients, rather the priority is taking care of the staff and their relationships with one another.

> Amelia: it's the safe space where we can talk and process
>
> Siobhan: there is something about that group making me feel secure.
> Sarah: because it's the only structure that feels safe and contained at the moment
> Siobhan: Yes. It feels safe.

6.4.1.1 Exposing vulnerability

Through this experience of safety and security, the team can let go of the function of being the container and allow some of the disturbance and vulnerability to be expressed. These are the individual or relational experiences that are causing anxiety or distress within team. The group can therefore often feel uncomfortable, exposing and painful.

> John: Um, I think, uh, I've said things in this SSG I haven't ever shared with other staff teams before. To me, this generally feels a secure place.
>
> Paul: In- in- in a way there's vulnerability there, and I guess feelings are a bit like that. And I guess there's other things. There's, there's that, for me, fear, fear of upsetting someone. Or not believing, my, my thought or fear might be quite irrational or not very sensible and I think that's quite vulnerable as well. Cause if I'm actually having quite an irrational thought here, or not very PC sort of thing, it's a big deal to actually say that. Like being angry with someone, well maybe you shouldn't say that. That can be difficult, for me, to say to someone.

> Rebecca: But I really remember once being able to give the team something of what I was experiencing, how frightened and upset I was, it changed my relationship with the team, I felt much more a part of something. I felt much more secure in the team and then that made me much more secure in going about my clinical interactions as well. A bit like in terms of an attachment really, I had a secure base and then I could go off with a sense of secureness and take a few more risks with clients.

Through the expression of vulnerabilities, staff feel able to establish an emotional connection with one another. This is thought to strengthen the bonds between them. Staff describe taking-in or internalising this attachment and security, which they can then utilise to remain emotionally engaged in their clinical work.

6.4.1.2 Containing the container

The SSG is experienced as a container for the disturbances that are encountered. It becomes a space and point in time where emotional material can be held, a place to put the anxiety, confusion and distress that is being carried. This appears to provide continuity for the team, who are supported by the very presence of the group in their minds.

> John: Coming together in a space where those bits of the, kind of, work and how you feel about it-how we all feel about it, is brought together in one place, to me helps integrate me - in my mind, and helps to integrate the team. Which I hope, enables me to be a better therapist and a team member that's effective

> Siobhan: So, I thought it was really helpful to, kind of, just have that in mind, just from what we had been talking about on Tuesday, and then just, kind of, holding onto it and then, kind of, being able to, kind of, put it in the group, actually. And that's good because then that can be kind of held there, can't it? And then-you can kinda come- come back to it or, you know, not be holding onto things

As a container, the SSG provides a physical space where one's experiences can be taken to be organised and formulated. By dispersing their experiences through the group, staff, at times, are able to let go and leave behind that which has been preoccupying them or causing them concern.

6.4.1.3 Danger!

There is a need for balancing sensitivity and robustness when vulnerabilities are being explored. This is sometimes lacking in the group, particularly when staff are challenging one another and attempting to work-through relational dynamics. Staff members can get polarised

into positions of ‘attack’ and ‘defend’, which compromises the felt safety of the group. These could be understood as a manifestation of the disturbed relational context described previously. The staff have therefore experienced times when the group has not felt safe. Sometimes safety can be restored in the group but other times it cannot. This is understood as a contributing factor to irreparable relationship breakdowns with individuals who have subsequently left the team. These missing voices feature as a presence in the inquiry groups, a somewhat threatening reminder of the precariousness of the security upon which they are dependent.

> Siobhan: I, you know, I think over the years it's been very difficult to be in actually. It's been a bit cutthroat actually. [Laughs]. I have to say there have been times when it has not been that supportive to me. I think that’s down to when it starts, when it’s conflictual. I think I’ve been pushed into thinking, "Am I on this side? Am I on that side?" and it's felt really unpleasant. And I can see it as a kind of a given that it, you know, it-it's a good idea and there's something about it that makes sense to me, but it's not always been very easy place to be, I don't think.

> Grace: It was just such a disaster. It was really, it felt really, actually it became really quite awful. It wasn't a good experience. Yeah. Tough place to be actually. Far from being safe.

However, even when staff experience the group as difficult and contentious, there is a belief that something useful and valuable can be gained by sticking with the process and working through these difficulties over time. This is associated with learning and growth through the development of self-awareness and resilience.

> Claire: For a long time, and it was awful, actually-- this sounds a bit sadistic, but there was something about, we had to get through, to get to a particular point. It was really hard, and the way I think about the group now and the position we're in, for me, certainly-- it feels like we are all a very different group of people.

> Grace: It's kind of difficult really. It-it does take a lot of, um, robustness to sit things through or work it through but, you know, sometimes you have to sit it through before you can work it through. That can only be a good thing if you have a willingness to use this methodology to help us in the work, to develop here and stand up to what needs to be faced

So, on the whole, through experiencing security, staff are more able to acknowledge and share their vulnerabilities, which promotes secure attachments amongst the team. This is experienced as being internalised, enabling staff members to engage more fully in their clinical relationships. However, the group sometimes feels unsafe and this can feel ‘awful’ and

‘terrible’ for staff. There was discussion about past ‘victims’ of this who did not experience sufficient security and left the team. Yet, through more challenging experiences, there remains an overall hope and intention to work at it in order to re-establish the experience of security in the team. This in turn re-establishes the experience of attachment and connectedness amongst team members.

6.4.2 Theme 4: Emotional awareness and obscurity

There is an anxiety in the team about unrecognised and unacknowledged feelings and their potential to be acted-out in destructive and pathological ways. There was a forceful consensus amongst the team that a primary focus of the SSG is to name and process feelings.

> Amelia: I certainly missed the staff group last week because I was very aware that from the (business) meeting that I felt left with some feelings but then missed out on the safe space where we could talk about it and process it, so I was very aware that I haven't really processed -- and wanting to, sort of, um, check it out with other people because sometimes you're-- you're left feeling slightly paranoid or slightly like, "I can't read what other people are feeling and it might be completely different."

> Amelia: You need to engage in the feelings in order to really believe in the work, I think, and that's why that staff group is so crucial, 'cause it helps make sense of the work in a very visceral and emotionally thoughtful way. 'Cause otherwise, you do just split off, you know, your own feelings from the work. You think you can. Well, you can't, but you cannot think about it, and then end up acting it out, you know, minimizing or dismissing it. [Pauses] Or bailing out. [Chuckles]

> Sarah: You know, there's an acknowledgment of my feeling when you said that. Which then made me feel like -- in terms of not acting out. I might not then -- I don't know, be a bit distant from you or act out. You know, I don't know. In some other way.

The team describe the SSG serving the function of a container for the primitive and intolerable anxieties that are faced. These might be feelings absorbed from clinical interactions and/or the primitive qualities that emerge from the group dynamics of the team.

> Siobhan: And I think then, for me, I was very conscious then of being able to, kind of, go and be in the staff group on Thursday, and being able to, kind of, talk a bit more about that (Service) meeting in that sense of, kind of, "Why was I quiet in that meeting? And, you know, why was Sarah saying quite a lot in that meeting? And then, we talked quite a lot then, didn't we; about all the feelings we had about it all?

> Grace: There was an acknowledgement, actually, that this is really real, and, um, it stopped me from being stuck. So much so that yesterday I was able to not just be sort of licking my wounds, I was able to then think about other things. I-I was quite taken aback yesterday at how much actually, when I felt less preoccupied with what was going on between me and her, between the pair of us, I was able to recall what felt to me significant things that we had lost sight of

It would seem that central to moving from obscurity to awareness is the task of articulating the feeling state, of putting it into words. This supports a mutual acknowledgement of each other's experience and the moving from polarised and rigid positions into a more reflective state. The data suggested four processes encountered in the SSG that contributed to this: (1) loosening barriers to relating; (2) revealing primary feelings; (3) bringing feelings into awareness; and (4) holding back.

6.4.2.1 Loosening barriers to relating

The analysis pointed to 3 different ways that staff re-connect with their affective experiences in the group. The first process concerns when staff are aware of feelings they have towards each other but have not had them acknowledged in the relationship. At these times, staff feel stuck or blocked; the feelings are held in the relationship, acting as a barrier to authenticity and connection.

> Amelia: I thought it was useful for me to be able to just tell (team member) that when she said that to you that I felt quite angry. And because it was- it was a little block, in my relationship with her but I couldn't say it. So, it felt like that when I could -- it meant I could just sort of put it behind me. And actually, she dealt with it fine and it opened up a few things. That to me is an indication of how important it is for us to know the process of how difficult it is to say something like that, but how important it is because if we don't, it just sits there. And it can get in the way in the relationships.

> Sarah: So, it was a relief, you know, in a way to kind of - I'll tell you what it is, it's because I had felt annoyed with you. Again. Until you said, "All I could hear was Sarah's voice in my head." You know, there's an acknowledgment of my feeling when you said that.

Staff experience being freed up from their stuck positions through a relational interchange that acknowledges each other's feelings. This is experienced as leading to new, shared understandings.

6.4.2.2 Revealing primary feelings

Staff members might also reframe their original, perhaps defensive experiences to reach a more attuned connectedness with themselves and others. This is experienced when secondary feelings are moved through the process of reflection, to reveal the primary affect underneath.

> Sarah: I think what was useful for me in Thursday's staff group in relation to that issue was that I hadn't -- until that staff group, I think I hadn't fully acknowledged the sort of negative feelings that I'd had about that meeting--'cause actually after it, I kind of thought, "Oh, I felt like -- on, okay, that was alright." . So, I had really been in touch with that earlier on in the week, so when we got to the staff group, and hearing you sort of talk about -- I don't know who spoke first about-about it. I think we all -- It was kind of, actually, I got back in touch with actually, "Ugh, actually, that meeting felt so difficult." You know, and I -- and I tend to do that, you know try and be optimistic in the face of something really quite awful.

Through the uncovering of primary feelings, the SSG supports the team to reach a more authentic and attuned state of contact with oneself and with each other. It would seem that this cannot be done on one's own. It is through the relational interchange of the SSG that this fuller, more complete account of one's experience can be brought into awareness.

6.4.2.3 Bringing feelings into awareness

The team also feel they support each other to recognise feelings that might otherwise sit outside of individual or collective awareness. They engage in a collaborative process of providing feedback and questioning of one another, often referred to as 'checking out. Checking-out is thought to help clarify feelings that might underlie particular interactions. This role is sometimes taken up by the external facilitator who is in a unique position to bring attention to her experience of what is out of the collective awareness.

> Siobhan: It was quite helpful when you said, "You - you know, I get again that you're overwhelmed." 'Cause I still - can't quite work that out though even, "What did I say to let you know that - how was I saying things, what made you come to that conclusion?" and - and I'm still kind of thinking about that.

> Rebecca: I was thinking that the SSG on Thursday, in terms of how - helping us to name the awfulness of some very subtle things, actually. That you could almost, sort of, miss. Like when she commented the state of the room…how it looks so neglected…reminding us what it's like to feel you say something and it politely gets brushed aside. That was something that for me

- It really, really struck me as sort of, "Yes, I have found that incredibly painful actually that," but she had to sort of help me to allow myself to go there.

All three of these processes were reported to develop awareness of what one another is feeling and facilitate an authentic relational exchange as a result. Articulating affect or putting feelings into words is therefore viewed as a central action of the SSG, which influences the intrapsychic and interpersonal dimensions of connectedness.

6.4.2.4 Holding back

Despite the group's collective agreement about the importance of naming and processing feelings amongst the team, this is often a task that poses a number of dilemmas for individuals. There was a concern about the potential for 'dumping' emotional material on one another that might not be useful or relevant for the group; concerns about the group's capacity to receive one's feelings non-defensively; there were also concerns about the potential impact of 'knowing', for self and other, and a questioning of whether this is always best or helpful. This holding back on account of one's uncertainty and doubt can leave the group stuck and speechless at times.

Siobhan: Well, it's the difficulties but I think partly bringing in your - one's anxieties into a group when we haven't sort of fully formed them properly. You know and kinda thinking, you know, it's difficult, isn't it? Just, um, not wanting to kinda provoke something unnecessarily - or, you know. How do you-- I don't know. To be ab- to be able to really be honest about those. I think it's really really hard.
Amelia: Yeah 'cause you have to watch out that you're not so unprocessed. That you're just dumping something that isn't appropriate

Rebecca: And what do you think stops you from doing that checking-out where people are at more?
Siobhan: I don't know actually.
Amelia: Fear of knowing (laughs). 'Cause then you have to deal with it.
Siobhan: Maybe to some extent. Maybe - then maybe somebody will ask me back. [Laughs]. And I don't quite know maybe what I'm feeling or I don't know if I want people to know maybe. Maybe there is that bit, maybe that kind of concern about being destructive. "Am I that?" or you know, like you're question about "how am I coming across?" "What am I bringing in?" "Am I bringing in something that's not very palatable or wanted or needed, maybe, you know? So, then I kinda stop myself. Don't know if that's mixed in with maybe not wanting to know what the other person might be thinking or feeling.
Rebecca: This is a bit of a dilemma. [Laughs]. Wanting to know—not wanting to know.

I was reminded of the words of our facilitator as I encountered this issue of withholding feelings in the analysis. Her position is always that we should speak to one another, that we must say how we feel. She interprets our rationale for withholding from one another as persecutory anxiety, that if allowed to dominate in our relationships with one another will breed paranoia, isolation and a misrepresentation of the other as either potentially damaging or fragile. This highlights how, when working with such trauma and disturbance, the pull and desire to disconnect and dissociate is strong. Each of us requires the support of the team and the SSG to resist it.

Sarah: Mm-hmm. I suppose I'm just saying it- it's- it's the first time I've ever really questioned that. You know, in terms of this research.
Amelia: You mean the limits of it?
Siobhan: The value of it?
Sarah: The value. You know, is it useful?
Siobhan: Is it useful to be open, honest, transparent?
Sarah: Yes!
Siobhan: Saying things, how you feel…
Sarah: Yeah.
Rebecca: To know how depressed you are.
Sarah: Yes, exactly. Is it that helpful to other people? I sort of feel, particularly for me, now, I feel am I just shitting on everyone
[Laughter]
Amelia: No, to me, it's helpful.
Sarah: [laughs] And then, you know, right now it just didn't—
John: Shit more
[Laughter]
Sarah: What did you say?
John: Shit more.
[Laughter]
Siobhan: Bring it on!
[Laughter]

The SSG is therefore a place to name and process feelings in the team, which contributed in restoring and maintaining interpersonal connectedness and minimising the potential for acting out. However, there was also a great deal of focus on the difficulty of talking about how one feels: the lure of remaining disconnected. There are times when members require the support of the group to move out of what is thought to be persecutory fantasy and into a robust understanding of the relational necessity of authentic communication.

6.4.3 Theme 5: Relational witnessing and turning away

The experience of noticing each other and being noticed was identified as an important experience that takes place in the SSG. The previous category indicated the importance of recognising what one is feeling, whilst this category is about the relational process of one's state of mind being seen, received and understood by the group. I have therefore termed this 'relational witnessing': the intersubjective act of sharing and reaching collaborative understandings of one another and our experiences. The data led to four processes that contributed to the experience of relational witnessing and turning away. These were (1) receiving a response; (2) not receiving a response; (3) checking-out and; (4) learning about yourself through others' experience.

6.4.3.1 Receiving a response

A core feature of relational witnessing appears to involve responding to one another. When someone responds it can confirm that they have seen something of the other and are holding it in mind.

> John: Like (therapist) said you can have a response from someone that can be firm. Or it can be just a response that says they understand. Or just to have it witnessed can be supportive. Can make you feel secure and strengthened.

> Sarah: That can be quite helpful, that other people can notice that you might be struggling a bit and-that- I think those are the times when I'm more likely to bring something in, when another person notices me, can see that there is something going on for me.

A response might be acknowledging what has been said, identifying with it or challenging it. Indeed, it appears that it is not so much about how one responds but that there has been a response; there is always the possibility of clarifying and working through misunderstandings, mis-attunement and misrepresentations if people are able to openly respond to one another. At the most basic level a response appears to communicate one's willingness to be connected with the other.

6.4.3.2 Not receiving a response

The process of noticing one another in the group and bearing witness to each other's experience is typically a positive experience, perhaps because it establishes a felt sense of

connectedness and this feels good. The opposite is true, however, when a response from the group is not forthcoming. This appears to have the potential to push staff into positions of isolation, paranoia and self-loathing.

> John: Oh God, the silence. The painful, shameful silence.

> Rebecca: How is that Karen describes it? It's like someone has offered something to the group and we just let it drop into an abyss of silence. All kinds of awful things can happen for me in that silence

Offering a response is the action of making explicit how one has been encountering the other. In this way it appears to play a critical role in initiating the restoration of connectedness amongst team members. Leaving members contributions to float into the group space without acknowledgement is experienced as hostile rather than benign. This allows for negative fantasies to take shape and members are ultimately left alone and disconnected.

6.4.3.3 Checking-out

The giving and receiving of feedback was also identified as a key aspect of relational witnessing. When staff gained a sense of how they are experienced by others, they experienced a deeper self-awareness. Offering feedback often happens through the form of 'checking out': offering an invitation to explore someone's state of mind during a particular interaction. Checking something out usually occurs because the 'witness' is concerned or confused.

> Sarah: if I've got something going on, outside, I'll know that that's influencing me in some way but I'll need to make a judgement about whether or not that's impacting upon my work. And, it's often when - if other people say - what sort of
> Amelia: What's going on?
> Sarah: Yeah, yeah. Exactly. That I might think of maybe - maybe I am. You know, it's kind of that, isn't it? That- getting that feedback 'cause sometimes you don't know yourself. That's the value of the group, isn't it?

> Rebecca: It just makes me think about, and there are different ways to think about this, but there is something about how we, how we see each other - how we are seen by each other. Um. Makes a difference in terms of how we are with each other. Are you saying?
> Siobhan: Yeah. Cause we can make a lot of assumptions, I think, about people. If I make assumptions, then it's not really based on anything real, is it?

Amelia: It’s good to have somewhere to check things out, safely, isn't it?

Checking out can be understood as an important way of establishing an authentic state of relating. It moves us out of ‘not-knowing’ which can be a breeding ground for persecutory anxieties, isolation and ultimately, disconnectedness. Checking-out is also a direct noticing of a breakdown in connectedness and the reaching out required to repair and restore this.

6.4.3.4 Learning about yourself through others’ experience

The staff expressed their belief that there is a great opportunity for personal learning and growth when working in a culture where relational witnessing is a feature. Developing and fine-tuning one’s self-awareness as a therapist is viewed as a positive and valuable outcome of attending the SSG. This is thought to be made possible through the willingness of others to share their experiences of you. This offers a further suggestion that being witnessed by another establishes both intrapsychic and interpersonal dimensions of connectedness.

Sarah: I remember a staff group not long after I began here, and, um, he said-um - I was talking about something. He said, "Oh, uh," he said, "I'm not sure your optimism is as infectious as you think it is."
Siobhan: [laughs]
Sarah: Do you remember that?
Siobhan: [laughs] I do.
Sarah: I will never forget those words. I must have written them down, actually.
Grace: Did it feel like a slap?
Sarah: Yes, but-but-but no, actually. It felt like - in those days, I think - I don't know. I know it was really helpful. I mean it was a - It was really the first time that I kind of began to look at my own personal process in a staff group setting 'cause I was new to this kind of work. And, um, so it was incredibly helpful.

Sarah: I know I've had sort of aha moments through talking in the staff group about myself and what I do, I - I recognize those things. So, I can integrate the kind of how I'm behaving here with my own history and my own sense of what I'm - I might be bringing in a not so helpful way, maybe. I mean, I had a moment the- there where we were saying about actually looking after other people and being concerned about other people’s fragility and thinking, "Oh, blimey. You know. There I am again".
[Laughter]. You know, the depressed mother. It's like, I suddenly thought - I started to think, "Oh my gosh, it's like the group is the depressed mother that I'm - about to abandon." You know, like I had that moment then.

Amelia: And it's recognizing, isn't it, that it's not - it's not our own therapy but actually it does - that does have a - that's of benefit to me, like personally. I feel, "Okay, that's helpful." But it - it relates to the work in that maybe I need to really think about what I'm doing there so that I'm not doing that - or I can - You know, that sort of stuff, isn't it?
Sarah: and it allows the group to help. If we know that that's the issue.
Amelia: Yeah. It is part of what makes working in an environment like this attractive and bearable, isn't it? It's that you do- you do learn about yourself, you do integrate more, ideally.

The process of seeing and noticing one another was experienced as a critical process that takes place within the SSG. This includes the importance of responding to one another, checking out and providing challenge and feedback. This was felt to facilitate a reconnecting with self, through the process of being seen by the other. Witnessing one another can feel exposing and shaming at times, there is a need for being careful in the delivery of relational feedback. However, valuable learning can take place when the group are encouraged to share their experiences of one another and this establishes another mode of enhancing intrapsychic connectedness. Furthermore, checking out and providing feedback was experienced as a direct expression of one's desire to re-establish and deepen connectedness and cohesion amongst fellow team members.

6.4.4 Theme 6: Integrating and splitting

The SSG is the primary space in the service where team relationships are attended to. The team are acutely mindful of their propensity for 'splitting' as a result of the disturbed relational context within which their relationships exist. This is felt to be evident in the arousal of strong feelings and seemingly acute and rigid differences about treatment delivery..

Sarah: Also, it's kind of the minimizing of splitting as well, isn't it? 'Cause I think I - I was thinking about what - what it was you were saying that you were, um -
John: Couldn't be bothered.
Sarah: -couldn't be bothered. It was something about [pauses] recognizing, you know, I - 'cause I feel in a way, like, because I've been talking about le-leaving "I feel like - might be the bad guy - in the team. The thought that our ambivalence wouldn't' be sort of processed in the team really worries me? So, something about actually that being shared made me feel- made me maybe feel better
Rebecca: Then I guess when that isn't put into words and spoken about and shared like you said, then, there's more danger that's acted out by the individuals who're taking up that position?
Amelia: Or, you get stuck very much in that - Yeah, you're not allowed to show any other sides or

Siobhan: As you said that kind of perpetuates the split, doesn't it?
Sarah: It perpetuates the split, that's the thing isn't it?
Siobhan: And actually, the reality is that we do share the ambivalence

Grace: I was thinking in terms of conflicts that we've had, sometimes they can get isolated between two members. And I think coming into the staff group shares that out. And actually, other people can begin to feel like it's not just located with those particular two or that particular person.

Splitting can therefore be understood as an indication of interpersonal disconnectedness amongst staff. Having a specific space to address team dynamics is therefore felt to be critically important. Two processes were identified to be incorporated with the experiencing of integrating and splitting. These were (1) Focussing on team dynamics; and (2) Collective responsibility taking.

6.4.4.1 Focussing on team dynamics

So, whilst earlier in the chapter I have discussed the importance of the SSG in terms of the naming and processing of feelings, this theme concerns the specific task of naming and processing the feelings staff members have towards one another.

Claire: Well, it's all - it's all about the work. If you think about a place like this. The - the main purpose is to help people with their relationships with-with our clients, then we have to be able to relate to each other - in the - in that way. And this (SSG) is the best way that we can relate to each other

Amelia: That's the difference between the staff group and, like—Supervision. She (facilitator) wouldn't allow us to reflect too much on things that are external to us; we need to be focussing on what is going on between us.
Rebecca: So, the difference is that…?
Amelia: That the actual focus is on the team dynamics, the interpersonal issues between the staff and how they impact or are impacting on all of us

Sarah: It's about trying to help our clients get better ultimately. And the staff group is a place where our feeling towards each other can be talked about so that that it doesn't impact on-on-on the work with the patients

By focussing on feelings staff members experience in relation to one another, splits can be brought into the collective awareness of the team and work can be done to 'join things

up', to reach more integrated and reflective positions. The potential outcome is felt to be the restoration of the team as a stable and cohesive unit. For some of the team, this is seen as the most important function of the SSG.

6.4.4.2 Collective responsibility taking

The SSG also seems to support staff to remain curious about interactions, have a willingness to talk about these and to hold goodwill towards one another whilst doing so. Breakdowns are viewed as the responsibility of the entire team, not just the active protagonists and so they require the work of the entire team to repair them. The SSG's role in reminding the team of this, which appears to support the cohesion of the team.

> Grace: It's not just the impact of patients have on us. It's really to do with our interactions and our impacting on each other and how we manage to find a way to say it in a way that's respectful enough so that we can still survive and go on working with each other. And not just work stuff out and go on working with each other, maintain good will as it were, feels like. We all need to be-be much more thoughtful and temperate in your whole approach to your - how you're managing those feelings of frustration when managing your interactions with somebody you're working with. And all of that, the interpersonal stuff is so important. It's basically a parallel to what you're trying to be with your patients.
>
> Amelia: Yeah, the group helps us to work as a team so that people don't get isolated or left holding unhelpful bits. You know, like you were saying about primitive things. You know, that we can integrate -
> Grace: Mmm, like with this example, using the group, it felt like us coming together and bringing our reflections and questioning our reflections and our own hostilities and -
> Amelia: Yeah, and I suppose the helpful thing is that different people will hold different bits won't they? Of the same patient or the same incident and the same [pauses] sense of, I don't know, one another. But overall we all have our part to play in what happens in this team. We can influence each other by being involved, by abstaining, by being absent, by not owning certain feelings we might have so someone else has to take them up on our behalf, it's always to do with all of us, I think the group really helps to remind us of that and work at that level

Working through ruptures and integrating splits does not seem an easy process for the team. Staff must expose their vulnerabilities to one another (as discussed earlier), as well as maintain a willingness to stick with difficulties that might need to be repeatedly returned to before repair is experienced. Sometimes team members are left to 'fight it out' without the active support of the team.

> Siobhan: It was such a disaster. It felt really, like actually, it was quite damaging. It wasn't a good experience. So that kind of left people - well, it left me with the feeling of, oh, that's terrible, you know? This woman comes in, she was really subjected to something, she never came back to the group and that was it. It was very uncomfortable. And it wasn't in my mind resolved particularly well.
>
> Grace: And then the consequences came up that we had to deal with and they didn't work very well. And you know, people were caught up in quite a bit of difficulty for a long time and it kind of felt like it, it wasn't worked through. It was sort of ending because people left the- left the group and that was the way it was managed. Rather than resolve - it being resolved, if you see what I mean.

In this clinical setting, there is an experience of being exposed to many pressures to hold different and seemingly incompatible positions. The team felt that in order to function effectively and safely in their role as treatment providers, they need the SSG and its unique focus on team dynamics. This supports them to repair and integrate ruptures and splits. This can work well and promotes a sense of good will and cohesion amongst team members.

However, there are times when breakdowns in relationships have not been repaired. This causes the ultimate split as team members have left. The implicit message around this in the team is that if you can't use the SSG fully to learn about yourself, to receive feedback about yourself and 'grow' then your place within the service eventually becomes untenable. Unfortunately, the power dynamics that were at play here were not explored in the inquiry groups but lead me to question, to whose will must one have to bend and why? The group did touch upon how terrible this can be to experience. Members can be left with an unease and something 'awful' stays, the guilty weight of having participated in the 'killing off' of a colleague. When splits can be repaired in the SSG, however, the interpersonal relationships within the team appear to establish and re-establish the felt sense of connectedness necessary to provide a stable and containing treatment.

6.4.5 Theme 7: Belonging and isolation

The team reported that the SSG can protect staff members from isolation and promote an overall sense of togetherness. Team members can find it difficult to withstand the psychological and emotional disturbances they encounter without the subjective experience of being together and a part of something. Two processes were identified within this category: (1) Coming together; and (2) Caring.

6.4.5.1 Coming together

Coming together encompasses the aspect of the SSG that invites awareness of the collective, shared experience. This supports the experience of belonging, which in turn facilitates connectedness with both self and the group.

> John: Doesn't make about, you know, it coming together in that space. It is this work, it's disturbing - and it can disturb your mind. And I think in this work, it's important you don't become isolated in that. Therefore, coming together in a space where those bits of the, kind of, work and how you feel about it - is brought together in one place and shared, to me helps integrate me -
> in my mind, which I hope enables me to be a better therapist and a team member that's effective.

> Rebecca: Like at a very basic level. If your mind is isolated and you're being disturbed and you've got nowhere to take that and no one can hold that with you - then you - I just feel like you - you'd lose it. The group, the group holds it with you.

Members found they could identify with one another in the collective challenges and endeavours of the service that are expressed in the SSG.

> Rebecca: You know there's something about actually joining- joining together as well isn't there? That's another function it's a different thing than working through a conflict but there's also something about joining together. Um in a way that we share we might have different feelings and experiences but we do share the experience

> Sarah: It can help us come together and share things together, whether that's a conflict with each other or whether it's just saying, "God this is really hard isn't it guys?" Like you know actually that's - this is ours

> Siobhan: kind of, knowing that we are, kind of, together in something really, really difficult, and feeling really different things. Similar and different things.

When staff feel that they are together in their experiences they feel supported and the work is more manageable. Experiences can be identified with and normalised, so that there is a sense of being protected against the fragility and disturbance that arises from an isolated mind facing adversity.

6.4.5.2 Caring

One aspect of belonging appeared to be the experience of caring for one another and of feeling cared about. This is established through the process of noticing one another and experiencing each other as supportive. The very provision of the SSG within the structure of the treatment program and the provision of an external facilitator is experienced as an act of care from both management and the wider-organisation.

> Rebecca: I was thinking in term- when you said that I kind of thought that made me feel quite cared about - which is so important. You know, I'm just sort of thinking. Even the fact that we have an external facilitator, who the service pays for, it's something that feels caring, doesn't it?
>
> Paul: So, the well- well-being, that comes from the group, kind of, -comes to me quite a lot. When people say, "I'm worried about you, Paul" or maybe just say, "Are you okay?" you know- -that kinda thing. That supports me a lot.

It was thought to be through the experience of coming together and being cared about that staff felt stronger, more stable and more able to tolerate and utilise the experiences that they face at work. Recently the team have faced an unusual amount of loss and transition, and they spoke of how sharing this in the SSG appeared to mitigate what was otherwise a disintegrating and fragmenting process.

However, my thoughts also return to those past members, who remained isolated and did not belong. I wonder what contributions they might have brought to this theme? I wonder what it might have been like for them to have to attend the SSG week after week to be confronted and exposed but without experiencing the solidarity or care? I certainly remember one former team member who's behaviour was regularly challenged and yet who did not agree with the challenges and therefore did not (could not?) use this feedback to fit with what was being asked of her. In many ways the SSG then became the space where her exile most fervently took place. From this perspective the SSG could be seen as a rather more cruel and hostile experience, where 'togetherness' and 'care' might in some way be contingent upon whether you can agree, acquiesce and adapt at the behest of the group.

6.4.6 Theme 8: Developing a therapeutic atmosphere

Having the SSG appears to develop a culture of connectedness amongst team members that extends beyond the weekly group and into the daily life of the service itself. This can be

understood as an acculturation of the practices, processes and ways of being with one another that have already been identified in this chapter. The processes of: (1) Authentic communication; and (2)Modelling the treatment philosophy were identified as playing a role in how the SSG is experienced to support the therapeutic milieu.

6.4.6.1 Authentic communication

One aspect of this atmosphere is the authentic communication styles that are thought to develop amongst team members through the SSG. The SSG provides the team with the permission and safety for then openness and honesty required to notice, challenge and express.

> Paul: there's something about how, I feel like the group has helped me to say a bit more in other spaces as well. It's like having the group means that we - we
> Rebecca: We got permission.
> Paul: Yes, exactly. We got permission. Yes. I don't think you could have that, have that honesty, if you didn't have the group

> Rebecca: At the same time, I don't know, I think the fact that we have that group, and there is a kind of encouragement to do it there, that means we can do it a bit more in other spaces. You know, like I'm thinking, just an example, yesterday when we were talking about Client X in the office and the phone call and you sort of saying, "well actually, I have a feeling about this". "I have a feeling about her not talking to me and then ringing you up" and, -- you know, there's something about it creates a culture, doesn't it?

This authentic way of communicating with one another is experienced as extending from the SSG into clinical supervision settings, co-working in therapeutic groups and community settings, and in ad-hoc informal discussions that take place as the need arises. This atmosphere is thought to provide a protection from the frequent attacks to connectedness that staff experience throughout the course of their work.

6.4.6.2 Modelling the treatment philosophy

This atmosphere is also thought to provide a model of relating for the clients to experience and develop in through the course of their treatment. Through the practices developed in the SSG, staff can hold a reflective and relational frame for treatment that is characterised by maintaining emotional connectedness and facilitating authentic communication. This is more than just a modelling of healthy relating to clients. The ways of being established in the SSG

serve as a microcosm of the entire treatment philosophy, which is underpinned by the premise of using “relationships as a means to managing life” (Sarah).

> Sarah: you know I think it was a real problem with (former staff member) because her position wasn't congruent with the- the way we were perceiving the whole process of the work and the SSG being sort of integrated in that process. So, it was more than just a problem in the group, it was about how the whole way of working and how that's integrated

> Rebecca: it's so central to my sense of, you know, being congruent with what we're trying to achieve with the patients. Like I can't imagine without it but there are services that do deliver a service to personality disorder patients without it (an SSG model). It is just interesting isn't it, to think, 'cause we're saying it's kind of essential but that's - we are working in a particular way here aren't we?

The team experience an atmosphere of relational connectedness that is carried throughout the workings of the service. This is felt to cushion staff from the interruptions to their capacity to maintain connectedness. What is more, this culture is an interpersonal embodiment of the relational framework that underpins the entire treatment model. There is some hint to missing voices; those who have not been able to adopt this model or way of working, which resulted in them leaving the team. Does this indicate the role of the SSG as a vehicle for ‘cleansing’ the team from those who agitate it and its model? Or does it allow the service to differentiate between those who have the necessary skills and personal attributes required to work in this type of service with a treatment model like this? Perhaps the answer lies somewhere in the middle, with the need for change and development but not at the cost of implementing a coherent and stable framework. Some further interrogation of the missing voices in this research may have enhanced the development of this category and the processes at play in creating a therapeutic atmosphere.

6.4.7 *Theme 9: Energising and depleting*

The final process identified was the experience of the SSG energising and revitalising staff. The psychological disturbance in the service was felt to have the potential to cause emotional fatigue and burnout. Staff reported they use the SSG to ‘recharge’. In particular, they experienced relief and a sense of meaning in describing their experiences of the SSG.

6.4.7.1 Experiencing relief

The SSG was understood to provide a sense of relief from the emotional burdens that staff carry through their work. Relief appeared in a variety of ways, including the relief of sharing what one is carrying so that it can be held by the group; the relief of repairing and attending to staff ruptures and tensions; and the relief from the realisation that one is not alone. Relief is a positive and restorative experience.

> Siobhan: And then, we talked quite a lot then, didn't we, about it? And I think that offered a huge sense of relief, actually, after that meeting, I have to say, after staff group on Thursday. It felt great. Knowing that we are kind of, together in something.

> Sarah: I then felt like -- hearing you say that you couldn't be bothered to contribute in those (merger) meetings. I felt so much better for hearing you say that. A relief of something connected. I don't know. So--
> Rebecca: Because you knew where John was at or because it-?
> Amelia: It was an active choice, maybe and you don't need to worry about-?
> Sarah: Um, [pauses] no, but it's like its sort of identif - I identify with it. I mean I have that feeling but I very rarely act on that feeling.

It would have been pertinent here to develop the category further with the experience of what happens when relief is not experienced. This is another theme where some of the missing voices of the SSG become more apparent. From my own experience, a sense of relief is not always achieved. There have been times in the past where I have attempted to use the group to free myself from some burden I was carrying and the group were not able to support me in the way that I would hope. Indeed, rather than be a relief, the sense was of feeling somewhat further depleted as I felt that my concerns had not been properly acknowledged or held. In addition to the original concern I was bringing, I then also began to feel preoccupied with the fantasies of why my concerns were not being adequately held by the group. I could imagine how, if this experience was too prolonged or severe, as may have been the case of former team members, then the work would be unsustainable.

6.4.7.2 Finding meaning and value

The team reported feeling energised by the SSG providing meaning and value to their work. This appears to facilitate both personal and professional rewards. Personal, in that staff learn about themselves and professional in that there is a sense that the work that they are doing matters.

Amelia: You've just got to be relentlessly energized to do it, to believe in it, but that's why the staff group, I think, is so important, 'cause it's - it's sort of giving us an experience of someone holding us in mind and thinking that everything that happens has meaning, needs to be thought about, in order for us to have that energy to do it. Otherwise, we will dismiss - I think that's what's tricky. We can easily just make light of or dismiss things that actually are really important.

Sarah: Yeah. The group, it's - It is part of what makes working in an environment like this attractive and bearable, isn't it? It's that you do - you do learn about yourself. [Laughs]

Sarah: One of its functions though is - is the message that it gives about the work that we're doing. It says this is important and it matters. What you are doing - is difficult. And you know if you can talk about those difficulties, it, sort of gives - it gives us a feeling of, um, value to what - to - to what we're coming in everyday to do. I - I mean, that's a big part of it for me.

The data therefore suggested that the SSG can restore the team's energy and revitalise them. This is mainly through relieving staff from the heavy and burdensome challenges of working in this environment and by providing an essential sense of meaning and value to the work.

6.5 Theme 10: Supporting conditions

Through their experiences of attending the group, the team feels that their capacity and desire to maintain a state of connectedness within the personality disorder service is restored. This is thought to mitigate the many pressures staff face to dissociate and disconnect and the associated detrimental outcomes of these. However, the analysis also identified three factors that the group felt were central to the functioning of the SSG and its capacity to be experienced as a means of support and development. These were as follows:

1. The team thought that it was essential that the SSG has a skilled facilitator who is external to the team
2. The team felt that leaders play a unique role in carrying a culture which supports and values the SSG
3. The team also thought that the group worked for them because there was a clear boundary of bringing material to the group that concerned the occupational functioning of the team.

6.5.1 Externally facilitated

Discussions about the external facilitator illuminated a number of functions of this role. It was seen as particularly important that the facilitator's relationship to the group is one of an outsider to both the service and the wider organisation. This promotes a sense of safety and security concerning the boundaries of the group, enabling staff to share their feelings and expose their vulnerabilities. By virtue of her not being involved in the workings of the team or the wider organisation, the external facilitator is in a position to listen, reflect upon, acknowledge and attend to the experiences that the team bring to the group in an open and impartial way.

> Sarah. For me the most important thing is that she is external. I have to say, because I think you could have a really skilled facilitator but if they're internal even to the Trust, it would not feel mutual and safe to me actually.
> Amelia: They would have their own agenda and their own relationships with the Trust that could impact or influence.
> John: I think I'd be more inhibited in not being my authentic self about how I feel about our relationships internally.
> Amelia: Cause you might come across these people in other settings
> Rebecca: that's a really important boundary
> John: And having someone from the external looking in is so helpful.
> Amelia: With no agenda.
> John: With no agenda, yeah
> Amelia: Except to be there for us
> Sarah: And also, it's not just that they don't have an agenda; they're not hearing anything about us from anywhere else except us. I think that's a really big thing. You know how that influences you if you do have that knowledge of the team

Furthermore, the team thought that the facilitator's external relationship to the group meant that she was less likely to be caught up in the unconscious dynamics of the team and could therefore offer a perspective on these. In this way she is thought to alight upon aspects of team dynamics which would otherwise remain outside of their awareness.

> Sarah: I think the-the sort of psychoanalytic interpretations that she sometimes brings that I think just often really hit the nail on the head for me, that helps me-- that really helps me to shift in my sort of thinking about different members of the team.
> Rebecca: So, she puts something into words that we can't necessarily—access.
> Sarah: and takes it away from the personal and the political

The facilitator's external relationship to the team and the organisation also means that she is in a position to level out the power dynamics in the team during the SSG.

> Rebecca: What has she got to be experienced in?
> Amelia: Running a staff group. Well just being able to manage dynamics. Manage groups; manage that idea, difficult differences. As a manager I need to feel like I can sort of let go and trust that she is solid enough to be in charge.

> John: I-I think she's quite good at challenging and talking to all of us but in particular to the leaders of the team. At times it was difficult with (former leader) and she would take something up with her that we were facing as a team, and she was quite challenging of that. To me that's helpful to see
> Amelia: And yes, so she didn't' collude in not being able to sort of talk about, those elephants in the room.
> Rebecca: Yeah. She flattens the hierarchy a bit.

The facilitator is viewed as someone who is in a good position to take an authoritative position with managers and leaders, holding them to the same group boundaries as the rest of the team. This provides an important, experience of temporarily flattening the hierarchy.

6.5.2 Manager endorsed

Leaders in the team were experienced as endorsing the values of the SSG and a commitment to its' process. This was felt to be fundamental to the success of the SSG.

> Amelia: I think that staff group is the most important group that we have in the week actually, at the moment especially, we are going through so much.
> John: It's really important I think you say that as the leader of the team, as well. It's something (former manager) used to say a lot. So, there's that bit, I think it's personal to you, but also the message you give out to the team about your experience, you know it helps me to know that you value this so much.
> Rebecca: So, maybe what you are saying, this process is not just dependent upon an external facilitator, I think you are also saying that it's also dependent on those in a position of, um, power?
> John: Authority
> Rebecca: Authority, Those in a position of authority are just as committed to the group
> John: Yes. I think that's right.
> Amelia: Yeah everyone has to be signed up, everyone has to attend. Everyone has to treat it as a matter of priority.

Rebecca: But, are you saying something about the fact that Amelia's a manager, that she's signed up, that carries something for all of us, in a way.
John: Exactly, yes.
Siobhan: yes, I'd agree with that

Grace: because, of course, there was a time when we didn't have it systematically and - the thing that made the difference, I felt, was that she was insistent everybody should come and, um, if you were any-anywhere on the scene, you needed to be in it. She didn't let us-- anybody off the hook and I think standardizing it in that way made a lot of difference because people couldn't just take themselves out because it wasn't convenient or there was some contentious issue that they didn't want to work-- be involved in

Team leaders demonstrate their endorsement of the practice through their own commitment to using the group, the expectations they hold for the team to use it, and through the structures they put in place to ensure that the group is centralised within the work of the service.

6.5.3 *Occupationally focussed*

Staff thought it was important that a boundary around the focus and content of the groups is maintained. Being an SSG within an occupational setting, the material that staff bring into the group should have an occupational focus. The SSG is not a group for personal therapy.

Siobhan: This isn't a therapy group. This isn't your therapy. You're not in a group process as such. I think you have to be quite careful actually, or quite distinctive about that, don't we? And hold to that, because actually then we can just get into too much, sort of, navel gazing almost, maybe, about ourselves to - to an extent. You know what I mean? I think that's quite -- I don't know, it's different, isn't it? I mean, it is here, we are here to, kind of, work.
Paul: Yes, we're here to function as a team.

Amelia: We monitor our own self-disclosure, don't we? To what is appropriate to the work setting.
John: But also, our responses, if someone shares something personal relating to the work, the other people's response to it isn't - I don't expect the team to respond in a way that sorts out my personal problem that I'm bringing in relation to the work.
Rebecca: It's more about helping you manage the work in relation to that?
John: Yes. Rather than my problem.
Sarah That's why anything personal might be relevant. There is no, you know, there's a different boundary from how you would be with clients, for example, isn't it? Because, actually,

> anything could potentially be relevant to bring into a staff group if it's impacting on the way you're functioning at work.

It is the responsibility of the individuals, the team and the facilitator to ensure that this boundary is maintained. Historical and personal experiences that are external to the group will undoubtedly need to be explored at times, however, this needs to be done whilst having considered the questions: 'Is this impacting upon my work and if so how and why?'

6.6 Summary

The grounded theory analysis of staff experiences led to the development of a model for the SSG which is underpinned by a core category of connectedness. From this central and overarching theme, we can see how connectedness is implicated in both the unique needs of the team in this particular setting and the processes of the SSG that work to support wellbeing and functioning at both an individual and a team level. Without this group staff believe that they would be more likely to experience states of disconnectedness, fragmentation and dissociation as a means to manage the emotional intensity of their work. In fact, what appears to be the case is that when the staff experience connectedness with themselves and with one another they find they are stimulated and personally rewarded with work that they find value and meaning in. In the following chapter I will discuss in further detail the implications of these findings within and beyond the current setting.

7 DISCUSSION

7.1 Introduction

The paucity of literature concerning SSGs has provided me with an exciting opportunity to make a timely and unique contribution to the literature concerning SSGs and locate this within the broader context of organisational reflective practices and staff support. On reviewing the literature, I found myself grappling with the following questions that I thought remained unanswered:

1. How do team members participating in an SSG understand what is happening in the group?
2. What are the processes they feel they are in engaged in?
3. In what ways do the staff experience the SSG to impact upon team functioning?
4. In what ways do the staff experience the SSG to impact upon their emotional engagement in a challenging environment?
5. How do the staff understand the rationale for their participation in an SSG in their setting?
6. What supports the functioning of an SSG?

My attempt to respond to the gaps in the literature has been to utilise a grounded theory analysis to the team's cooperative inquiry of our SSG to to develop a conceptual framework of an SSG and its processes. As far as I am aware, this is the first study of its kind to provide a deep exploration of staff members' experiences of utilising an SSG as a form of reflective practice This has provided an original model of *Connectedness* to the field, highlighting a number of key processes through which connectedness is felt to be restored and maintained through participation in the SSG.

This chapter has therefore been structured to provide an interpretation of the findings of the previous chapter. Firstly, I shall provide an examination of connectedness and its relevance to the systemic manifestation of trauma in work with personality disorders. From this basis I will then explore the processes of security and danger, emotional awareness and obscurity, relational witnessing and turning away, integrating and splitting, belonging and isolation, developing a therapeutic atmosphere and energising and depleting and their implications for practice in this setting. I will also examine the conditions which were identified by the team as intrinsic to support the process of the SSG and its restoration of connectedness within the

team. Finally, I will discuss the impact of this research on the team and the wider-field, whilst considering the limitations of this study and potential avenues for future research.

7.2 Connectedness

The findings implicated that the SSG was a useful and essential feature of the team's work because of its role in attending to the connectedness of the team. But what is meant by connectedness and why is it an important issue for this team? Connectedness captures a state of awareness in relation to oneself and others that is necessary for staff members' attunement, attachment and engagement in this setting. Connectedness appears to have intrapsychic qualities, applying to the individual's recognition and acknowledgement of their internal experiencing of events (thoughts, feelings, behaviours) at work. However, this is not separate from its interpersonal dimensions which, when incorporated, illuminate connectedness as the mindful experiencing of oneself in-relation-to the mindful experiencing of the other. Through this process, staff feel they are supported to stay present and engaged in their encounters with disturbance and distress, which is felt necessary for establishing clinical relationships which can be therapeutic rather than harmful. Furthermore, connectedness was related to an overall sense of wellbeing amongst staff members, arising out of a collective engagement in meaningful and valuable work.

7.2.1 Disconnectedness

One cannot ignore the dialectical premise of connectedness, bringing into focus the issue of disconnectedness within this setting. Staff reported repeated exposure to overwhelming emotional responses to their work in this *disturbed relational context*. This raises anxieties in the team about 'going mad' or becoming unwell. Staff understand that there is a potential to engage in defensive processes as a means to protect themselves. This is understood as an 'acting-out' of emotions, engaging in potentially harmful and destructive behaviours as a means to express anger, fear, guilt and hopelessness that characterises work of this kind. However, the significance and relevance of these defensive actions can be illuminated further through an examination of early trauma and its relational expression in the treatment setting.

7.3 Disconnectedness and personality disorder: the manifestation of early trauma

Early life for clients with a personality disorder is often characterised by emotional, physical and sexual abuse (Vermetten & Spiegal, 2014). This has led to calls for a more compassionate understanding of personality difficulties as a result of complex post-traumatic stress disorder (CPTSD) (Herman, 2015). Herman's (2015) seminal account of CPTSD elucidates that disconnectedness is at the heart of the traumatic experience: "in trauma, connection is shattered" (p 52). This disintegration occurs as a result of dissociation: the ultimate defense against the physiological impact of traumatic stress, impairing memory and communication between brain regions and self-states (Schore, 2011; Nijenhuis, van der Haart & Steele, 2010; van der Kolk, 1994). Dissociation therefore becomes the "fundamental principle of personality organisation" in clients with a personality disorder diagnosis (Herman, 2015: 102). Therefore, staff who work with clients with a diagnosis of personality disorder must address the profound and pervasive issue of disconnectedness which characterizes the nature of 'difficulty' within this field.

When the staff team describe their experiences of disconnectedness within their work, one can assume that this is trauma-in-action in the treatment setting. As Herman (2015) posits, "trauma is contagious" (pg. 140) The experiences of the staff team in this study support this idea, providing a sense that disconnectedness, fragmentation and disintegration have the potential to permeate systems of care for victims of trauma (Scanlon, 2012). This goes someway to explain why the treatment of clients with a personality disorder too often results in further harm rather than help (Hinshelwood, 2002). The experience of the staff team elucidates the manifestation of trauma across all relational levels in the setting. Staff described a disruption to their self-experiences in light of emotionally arousing clinical encounters. They also experienced the (re)traumatizing potential of the therapeutic relationships, where both sides of the dyad can exchange positions of 'victim' and 'perpetrator'. The experience of 'splitting' that the team refer to might now be better understood as a manifestation of trauma and dissociation that occurs between staff members. Staff also describe feeling dehumanised and attacked by the organization.

Just as systems-psychodynamics posits the need for 'subsystems' of collective reflective practices to contain the primitive anxiety of an organization, so too can we understand the SSG as a subsystem which has the potential to dilute the effects of disconnectedness within the service. From this basis we can see why connectedness is at the heart of the work of this team, reintroducing to the system therapeutic essences of compassion, tolerance and the

transformation of disintegrated and overwhelming events into a collectively-earned, coherent form. The findings from this research therefore make a cogent case for group-based reflective practices that enhance team work within personality disorder settings. The findings have also elucidated *how* the SSG works in restoring, it is to these processes that the discussion now turns.

7.4 Reconnecting through the SSG

In order to provide an interpretation of the processes that elucidate how the SSG influences the experience of connectedness for team members, I shall now discuss the themes of security and danger, emotional awareness and obscurity, relational witnessing and turning away, integrating and splitting, belonging and isolation, developing a therapeutic atmosphere and energising and depleting, respectively.

7.4.1 Security and danger

The findings indicate that the staff team develop feelings of security and safety in the SSG. From this basis, relationships can be built upon openness and trust. Indeed, the theme of safety proposes a relationship between feeling safe and being able to be vulnerable with colleagues. We can imagine that this is likely to be a reiterative process, whereby the experience of security is reinforced by the experience of being supported in one's vulnerabilities and this, in turn, facilitates deeper relationships, a deeper experience of trust and a deeper level of exploration. According to the team, it is in the context of feeling secure that the bonds between them develop.

Team members used the term 'secure base' to describe the impact of security on their work. In attachment theory, the concept of a secure base refers to the experience of an attuned and responsive relationship to which the child can turn to in times of distress or anxiety (Bowlby, 1988). As the theory ascribes, more than simply seek comfort from one another, team members seem to internalise this soothing and utilise it as an affect-regulatory function as they go about their work (Sroufe, 1996). This appears to equip them to manage their emotions and engage in their clinical work with a sense of confidence and competence. It has been proposed previously that an SSG might function as a secure-base (Carson and Dennison, 2008), the findings from this research ground these ideas within the actual experiences of SSG members in the field.

The SSG is also described as offering both an internal and external place-to-put experience for the team's support and attention. Bowlby argued that a secure-base incorporates both holding (Winnicott, 1971): the sensitive physical and emotional provision of care; and containment (Bion, 1963): a receptacle for processing affective experience. The study findings imply that when staff feel held and contained in the minds of their teams they are available to provide this experience to clients, despite the heightened affect that might characterise the encounter. Therefore, the team's experience of security in one another allows for the establishment and re-establishment of connectedness in their clinical relationships. The findings from this research also illuminate the damaging experience for team members when security is lacking. If we assume that this is a reflection of how teams can become "contaminated with the toxicity inherent in this work" (Foster, 2019(b): 69), then it is essential to find ways to introduce safety and trust into the system.

7.4.2 Emotional awareness and obscurity

The findings from this research point to the important task of recognising and processing feelings that takes place in the SSG. For some, attempting to understand the basis of one's emotional reactions in practice encounters is a defining feature of reflective practice (Boud et. al, 1985; Dallos and Stedmon, 2009). These findings correspond with a range of literature claiming the importance of SSGs for supporting the emotional health of staff (Carson & Dennison, 2008; Kennard & Hartley, 2009; Reid et al, 1999b). For this team, the articulation of affect is unanimously understood as a core task of the SSG. There are a range of ways in which this task is carried out in the SSG that cover both the internal recognition of emotional experiences which are then expressed in the group, and the recognition or uncovering of emotions that would remain largely out of awareness if not for being experienced through relationships.

This is a critically important function of the SSG if we consider the potential defensive manoeuvres that can be utilised if emotionally heightened experiences remain dissociated. As Menzies Lyth (1960) illuminates, practices can become increasingly cold, callous and dehumanising. If left unattended we risk reinforcing and repeating the early relational traumas of our clients and contribute to burnout in the staff. As Freud said, "the thing which has not been understood inevitably reappears" (Freud, 1909: 122). Indeed, the staff team were particularly concerned about the potential for 'acting out' repressed or hidden emotions through behaviours which might be destructive to self and others.

We can apply Bion's (1963) ideas to reach an understanding of how, in facilitating the emotional awareness of the team, the SSG can function as a container. Through the reflective thinking that is required to articulate the experience, the group can process raw affect. The collective process of putting into words that which has been felt returns the experience to members in a more tolerable and coherent form. Consequently, they believe that feelings no longer need to be pushed out of awareness or expressed through destructive and defensive means. This leaves them available to utilise the full-range of their emotional experiences in their therapeutic work. This process can also bring into the traumatised system of a personality disorder service the essences of tolerance and containment. The understanding and processing of their affective experiences is therefore an essential safety mechanism and of therapeutic value to both clients and staff.

7.4.3 Relational witnessing and turning away

The SSG affords the team a unique opportunity to share and experience in the process of relational witnessing', contributing to the experience of connectedness amongst team members. The term 'relational witnessing' describes the development of self-awareness that can occur through the experience of being seen and understood within the collective of the group. This lends support to claims that really reflective practice at work is a collective action that cannot be achieved in silo (Boud, 2009). This theme included two processes, responding and checking out. This again indicates a relationship between explicit communication and team member's connectedness. Both responding and checking-out encompass aspects of articulating what one is understanding about the other, putting what is in out into the group. As the experiences of the team inform us, when this explicit communication is lacking, the resultant disconnectedness feels like a 'painful' and 'shameful' 'abyss'. Through the explicit exploration of moments of misattunement in the shared, collective space, one can move out of persecutory anxieties and into an authentic and supportive relatedness that in itself can reduce anxiety. What is more, we are afforded a unique perspective of ourselves in relation to others and our work.

Psychological theories which indicate the importance of intersubjectivity and social influence for the development of the self can be used to link relational witnessing to the overall theory of connectedness (Stolorow & Attwood, 1994; Fonagy, Gergely, Jurist, & Target, 2018). Relational witnessing can be seen to encapsulate the processes of joint attention, empathy and mirroring that underpins the social exchange in the SSG, these are "important foundations of sociality, providing a basic sense of social connectedness and mutual acknowledgement with others (Rochat, Passos-Ferreira and Salem, 2009: 174). Mentalisation theory (Fonagy et

al, 2018) posits how these processes form the basis of reflective functioning, specifically the ability to infer the mental states and intentions of others. From this perspective the SSG supports the staff to have 'mind in mind', facilitating their understanding of the misunderstandings that occur between them. Relational witnessing is the process through which this can be explored, potentially deepening understanding of self and others and enhancing the quality of relatedness and connectedness within the setting.

7.4.4 Integrating and splitting

The findings from this research draw our attention to the important function of integration and repair that takes place in the SSG, promoting an essential cohesion. The SSG pays explicit attention to the difficult feelings that can be aroused between team members, particularly at points when they become fixed and polarised in their differences, or 'split'. Being 'split' is the essence of interpersonal disconnectedness in teams and is identified in the literature as a core issue for professionals who work with clients exhibiting difficulties characteristic of a personality disorder. The concept of splitting is rooted in Melanie Klein's description of the paranoid-schizoid position, which refers to the psychic failure to bring together both the positive and negative qualities of the self and others, so that relatedness is based upon only partial perspectives and representations. This is an acute issue for clients in this setting, due to the irreconcilability of abusive care giving in their early life (Fonagy, 2000). These failures of integration are manifest in the clinical relationships within treatment settings, where clients tend to relate to staff as either entirely good or bad. The tendency is for staff to respond accordingly, usually by either condemning the client as unworthy and untreatable or proving their worth through indulgent reassurance and "pure kindness" (Hinshelwood, 2002: 25). These conflictual positions can manifest in a powerful resentment amongst team members which can be stressful and distressing. Furthermore, it can make reaching a consensus about treatment decisions a highly emotive and contentious process.

Rightly so, the SSG reinforces a perspective within this clinical setting that splitting is both a manifestation of team factors as well as the client's internal dynamics. Without structures like the SSG to explore the individual staff and team dynamics that contribute to splitting, one is at risk of resorting to a patient-blaming perspective which assumes that it is difficult clients who split teams. Developing one's critical reflexivity through reflective practices such as the SSG "move beyond a focus on individual patient psychology and pathology, to incorporate the predispositions, motivations and sensitivities of everyone involved" (Green, 2018: 264). Moreover, it is in the spirit of this SSG to support collective responsibility taking for any problematic differences in the team. The intention is to explore the collective dynamics through

which such positions might arise. In a system that is characterised by disintegration, the team's focus on cohesion and joint understandings is an essential antidote.

7.4.5 Belonging and isolation

The SSG was felt to limit isolation at work. Sharing experiences of the work with one another facilitated a sense of belonging and togetherness. This corresponds with prior research which suggests the role of belonging contributes to positive experiences in SSGs (Crawford, et al, 2008; Fortune et al, 2010; Kurtz and Turner, 2007). The current findings identify 'caring' and 'sharing' as central features within this process. Talking about the experience of caring for one another did not come easily to the team, only dawning on members towards the end, that of course this was an experience that the group afforded them. I see this as a manifestation of the systemic "virtual reality" of caring in the NHS, where the energy that must be invested in supporting a culture of targets and outcomes overrides the issue of actual care within the organisation: "like the song of the mechanical nightingale, the signifiers of care thus become more important, more real – and more attractive – than the actual care they signify" (Rizq, 2014: 263). Fortunately, the group got there in the end and the experience of care, through the expression of kindness and support, was explored. The prioritising of the group in terms of time and money, felt as if someone was looking after their needs. In this way, the very provision of the SSG can be seen to respond to the human needs of staff, which in itself can promote a compassionate culture throughout the system.

Furthermore, through the task of collective reflecting, staff members are reminded that their experiences are shared. This is a comforting feature of belonging, compensating for the anxiety of becoming isolated, which is feared to lead to madness and breakdown both in the current study and elsewhere (Kurtz and Turner, 2007: 427; Deodhar and Goswami, 2017).Therefore the shared experience that is realised through the SSG can be seen as a critical protective factor, bolstering and strengthening individuals by offering them a "place in the shared identity of the group through the commonality of their experiences and values" (Alexander, 1993: 128). This makes a cogent case for the provision of collective or group-based reflective practices to support the wellbeing of staff whose roles as care-providers expose them to emotional distress. What is more, the experience of belonging is identified as contributing to staff members' capacity to maintain connectedness with self and others at work.

7.4.6 Developing a therapeutic atmosphere

The SSG is believed to be a place where the team can experience and internalise the values, ways-of-working and being with one another and then extend these into the setting, reinforcing a therapeutic atmosphere throughout the service. This supports prior research that SSGs can be used to establish a therapeutic milieu (Heneghan et al, 2014), or a "culture of enquiry into the personal, interpersonal and intersystem problems...of impulses, defences and relations as these are expressed and arranged socially" (Main, 1983). Across a broad range of care settings, the literature points to the importance of supporting staff to develop practices which promote an atmosphere characterised by "safety, containment, openness, and involvement" (Heneghan et al, 2014: 334:), alongside "sympathetic care and explicit confrontation" (Scanlon, 2012: 227). This atmosphere has been defined as the 'relational security' of an institution and is now seen as good practice within prison environments (Allen, 2010).

Through establishing and reinforcing a good therapeutic atmosphere, the SSG enables clinicians to utilise reflection-in-action, just as Schön (1983) ascribed in his model of reflective practice. This concerns the implicit and tacit embodiment or expression of the knowledge and values which underpin the work of the service. For the current team, the SSG provides an opportunity to experience, internalise and then later carry this culture into the philosophy which underpins the entire treatment model. This philosophy is built upon the premise that it is through connectedness, authenticity and presence in relationships that one has a means to respond to the damaging aspects of self that have been damaged by early trauma. As has been proposed in prior research, the SSG's role in creating an atmosphere of relational security can therefore be viewed very much a part of 'the work' (Heneghan et al, 2014).

7.4.7 Supporting conditions

According to the team, the success of the SSG in restoring and maintaining connectedness depended upon a number of prerequisites. These were the provision of an external facilitator, manager endorsement of the SSG and the importance of maintaining a boundary of sticking to the theme of occupational functioning within the discussions in the group. The team emphasised the importance of these conditions. This corresponds with existing research and descriptive accounts examining what works in SSGs (Alexander, 1993; Heneghan et al 2014; Hunsberger, 1989; Kanas, 1986; Moynihan and Outlaw, 1984).

7.4.7.1 Externally facilitated

The team posited a critical need for the group to be facilitated by someone who is external to the team. The external relationship reassured the team that the facilitator would not be personally caught-up in the pre-existing dynamics of the team but would instead provide an outsider perspective on these. This was thought to promote a temporary flattening of the hierarchy in the group, where all members in the SSG hold equal value and status, albeit different roles, in the eyes of the facilitator. Furthermore, the provision of an external facilitator is an indicator for the team that the SSG and the team's wellbeing is a priority (Hunsberger, 1989).

However, the professional expertise of the facilitator seemed an equally, if not more pertinent issue for some. The staff team both valued and thought that they needed a facilitator who was confident and experienced in managing and translating unconscious group process. This role includes providing insight concerning transferences, projective processes and defence mechanisms (Alexander, 1993; Hunsberger 1989). This knowledge and skill predominantly resides in the theories and practices of psychologists and psychotherapists and it is to these professionals that a broad range of services are turning-to to develop and inform reflectively informed practices in their settings. This has been a developing trend over recent years, with more 'psychologically informed' strategies being promoted across a range of fields including health, mental health, forensics, homelessness and social care. As such the aim is that clients are more deeply understood, practices are less defensive and there is an acceptance of the relationship between compassion and care (Department for Communities and Local Government, 2010; Innovation and Good Practice Team, 2007; NHS England, 2015).

7.4.7.2 Manager endorsed

The team also believed that the team leaders' endorsement of the group was a significant contributor to making the SSG a useful and effective space. It is important that leaders carry the culture of valuing reflection and are committed to supporting the process of the SSG. This is carried out through structures in the service which prioritise the SSG: for example, including the SSG in clinician's job descriptions; making attendance compulsory for all; allocating finances for external facilitation and staff time; prioritising attendance to the group over other service needs; and actively using the group to facilitate their own learning, development and support. This provides a clear message to the staff team that the SSG is a central feature of the work. An important feature of effective leadership can be understood as the extent to which they protect their team from the depersonalised, managerialist demands of the organisation. Through their endorsement of reflective practices such as the SSG, leaders can protect staff

from the potential damage of the anxiety laden task culture of the organisation by prioritising time to pause and reflect (Heneghan, 2014).

Leadership participation is frequently cited as a contributing factor to whether an SSG succeeds or not; when senior members of the team exclude themselves from groups, then the groups do not feel safe and in the main do not survive (Hunsberger 1989; Reid et al, 1999b). However, when team leaders attend and participate the research indicates SSGs are received as positive and supportive. This has led some to conclude that leadership participation "sanctions the group's existence; strengthens the positive, supportive aspect of the supervisor-staff relationship; and enhances the supervisor's understanding of the staff's needs" (Moynihan and Outlaw, 1984). The current research supports these ideas. If SSGs are to avoid being an empty and meaningless process, then managers and seniors in the team must be prepared to demonstrate their commitment to the process, both in terms of the structures they put in place and through their own participation in the process.

7.4.7.3 Occupationally focussed

The current study indicates that the purpose of the group needs to be clear, so that the SSG is only used for focussing on work-related issues. It can be hard sometimes to know exactly where to draw the line between the personal and the professional when engaging in critical reflexivity concerning one's practice, but the team values the underlying distinction of the SSG from a therapy group. This issue has been raised before in the existing literature (Alexander, 1993; Kennard and Hartley, 2009). However, the current study provides an indication of how SSG members are able to make this distinction in practice, by asking of each other: 'is this impacting upon how we are functioning at work?' In this way the team are able to find a way to boundary what is brought in and how it is responded to in the group, which makes the group safe and appropriate for the workplace context. Furthermore, it centralises the aims for the reflective processes that occur within the group, the point is always to support staff to stay on the task of delivering a thoughtful and helpful treatment to clients.

7.5 Summary

The present study led to the development of a model of connectedness, which captures the experiences of staff who regularly attend an SSG. The staff team expressed that their capacity and desire to remain interpersonally engaged, attached and present in their work was supported by their experiences in the group. For clients with a diagnosis of personality

disorder, who are most likely to have developed within a traumatic relational context, the capacity of staff and teams to remain connected to them in their disturbance is likely to be a much needed therapeutic ingredient. At the very least, connectedness can support the delivery of care that is compassionate and not critical. Furthermore, the SSG and its ability to restore connectedness in the team is an essential means to supporting staff. It offers staff the opportunity to 'detoxify' and support their overall wellbeing (Foster, 2019). Moreover, the insight, learning and quality of relationships that are developed through being together in this uniquely open and explicit manner provide the team with a deserved sense of purpose, value and meaning to their work. So, whilst their work might be indeed challenging, it can also be highly rewarding.

7.6 Statement of originality

Whilst hitherto we might have assumed the process and impact of managing one's experiences within a reflective group were advantageous, the findings from this research provide an original, empirically established confirmation of these ideas. To my knowledge this is the first study to confirm that the social actions of: establishing emotional awareness, relational witnessing, integrating, promoting belonging and energising are key mechanisms through which a group based reflective process takes place. What is more, this research establishes that the social action of reflecting in an SSG forum can be organised within an overarching theory of connectedness and its mutually reciprocal characteristics: the mindful experiencing of oneself in relation to the mindful experiencing of the other. Whilst previously we might have intuited this to be the case, the present study confirms these ideas within a research framework and thus provides a robust contribution to the knowledge base concerning group reflective practices. Through the establishment of an original higher order model, the processes and social actions that lead to connectedness and/or disconnectedness have now been better delineated and made explicit.

The higher order model of connectedness was grounded within the experiences of a staff team working together in a clinical setting. Therefore, the significance of connectedness within an occupational and team based context has now been implicated through research for the first time. The quality of relatedness amongst colleagues is now substantiated, rather than assumed, as critically important to the functioning and reflecting of a clinical team working in an emotionally challenging environment. Furthermore, this research is the first to elucidate the impact of such disturbing environments on team dynamics as a whole, rather than at an individual level. The model highlights the propensity for poor team relationships and

functioning in a disconnected team and the factors which may lead to this. As a result of this research, we now have a better understanding of the instrumentality of connectedness within a staff team and its role in supporting staff to stay present and engaged in the face of the distress and disturbance they experience in their clinical roles.

A more detailed examination of the potential impact and contributions of this work will now follow.

7.7 Contributions

7.7.1 Local contributions

The study has four main contributions locally. First, a central premise of recent perspectives on qualitative research is that the research serves to develop local knowledge and ultimately should be of benefit to its participants. Through the inquiry process the team were given an opportunity to explore and articulate their practice in a manner which appeared to deepen their understandings and develop their practice. This opportunity came at a time when the team were reeling from the shock of service cuts, redundancies and an upcoming merger. It was not so much the proposed changes themselves that shocked, but more the manner in which they had been delivered with a seeming disregard for the impact they would have upon a well-established team who were committed to their work. As a result, the process felt like the annihilation and undermining of deeply held values upon which the team were united and committed to. The current study gave them an opportunity to regroup, remember and rebuild the meaning and purpose of their efforts. At times it felt like the organisation was the audience to whom they directed their thoughts and ideas during the inquiry. This fuelled a sharper motivation to establish a sound argument for the preservation of relationally informed teams and treatment models. In this way the study was experienced as a creative, affirming and restorative process for the team.

Second, the inquiry process of the study was underway during the same time period as the two merging teams began meeting to design the model and structure of the new service. The inquiry process inevitably fed into these service-design meetings, confirming for the team the importance of the SSG in their work and determining the premise upon which they wished to preserve this practice. In particular, the inquiry process established for the team a sense of its unique capacity to attend to the needs of the team-as-a-whole and for having the necessary explicit conversations about each other that they felt contributed to a stable and cohesive unit. So much so, that it became increasingly apparent that these tricky conversations with the new

team were not happening and that the strength of feelings that were manifesting in the service-design meetings needed a joint place to be processed and integrated. A newly formed SSG with both teams was then arranged to begin the emotional work of merging.

Third, throughout the inquiry process, individuals commented about the insights they were gaining from the examination of their own personal ways of using the group. For some this led to changes in how they used the group, such as making an active choice to check out more where other people were at, if they weren't sure, or to be more forthcoming in responding to others' contributions as a means to both support one another and to make more explicit their reactions to the material being shared. This can be seen as a process of defining and then refining what they felt were the beneficial functions of the group and the individual contributions they could make to support this process.

Fourth, I also found myself benefiting from the research process. I left for maternity leave 2 weeks before the official merger took place. I had an acute sense of the significance of this separation at this time, leaving my professional self in the middle of a process that I would not be able to see through with the rest of my new team. Analysing the study data and writing this thesis during my maternity leave served as a means of staying connected with the team and the work whilst away. On the whole, I found the process of conducting this study helped me manage my personal experience of grief and loss as a result of the events which surrounded the merger. This has led to existential concerns for me about whether the therapeutic endeavours of myself and the team over the years have had any real meaning or value. Perhaps there has been a destructive temptation to 'jack it all in' in the face of the attack. The study has provided a continuity, a red-thread (Thompson, 2018), which has forced my flagging creativity to hang in there, to define and articulate some of the premises that I feel have mattered in my work. This has undoubtedly supported and changed me as I transitioned from old to new.

7.7.2 Clinical contributions

The study findings have clinical relevance to therapeutic work in the field of personality disorder in three main ways. First, too often, the rhetoric concerned with caring for this client group focuses on negative experiences for all involved. Staff and clients report feeling abused, and institutions are found to be ineffectual in providing meaningful support. As a result, the supposed provision of care runs the risk of reinforcing the early traumatogenic processes that clients with a diagnosis of a personality disorder are likely to have encountered. If all that staff have to manage the powerful feelings that arise in this work are strategies which defend

against their experience then they are more likely to become uncaring and unwell. The present study makes a cogent case for structures which support staff to reflect upon and make explicit with others the nature of their encounters so that they are afforded the supportive benefits of being connected to their experiences and to the people that they share them with.

> *Disturbed clients need agencies and systems (containers) that are reliable, stable and robust.; capable of holding and detoxifying the distress arising from the nature of the work and the demands of the wider political context in which it is undertaken. Only when these systems are in place can we hope to do a good enough job of caring consistently and appropriately for some of the most damaged (women) in our societies. (Foster, 2019: 71)*

Secondly, this research uniquely emphasises the critical role of teamwork and the need for psychodynamically and systemically informed perspectives to understand and develop team processes. This is a particularly pressing issue in the field of personality disorder and the psychological therapies more generally, where there is a need to emphasise the role of teams to hold up psychotherapeutic efforts. This is an essential, yet hitherto neglected area of practitioner research for our field, which is often overly preoccupied with the therapeutic dyad. This can be viewed as a reflection of the western prioritisation of the nuclear family, which often neglects the influence and importance of the wider social context. We must not forget 'the village', because in doing so we run the risk of leaving practitioners in silo to deal with the distress and disturbance they face in their role and the seeming impossibility of their task.

> *To make the team the focus of attention is also to pay due respect to the pervasive, (dis)organising social defences and potentially traumatising group dynamics that are at the heart of all work with difficult people in difficult places; and to acknowledge that, if we are to stand any chance of managing ourselves effectively in these difficult conversations in and about these dilemmatic spaces, we have to work together. (Scanlon, 2012: 214).*

Thirdly, the findings from this study emphasise the role of collective reflective practice groups, such as SSGs, as means to address the quality of relatedness between team members. Not only does this afford staff members the essential holding and support required to carry out emotionally demanding work, it is the quality of relationships amongst team members that gives rise to this work being experienced as positive and rewarding. Whilst this study focuses on the team dynamics within a personality disorder setting, the significance of team connectedness and the use of collective reflective practices to enhance this may also be relevant to a range of care professionals facing distress, dying and disturbance in their roles.

7.7.3 Organisational contributions

The study findings could be utilised at an organisational level by informing interventions designed to improve the quality of relatedness in teams. This could be relevant within health and social care settings. As such, collective reflective practices, including SSGs, could be used to form strategies for improving the wellbeing of their staff and the quality of care provision for their service-users. The findings from this research indicate that it would be wise to employ external facilitators for these interventions, as they can be seen to encourage a broader range of perspectives on dynamics they are not personally enmeshed in. The staff team's experience of the influence of leaders in this role is also noteworthy. From the top-down, the implementation of reflective thinking amongst colleagues needs to be an authentic endeavour that is seen as the work of all, not just some members. Staff in this research described a willingness to 'follow suit' if their leaders are clear about the value that they place on SSGs and they actively demonstrate a commitment to the process. Collective reflective practices that are not genuinely endorsed by managers may run the risk of being related to as another empty, box-ticking, managerial enterprise. If so the benefits of practices like the SSG are less likely to be realised. Moreover, the group will be unlikely to be able to impact upon the development of an overall culture or atmosphere.

7.7.4 Psychology and psychotherapy contributions

More and more, psychologists and psychotherapists are being approached to lead in establishing psychologically informed care-settings (Department for Communities and Local Government, 2010; Innovation and Good Practice Team, 2007; NHS England, 2015). In particular, we are able to provide a unique perspective to creating relationally secure atmospheres or therapeutic milieu through the implementation of reflective practices that improve team working and standards of care. This study indicates a model for improving relational connectedness in services, where staff can explore their reactions to work and form a stable and cohesive unit, supporting an overall atmosphere of compassion and connectedness throughout the entire setting. The findings of this research are therefore highly relevant for the training, continuing professional development and practice of psychologists and psychotherapists across a range of settings who are likely to be running or participating in such groups.

7.8 The applicability of the model of connectedness to other group settings

I am aware that the qualitative nature of this research design limits the potential to which the model of connectedness can be applied to other groups. The model of connectedness was interpreted by a unique researcher, grounded in the experiences of a specific staff team, and within the context of a unique clinical setting. This localises and contextualises the model of connectedness to such a degree that it could be argued this model is predominantly relevant to the service and organisation within which this research was based. Indeed, generalisability of qualitative research is not an expected attribute nor was it my primary aim to make claims about connectedness for other groups or services. Rather my aim was to offer a conceptual framework for the current SSG from which managers and practitioners could consider its usefulness for their own environment given the particularities of the study setting. However, qualitative researchers must address the issue of usefulness in their work if their work is to be considered more than merely interesting. This can be done by "making logical generalizations to a theoretical understanding of a similar class of phenomena" Popay et al. (1998). It is therefore necessary that I consider the relationship that my findings have to other settings and any inferences that can be drawn from the model of connectedness.

How might this model have explanatory power for others in similar situations and to what extent do I believe the model of connectedness refers to practices beyond the research context of this study? On the whole, I would hope that staff teams working in emotionally challenging environments, where intrapsychic and interpersonal associations are looked for to mitigate the impact of the disturbances faced, could refer to the grounded theory model. This model could provide them with the necessary case to establish and/or continue an SSG or team-based reflective practice group. The derived grounded theory model of my study provides some guidelines or signposts for the relational processes one might be trying to achieve in any such group if they are in agreement that the overarching aim is to achieve connectedness at a personal, team-based and clinical level. In my view, the model of connectedness provides a framework for a reflective practice group within services who intend to embed 'relational security' within their systems. It highlights the particular importance of building safety, developing emotional awareness, attending to staff relationships and splits and encouraging cohesion and togetherness amongst colleagues. What is more, the model of connectedness confirms findings from previous research that external facilitation, manager endorsement and a focus on occupational functioning are key features to facilitate a productive and worthwhile group.

However, according to Lincoln and Guba (1985) in their treatment of the assuring quality in qualitative research, the responsibility of judging transferability lies with the reader rather than the researcher: “It is, in summary, not the naturalist’s task to provide an index of transferability, it is his or her responsibility to provide the data base that makes transferability judgements possible on the part of potential appliers” (pg 316). Therefore, the task of the researcher is to provide the evidence upon which the readers judgement can be made. They propose two ways that the researcher can provide this data base or ‘evidence’, both of which I have attempted to attend to in this study. The first is to utilise a purposive sampling strategy, ensuring that the selection of participants is based upon their specific ability to answer the research questions. The participants in this research were selected on account of their being particularly knowledgeable about the practice of team-based reflective practice in the forum of an SSG. This credits their longstanding experience as both relevant and potentially useful to teams working in similar environments or adopting a similar practice. The second criteria is to provide the reader with a ‘thick description’ of the research process, thereby setting the scene and contextualising the atmosphere which surrounds the study. It has been my intention in this report to elucidate the research process for the reader by providing detail about myself and the distinct qualities that I have brought as researcher and the decisions that I have made, as well as describing the clinical team, their membership, practices and the setting within which they work. I have also provided a thorough account of the situational context faced during the data collection process and my assessment of the ways upon which this might have impacted upon the data. The aim of this thick description is not primarily so that the study can be replicated elsewhere, but so that the research process of the current study can be made both transparent and meaningful to the reader. Through this the reader should have the understanding they need to ascertain for themselves, the extent to which my findings might “ring true” and therefore apply within their context (Shenton, 2004) : 69) .

7.9 Limitations

The main limitation of the study is its inability to capture a more divergent range of perspectives. The sample size of 8 is small, even for qualitative research, and the group studied consisted predominantly of white women from a psychotherapy background who all agreed in the value of the SSG. Whilst my intention is not for these findings to be transferable to a wider population per se, this small, homogenous group has limited the potentially valuable and informative influence of difference. The timing of the data collection following the announcement of the service cuts and proposed merger, may have also added to the homogeny of perspectives that have been derived, as participants may not have been in a

stable enough position to really challenge their pre-existing ideas about their practice in the SSG. Rather, they may have had a greater need to clarify and come together in a collectively held affirmation of the process of the SSG. As an insider-researcher, I too was under this influence and therefore overall, the inquiry process has predominantly been a confirmatory one.

This is the first time that I have conducted any qualitative research and therefore I am aware of its limitations, it is by no means an expertly delivered qualitative product. Much of the literature I came across concerning qualitative research methodologies presented themselves as strict authorities concerning intricate and expert methods that are unlikely to have been reproduced at this first attempt. This is likely to have been further compromised by my combining of grounded theory and cooperative inquiry methods, no doubt enhancing and limiting their impact and reach in equal measure. The view might also be taken that my capacity to maintain high standards of methodological rigour might have been compromised in my novice attempts to navigate my way through my insider-researcher status. These are no doubt limitations of this study. Having said that this project was conducted in the spirit of creativity and pragmatism. If we wish to encourage and develop the model of practitioner-research in our field then we may need to compromise and soften the tone of methodological gold-standards, which can appear daunting and off putting to an inexperienced researcher.

7.10 Statement of reflexivity

My relationship to the research as 'total insider' was undeniably close. I was a member of the SSG upon which this study has been based and the participants were colleagues of mine, most of whom I had worked with for many years. Indeed, the nature of our work together and the team's culture of critically examining our subjectivity with one another in relation to our practice meant that our relationships were particularly intimate and close. From the outset, my insider position shaped the course of this study and the research decisions that were made along the way. In the methodology section of this study I presented the social-constructionist epistemological basis of this research, demarcating that the intention was not to provide an objective account. However, the ethnocentric characteristics of my relationship to this research warrant further critical engagement.

The decision to carry out the research and the questions that were engaged with in this study were informed by my having been a member of the SSG for several years. This longstanding experience of being an SSG member had resulted in a confidence that attending an SSG was both beneficial to my individual practice and to the functioning of the team. I was aligned with

the clinical rationale that talking about our experiences in the forum of an externally facilitated staff support group was an essential task of my work, protecting both myself and the clients in treatment from the impact of unprocessed emotional material. Indeed, it was my personal endorsement of this model that prompted my decision to investigate it further for my doctoral research study. Therefore, I went into the research with the spirit of 'paying homage' to what I deemed to be something beneficial and good.

Clearly my position *vis a vis* the SSG was neither impartial nor unbiased. In what ways might this have impacted upon my critical engagement with the data? This was a question that I grappled with throughout the research process. During the data collection phase of the research, I was particularly keen for the cooperative inquiry groups to move into unchartered and hitherto unexplored territories. I hoped the exposition of unexpected ideas would verify that mine and the participants' biases and preconceptions had not impacted negatively upon what might be emerging. As the cooperative inquiries developed, I became frustrated with what I experienced as a lack of different or new perspectives, thinking that this would compromise the credibility and dependability of my findings. This concern forced me towards the outsider end of the insider researcher continuum (CITE), and I became active in challenging assumptions and persisted with a 'devil's advocate' style of questioning. Whilst this deepened and strengthened the quality of argument in the inquiry groups, ideas that challenged our original perspectives were still not being formulated.

One of the measures I took to counteract my lack of detachment from the field was the recruiting of others, external to the team and the cooperative inquiry, to support my critical engagement with the data. It was to these others that I turned as my frustrations and doubts about the impact our biases might be having on the quality of the data. The steering group were satisfied that the emerging data was credible given that what was being said about the group was grounded in longstanding experience of SSG membership. They reassured me that it was relevant and useful to make explicit, describe and confirm what we had intuitively felt as a team for many years. My critical research friend reminded me that the task was not to measure up to standards of objectivity. She validated that my closeness to the research and my own experiences of being an SSG could indeed be viewed as potential strengths rather than weaknesses of the study. We reflected upon the pervasiveness of the early positivist messages I received and how embedded these were in my notions of 'quality' in this research. Despite explicitly choosing to sign up to an interpretative paradigm that validated and centralised my presence in the research, I found myself measuring the study up to standards of objectivity.

My research supervisor supported me to consider the contextual piece impacting upon this research and the unconscious influence that the upcoming merger would be having on the interpretations of the data. There was an atmosphere of battle with the wider-organisation, who threatened the very existence of the team. Ways of working, established through values, extensive experience and the honing of skill was being disregarded by outsiders who knew little about our work, our client population or our clinical rationale. Within this climate there was a need to attach ourselves more firmly to one another around our pre-existing beliefs, and indeed the research process came to be seen as a vehicle through which we could defend our practices. I fluctuated between the position of outsider, who wanted to dismantle what was known and trusted, for the sake of coming up with something new and that of an insider who was wedded to a way of being and one who was being called upon by the team to champion our cause. Ultimately I aligned myself with the team's position and released myself somewhat from the cruelty of continuing to challenge the group and its faith in the SSG at this time. I began to value the confirmatory nature of the inquiry and to hold the merit and worth of the security it engendered for myself and the team.

The majority of the data analysis and final coding was conducted whilst I was on maternity leave. This prompted both a physical and emotional separation from the team and the SSG that in many ways supported my return to an outsider. As I coded and developed the theory, this detachment prompted a return to my concern about my closeness during the data collection phase and what I may have missed as a result. At times I felt there was an air of consensus and agreement amongst the participants and myself that I felt limited some of the potential for negative case analysis to support the developing categories. As I listened back to the cooperative inquiry discussions, I developed a curiosity about the past group members who had not aligned themselves with the model of the SSG or could not use it to full effect and, according to the narrative of the inquiry, were therefore not able to sustain being in the team. How might their inclusion in the data have influenced the development of the grounded theory of connectedness? Whilst I was aware that it was beyond the scope of my project to find them and interview them, perhaps there were other ways that I could have explored the notion of an 'SSG casualty' more robustly, even with the participants that I had. I think that this blind-spot was undoubtedly a result of my insider position, one that I had not been able to recognise until some distance between me and the team had been created.

In hindsight, however, I am not sure how much I would have done differently with regards to my insider position and its impact upon the quality of this research. Certainly, I would have created more space for perspectives concerning the 'SSG casualties'. I went to good lengths to support the triangulation of this research with researcher interviews, meetings with steering

groups, journaling, regular supervision, all of which examined the potential impact of my insider status and whether or not to mitigate this. Perhaps the research could have been better supported by the inclusion of grounded theory expertise and SSG sceptics in my steering group or research friends. Having said that, it is important that I recognise the social-constructivist, interpretive and pragmatic epistemological underpinnings of this practice-based research, which endorse my insider status and remind me that the most important measure of quality is that the participants of this study found their participation and the research findings useful and practice-enhancing.

7.11 Future research

The current study contributes to developing knowledge about collective reflective practices in a personality disorder setting. The design and interpretation of findings in this study also generates questions that warrant further exploration and investigation. Firstly, the aim of this research was to develop a conceptual framework of an SSG and its processes. In this way it has been intentionally broad in its scope. Having established this basis of connectedness in the SSG and seven potential processes which contribute to this, it would be useful to gain a deeper understanding of connectedness and the themes that were incorporated in this model, considering their individual and collective implications for the practice, wellbeing and functioning of the team. This might include examining their impact upon staff and client relationships and examining their influence upon outcomes for the team.

This research focussed on an established team with an established SSG that was very much embedded in the practice of the service. Therefore, it would be useful to examine the influence a newly established SSG might have on an already existing team. Can an SSG be useful as an intervention strategy for struggling teams? The relevance of connectedness in this particular personality disorder service has been proposed, but would connectedness remain the pertinent issue in other clinical settings? I imagine that it would, but it would be good to investigate this further.

Finally, I have been acutely aware of the missing voices throughout the process of conducting this study and what contributions they might have brought to the development of this model. In particular, I have found myself wondering about the clients, facilitators and those often-discussed team-members who were understood to have had negative experiences and subsequently left. In what ways would their input develop and inform the finding of this study? The perspective of clients could inform how the felt connectedness of the staff team maps on to their experiences and outcomes. Former team members could shed further light on the

claims that have been made about the group's impact upon team cohesion and especially upon developing the themes of connectedness and disconnectedness.

8 CONCLUSION

During a recent visit to our team, the chief executive of the large mental health trust where this study was based commented on how commendable it was that we had managed to preserve routine 'thinking-space' within the structures of our service. He added that this might be a source of envy for some of the other services within the organisation. I remember walking away from that encounter with an initial sense of pride in us as a team and a relief for being one of the 'lucky ones'. This served as comforting reinforcement of my place in this team, I was at home here with a good-fit between my needs and values and those of the service. However, there has been a growing unease about the chief executive's passing comment and its bearing on the state of mental health services and care services more broadly. This discomfort reminded me of the questions that generated my initial interest in the current study. Why is there such little opportunity for my colleagues in the wider organisation to think? What is the impact of this upon how they experience their work and their lives? What is the experience of service users who enter this non-reflective frame? How can something therapeutic be taking place when there is no agenda which acknowledges the fundamental humanity of the staff and client-encounter? How can staff be expected to continue to endure the challenges they face at work without meaningful systems to support them? What can be done?

What can be done? This research has been my attempt to answer this question and bring SSGs into view as a team-based reflective practice forum, a means of providing a thinking space which addresses the needs of teams who work in challenging environments. Through this deep exploration of the experiences of staff, we can see that a state of connectedness can be established and re-established amongst team members who are given the opportunity to reflect together in this way. Connectedness enables staff to experience a safety and security at work, which appears to make them less afraid and therefore more available in their clinical encounters. Connectedness supports staff to recognise what they are feeling so that they can bear what they experience. In bearing their feelings they no longer need to resort to defensive and destructive means of coping. Connectedness facilitates the mutual recognition of self and other, deepening the quality of relatedness amongst team members. This affords staff with a greater, more stable self-awareness that steadies them in their clinical practice and supports their development. Connectedness enables staff to attend to conflicts, generating an understanding of misunderstandings so that they do not fracture and divide teams. Connectedness creates fellowship amongst team members, so that they are protected from the potential harm of being alone when their work evokes their vulnerabilities. Connectedness

can support an overall therapeutic milieu, a relationally secure environment that has the potential to support compassionate care and the striving to truly understand a person's difficulties. Connectedness can renew the energy of the team, so that, in spite of the demands they face they are able to remain motivated and engaged in their work.

This study also informs us that achieving connectedness through team-based reflective practices is not always easy. Perhaps counter-intuitively it requires people to get in touch with their vulnerabilities and to undertake being vulnerable in the presence of others at work. It requires that team members maintain a faith and trust in one another and in the process, even when the route is rough, bumpy and not always clear. The experiences of the current staff team indicate that there are gains to be had if these discomforts can be withstood. The team feel better able to do their jobs, to provide something of value and worth to clients, and to be able to meet them in their distress. The team feel as if they are being taken care of too in a genuine attempt to attend to their wellbeing.

So, what have I interpreted from the chief executive's comment? Reflective practices are important and staff who engage in these are to be commended. Staff who do not have the opportunity are likely to be envious of those who do because they too need the support that reflective practices engender. Despite their value and the apparent wishes of services to engage in this type of thinking, it is not possible to prioritise thinking space over the other demands that they are facing. There is no room to think, it is a luxury that most services can no longer afford. I think it is time to reverse this message. I would argue that we can no longer afford to ignore the needs of staff. NHS mental health services are facing unprecedented challenges (Cummins, 2018), including staff shortages and high staff turnover which are impacting upon care standards and service user's experiences of their care (CQC, 2018; Sainsbury's Centre for Mental Health (SCMH), 2006). This has led to the conclusion that "radical new approaches to the mental health workforce are required…to overcome current shortages of staff" (SCMH, 2006: 9). The current study would suggest that considering team-based reflective practices in pursuit of these aims is warranted.

Perhaps most concerning about the chief executive's comments was his apparent disconnectedness from the role that he plays in setting the organisation's agenda in which services can prioritise, or not, the time and space for reflective practices. Indeed, this research highlights the significant role of leadership in creating the message that reflection is an imperative for the work and not a choice or luxury. Therefore, valuing and prioritising team reflective practices need to originate from the organisational agenda in order for services and teams to follow suit. As Oelofsen (2012):

> *Driving down costs through reduced investment in staff development might lead to short-term gains, but discounting the intensely human nature of the work in health-care will invariably come back to haunt (and hurt) those organisations that do not value their staff (para. 23).*

Indeed, if we consider the SSG that was the focus of this study, implementing team-based reflective practices do not require a great deal of investment. The SSG requires one hour a week of staff time and the funds for an external facilitator. The potential benefits of this investment, as reported by the experiences of the staff in this study would suggest that it is well worth it. Perhaps the most significant finding of this study is the significant shift in discourse that the SSG seemed to allow. Specifically, the challenging nature of the work was moved from 'relentless' and 'draining' (Kurtz and Turner, 2007) to 'rewarding', 'valuable' and 'meaningful'. I hope that the chief executives out there are listening.

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Appendices

Appendix A – Confirmation of ethical approvals

Appendix B – Presentation handout for team

Appendix C – Participant Information sheet

Appendix D – Consent form

Appendix E – Handout for cooperative inquiry process

Appendix A – Confirmation of ethical approvals

Health Research Authority

Prof Vanja Orlans
Faculty Head and DCPsych Programme Leader, Faculty of Applied Research and Clinical Practice
Metanoia Institute
13 North Common Road
Ealing
London
W5 2QB

Email: hra.approval@nhs.net

Letter re-issued 12 May 2017 to provide clarification regarding insurance.
07 April 2017

Dear Prof Orlans

Letter of HRA Approval

Study title:	**An exploration of a team's staff support group in a personality disorder service**
IRAS project ID:	**114233**
Protocol number:	**N/A**
REC reference:	**17/HRA/1183**
Sponsor	**Metanoia Institute**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

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Thursday, 1st November 2012

Rachel Hopping: Candidate No. 16818 / M00197091

Project Title:

How does attendance at a weekly staff support group impact upon a clinical team's capacity to tolerate and work with psychological disturbance?

Panel Decision: Approved with three conditions and five recommendations.

Strengths of the project:

A strong project which is timely and embedded in the practices of the NHS.

Conditions:

1. Re-visit the design of the project aiming at more coherence and closer links to the actuality of the group itself; this includes the explicit acknowledgement that you are not outside of the group; a co-operative inquiry approach might be more useful in this respect;
2. Amend the project title; use the question as your research focus;
3. Include psychotherapy alongside counselling psychology as a focus.

Recommendations:

1. We strongly recommend organising an expert reference group/steering group as a way of containing the project, dealing with validity issues, and providing a support for the project;
2. In keeping your own process notes, pay attention to the participant/observer continuum;
3. We recommend you review literature on analytic systems perspectives and also management and organisational development literatures; we also suggest looking more widely at literature on reflective practice and models of reflective practice;
4. Articulate more clearly the potential your research has for the NHS and for other organisations;
5. Think through ethical positions, for example, withdrawal from the project.

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

An exploration of a team's staff support group in a personality disorder service

Rachel Hopping
2016

Research Context

- Reflective practice
  - The process by which we bridge theory and practice gap
  - REAL LIFE - Unique, unexpected, conflicting values
  - What is required is clinical reflexivity, adaptability, flexibility and non-certainty and R.P supports opportunity for this
  - Through R.P. gain new insight and tacit knowledge (Boud et. al., 1985; Kinsella, 2009)
    - "theorising action as it happens" (Bleakley, 1999:328)
- A time of diminishing reflective practices in the NHS
  - Much of the literature refers to this within the frame of an organisational defense against anxiety (Menzies-Lyth, 1959) – what happens when we work with death, dying and disturbance
  - a "turning away from the realities of suffering, dependence and vulnerability and from the complexity of managing this" (Rizq, 2012: 9).
  - Standardise thinking – McGivern and Fischer, (2012)
    - Supervision records, process notes, closing of reflective practice groups
- What can we contribute to literature on reflective practice (SSG) in our team and how it improves outcomes for staff and clients?

Research Context

- Reflective practice
  - The process by which we bridge theory and practice gap
  - REAL LIFE - Unique, unexpected, conflicting values
  - What is required is clinical reflexivity, adaptability, flexibility and non-certainty and R.P supports opportunity for this
  - Through R.P. gain new insight and tacit knowledge (Boud et. al., 1985; Kinsella, 2009)
    - "theorising action as it happens" (Bleakley, 1999:328)
- A time of diminishing reflective practices in the NHS
  - Much of the literature refers to this within the frame of an organisational defense against anxiety (Menzies-Lyth, 1959) – what happens when we work with death, dying and disturbance
  - a "turning away from the realities of suffering, dependence and vulnerability and from the complexity of managing this" (Rizq, 2012: 9).
  - Standardise thinking – McGivern and Fischer, (2012)
    - Supervision records, process notes, closing of reflective practice groups
- What can we contribute to literature on reflective practice (SSG) in our team and how it improves outcomes for staff and clients?

Reflective practice literature

- Such challenging environments are associated with a range of staff and patient outcomes -
  - (Kahill, 1988), impatient and intolerant approaches to patient care (Maslach and Pines, 1977) high staff turnover (Jackson et al, 1986), absenteeism (Firth & Britton, 1989) and diminished job performance (Maslach & Jackson, 1985).
- There is a need for R.P. in these settings as research indicates that those who actively confront the emotional demands they face at work are less likely to develop burnout (Maslach et al. 2001)

Reflective practice and personality disorder

- Working with p.d. is emotionally challenging
  - A range of staff and client outcomes - Differential treatment (less optimism, less sympathy, seen as more difficult) (Cleary et. al, 2002; Markham and Trower, 2003)
  - Higher levels of staff burnout (Melchior et. al, 1997)
  - Lower levels of burnout and increased job satisfaction when experience of managers is favorable, team-work practices and effective leadership (Bowers et. al, 2005; Crawford et al, 2010) -
  - NICE, NIMH(E) cite the importance of reflective practices and support for staff in treatment guidelines
- Particular role for teams – under-researched
  - Threat of psychological disturbance in the 'team' – e.g. splitting (Crawford et. al, 2010)
  - Qualitative research indicates the source of stressors for staff working in p.d. settings centre on *staff relationships* rather than pt. relationships (Crawford et. al 2008; Fortune et. al, 2010; Kurtz and Turner, 2007)
  - Poor staff relationships the *foundation* of negative experiences
  - 'The loss of well-being that resulted from isolation within the staff group was pronounced, leading to the threat of breakdown or madness' (Kurtz and Turner, 2007: 427).
  - Summary – my view staff support group is a process of reflective practice that enables staff dynamics to be the focus and therefore an important avenue for investigating further

Reflective practice literature

- Such challenging environments are associated with a range of staff and patient outcomes -
  - (Kahill, 1988), impatient and intolerant approaches to patient care (Maslach and Pines, 1977) high staff turnover (Jackson et al, 1986), absenteeism (Firth & Britton, 1989) and diminished job performance (Maslach & Jackson, 1985).
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Staff support groups

- Lack of clarity in literature – what are they? What theoretical basis?
- In my mind what appears to be the interesting distinguishing feature is that they focus on the staff dynamics rather than the patients
- Loosely associated with systemic and group-analytic theory
  - Bion – containment and thinking – primitive affect and 'acting-out'
  - Foulkes – 'by the group and of the group' - neurotic processes addressed as meaning becomes communicated and understood by 'patient' (staff) and group
  - Attachment theory – group promotes experience of team as a 'secure-base'
  - Increase reflective function of team

Research on staff support groups

- Warnings! – a place where anxieties are acted out rather than contained – even their set-up may be a defensive manouvre against management issues
- Robertson and Davison (1997) – over 70 variances of SSG in a single psychiatric hospital
- Broad applicability - psychiatric, medical, forensic, social services and education – however dearth of clinical and/or research literature
- Quantitative – 2qs - what types and how useful are they?
- Kanas 1986 – reviewed a range of different SSGs – how they are set up is related to how 'effective'
  - – 'optimal' conditions – clearly defined, feelings focused on professional setting, have an 'active' external facilitator, a focus on group dynamics
- Qualitative – Reid et.al, (1999, b) – what supports mental health nurses? – anxious and ambivalent about SSGs – seens as unhelpful, - largely operational issues, including being unclear about their purpose, attendance to the groups characterised by inconsistency and avoidance and the majority of groups discussed lacked the support of a facilitator. Hierarchical dynamics also appeared to obstruct the groups, with managers reporting that they felt it inappropriate and unsafe to display their vulnerabilities
- Robert and Davison (1997) Semi-structured interviews – SSGs an 'object of fear – unclear aims, attendance is avoided particularly by senior staff
- Reid et al, (1999, a). When SSG seen as helpful, helpful they expanded with reports that they could be used to facilitate a sense of being part of a team, discuss the impact of patients freely and share their difficulties and concerns (Reid et al, 1999b).

Relevance to us and Research project

- As a team that meets the optimal criteria for a ssg…
- How might we contribute to clarifying/thinking about reflective practices and working with team dynamics in work with P.D.?
- Also…what do we think about our SSG? Why do we do it? Good or bad? Could we improve it/change it?
- How might we explore this?

Co-operative Inquiry

- Initially thought to interview individuals in the team on what they thought about the SSG – this was challenged by my research tutor – the focus of this research is a 'group' – therefore data should be gathered from the collective living interaction that characterizes the SSG itself
- Co-operative Inquiry (Peter Reason and John Heron)
- Stems from action-research –
  - With people not on people
- research that is embodied within real-life practices and experiences and has a direct impact/contribution to the 'researched'
- Thus research questions, designs and data will come from the team

Co-operative Inquiry

- It is still however a systematic process to research
- Cycles of research and action
- Four phases
  - 1. – Group reflection on shared area of interest (SSG)
    - Agree a set of questions or propositions to explore
    - Agreed set of 'actions' to explore these and record experience
  - 2. – Take these actions in to day to day work
    - Observing and recording experiences and outcomes of actions
  - 3. – members become 'immersed' in the experience – being open and deepening understanding of actual experience – might lead you away from original propositions/ideas
  - 4. – re-gather to share experiences - research questions, focus, actions and data-gathering might change at this point in light of member's experiences
  - Repeat as required
- Data will be analysed and used to induct a theory about SSGs that is grounded in our practice
- 2 branches – explanatory or change?

What next?

- Need to set some dates
- Sessions really need to be longer than an hour – this will give us a chance to reflect deeply on our group and then plan well for 'phase two and three'…

Appendix C

Participant information sheet

An exploration of an NHS team's staff support group
IRAS Project ID: 114233

Participant information sheet

Thank you for your interest in participating in a research study. Please read the following information carefully before signing the consent form.

1. Study title

An exploration of a team's staff support group in a personality disorder service

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part in the study.

Thank you for reading this.

3. What is the purpose of the study?

The aim of the study is to explore how our team uses our weekly staff support group to support our work in a personality disorder service. This will enable us to have a better understanding of the group and how it works best for us as a service. It will give us the opportunity to reflect on the impact of our membership of this group and its potential benefits and disadvantages. It is hoped that this research will also provide a valuable contribution to the literature on supports for staff working in emotionally challenging environments.

4. Why have I been chosen?

You have been chosen to take part in the study as you are currently a member of the staff support group that is to be the focus of this research.

5. Do I have to take part?

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

6. What will happen to me if I take part?

If you decide to take part in this research then you will be invited to attend an initial group meeting where we will reflect on our membership of the staff group and explore any propositions we may have about its use in our work. Based on this discussion we will then agree on a set of actions to explore this in depth in our day to day work. We will then meet again as a group to discuss our experiences and review how these influence our original ideas and thoughts about the group. This cycle of reflection and action will be repeated around 3 or 4 times over a period of about 6 months.

7. What do I have to do?

Participate in approximately 3-4 group discussions with fellow group members (discussions lasting 90 minutes). These will be tape-recorded and used as data for the study.
Record your experiences in your day-to-day work to capture the 'lived' impact of the group. This might be through reflective writing, art, poetry, voice recording etc. and will be agreed by the group during each meeting. These records will need to be collected by me as data for the study.
You might be asked to experiment with using the staff support group slightly differently or contributing in a particular way. For example, as co-researchers we might decide to experiment with being more honest about uncomfortable feelings in the staff group to see how this alters the group process and its impact on our work.
You might be asked to review transcripts of discussions to verify their trustworthiness

10. What are the possible disadvantages and risks of taking part?

There are no known risk of taking part in this study. However, we cannot know from the outset how the process of reflecting on the staff group, our work and the team dynamics might impact upon you and the workings of the team.

11. What are the possible benefits of taking part?

I hope that participating in the study will help you to gain a better understanding of the workings of the staff support group and how to maximise its potential benefits. However, this cannot be guaranteed. The information gained from this study may also help to improve the use of reflective practice groups in other settings.

12. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

It is possible however that due to the unique circumstances of our group and its' setting once the research is shared the team may be identifiable. Whilst every effort will be made to limit this possibility, this is something for you to consider when consenting to participating in the research.

There are limits to upholding confidentiality, where there is disclosure pertaining to significant risk to self or others. If this were to occur I will discuss with you first, wherever possible, to determine the best next steps.

All data will be stored, analysed, reported in compliance with the Data Protection legislation of the UK.

13. What will happen to the results of the research study?

The results of this research will be published as part of a postgraduate dissertation by the end of 2017. I will notify you when the results are being published and you will be offered a copy. No personal identifiable information will be included in any report or subsequent publication.

14. Who has reviewed the study?

The Metanoia Research Ethics Committee has reviewed this study and given their approval for the research to be conducted.

15. Contact for further information

Rachel Hopping (Researcher)	Vanja Orlans (Research Supervisor)
X	Metanoia Institute
X	13 North Common Road
X	Ealing
X	London W5 2QB
X	Tel. 020 8579 2505
X	vanja.orlans@metanoia.ac.uk

You will be given a copy of the information sheet and a signed consent form to keep.
Thank you for agreeing to take part in the study!

Appendix D

Participant information sheet

An exploration of an NHS team's staff support group

IRAS Project ID: 114233

CONSENT FORM

Participant Identification Number:

Title of Project: An exploration of a team's staff support group in a personality disorder service

Name of Researcher: Rachel Hopping

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……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. If I choose to withdraw, I can decide what happens to any data I have provided. ☐
3. I understand that my interview will be taped and subsequently transcribed ☐
4. I agree to take part in the above study. ☐
5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____ _____ _____

Name of participant Date Signature

Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix E

Handout to participants of initial propositions and early themes that emerged from 1st discussion

Here are some of the early propositions that we formulated during our first inquiry meeting for you to keep in mind during the experiential phases of the process.

FEELINGS

The SSG allows us to name and process our feelings so that we don't act out with clients/each other

External world

TEAM

good team working

functioning of team

SELF-INTEGRATION

Contains primitive process

Minimises the impact of our own material on the work

FACILITATION

Is dependent upon facilitator to work

Dependent on safety and trust

DEFINITIONS?

A reflective space

Acknowledge impact of work

Supports co-working and use-of-self

About thinking

Open and equal space

Based on trust and time

Enhances communication

IMPACTS

Sickness

Retention

Clinical outcomes

Responses

Here are some of the early codes that an initial analysis has revealed:

Supporting relationships with each other	It's about basically our relationships in relation to each other and also about what it's like to work here, I suppose And a part-- a big part of us being here is we need to be able to manage our relationships and emotions We come here and we do have to find a way to get on with each other first of all, 'cause if we don't have a good working relationship or, uh, not even good. you have to, as a group, start listening to each other's perspectives, and that's not easy, I mean, you can't be a manager-- you can't appreciate somebody's position as a manager if you have no understanding of it and the difficulties that they encounter and the things that they have to manage. For a long time, and it was awful, actually-- this sounds a bit sadistic, but there was something about, we had to get through, to get to a particular point.
'working'	Is that the intention to make you better at your job or is there a different intention? It was always the staff support group in the places where I felt that it was a really good experience of being in that ward. Well, it's all- it's all about the work. If you think about a place like this. The- the main purpose is to help people with their relationships with-with our clients, then we have to able to relate to each other which means that you can't actually get on with the work in quite the same way as you could do if you - you had something like this. it's not going to be easy to manage ourselves and the work and these, you know, our relationships. The -- is going to be affecting my work or the what has happened as a result of the work.
Acting out	And that if the staff-the staff aren't given that opportunity, then the difficulty is or whatever would kind of come out in different ways. So, there could be kind of, call it acting out, call it what you will.

	actually, all those kind of difficulties get played out out in other ways, c-come up in other ways, So I kind of agree with x that the likelihood is you don't have staff support groups then the acting out amongst the staff team is probably higher. And I've been in a staff team there hasn't been a staff group and the acting out from what I've observed and probably done myself has-has been more. And one of the things I can think of that moderate that is-is the function of the staff support group.
Trusting the process?	You know you've got to work out in my mind for yourself what's safe enough to say and what's not They would have a facilitator. So, it would need to be someone from outside It's kind of difficult really. Staff group is a very difficult place to be. It can-can be a contentious place and, you know, we're supposed to work things through. It doesn't always work like that. It's been a bit cut-throat actually. That's how they get their, uh, their comfort and their support and their-- or whatever but I think the group was struggling to contain it in the group and it was leaking outside. well, did-did-did the group then set out to do what it was supposed to do or had it not been there, actually, would it have been a lot worse? I've said things in this staff support group I haven't ever shared with other staff teams before. To me, this generally feels a secure place. For me, when I expose my vulnerability and the response I've had back that's about my relationship with staff have felt securer.
Because of damage or doing damage?	Just because we get so wrapped up in each other's transferences. I think it's been very important because the relationships we're working with it, we work with really damaged people and they have an impact on us and our relationships with each other, we as staff aren't perfect either, [laughs] and we can get into difficulties or get stuck or, um, or things can happen outside of here we might need to be supported and get support from each other to be able to work with very, um, very damaged people that have a lot of difficulties managing their emotions

	I would talk about my experiences with the patients, who were extremely aggressive, and some of the people who were supposed to be facilitating us didn't believe it. And it would impact on how we work with clients and we do- It's not something that you can separate, really. It can inflict serious injuries on us. You can't work with people who are damaged without them damaging you. We could also be quite damaging [laughs] towards the clients.
Managing conflict	Personally, I feel like in terms of conflict, I think the problem with the conflict would probably already be there to some degree. It was a highly contentious place, you know? That's when it starts getting conflictual. [sic] I've been pushed into thinking, "Am I on this side? Am I on that side?" and it's not been pleasant. And it wasn't in my mind resolved particularly well. So it-it's been quite a tough place to be actually it-it takes me back to something when I got bullied in the group, as well. That was really horrible and that's And I think coming to a staff or support group might heighten it. I'm not sure if that's a way to necessarily resolve it, because it gets too heightened and too hot, it's quite hard to resolve something. I was thinking in terms of other conflicts that we've had, sometimes they can get isolated between two members. And I think coming into the staff group shares that out.
A fabric of the programme	when I started this service there was no doubt in my mind that we wouldn't have one of these groups For me, it was part of the fabric of the program Well, it is actually in people's job descriptions to be involved in a job like this. It's all in our job descriptions I felt, was that you're insistent everybody should come and, um, if you were any-anywhere on the scene, you needed to be in it. People couldn't just take themselves out because it wasn't convenient or there was some contentious issue that they didn't want to work-- be involved in But it did make a difference, huge difference, having everybody be present and being involved and even if there-- they were to-to-to-- just- just accepting each other's opinion or position on things made such a difference.