TOWARDS THE RE-CONSTRUCTION OF A CLINICAL PSYCHOLOGIST AND A REFLEXIVE BODY OF PRACTICE.

1. Presenting myself, the research setting, and early research questions.

Presenting myself.

I enrolled at Bath University in the PhD programme several months after starting a new job as a Clinical Psychologist in an NHS Mental Health Unit. By that time I had been in the country for just on two years after moving here from New Zealand. For my wife Jan it was a return home after thirty years away, whereas for me and the children it was a first encounter. At both a professional and personal level I had experienced these two years as a time of adapting to a new culture. Although very similar to the one I had come from, there were many subtle differences and much family discussion in those first two years was about comparing and contrasting as we explored and made sense of our new surroundings. We were still 'feeling our way'.

Professionally I had come with strong roles as a practitioner and as a teacher and trainer and found that these were well received. However, my researcher role had been underdeveloped over the years, relegated to the background, remaining muted. Coming to a new country offered the opportunity to develop this role and I found a greater receptivity and encouragement for research here than I had experienced in New Zealand. In a different social and political climate I felt more liberated to explore the possibilities for research. But first, some background to why this was so and how this influenced my approach to research.

Research as 'problematic'.

By the time I enrolled at Bath I had been working as a Clinical Psychologist for twelve years. Two of these had been spent in Australia immediately after qualifying, followed by eight in Auckland, the largest city in New Zealand and the largest Polynesian city in the Pacific. I had worked across a variety of settings with a broad range of client groups. Over that period I had moved away from the mainstream models which informed Clinical Psychology in the western world.

Clinical Psychology formally presents itself as occupying a unique position among healthcare professionals through its adherence to the Scientist Practitioner model, in which practice is said to be informed by research based theories and methods. The latter are rooted in the experimental and applied experimental tradition, carried out in either laboratories or highly controlled settings, with a view to confirming or disconfirming a priori hypotheses about the events in question.

In practice, the prevailing model for treating or intervening in psychological disorder or distress is Cognitive and Behavioural Therapy. Essentially, this posited that the individual had learned 'maladaptive' ways of both appraising and responding to a presumed objective reality. It was the task of the therapist to help him or her to unlearn these maladaptive responses and re-learn new and 'more adaptive' responses. The Scientist Practitioner model eschews the more traditional forms of psycho-dynamic psychotherapy (originating with Freud) on the grounds that (within its own frame of reference) they were not based on theoretical models that could be demonstrated through research to be effective.

While this model and its methods has its place with a certain range of problems, to my mind they did not address the complexity I encountered in working with families, groups and organisations in trying to develop increasingly effective mental health services which worked with people in the context of their daily lives. Instead, I was drawn to family systems models such as Minuchin's (1974) Structural Family Therapy, the so-called 'strategic' therapies of Hayley (1976) and Watzlawick, Weakland and Fisch (1974), and the 'Milan systemic' model of Palazzoli et al (1978). These were grouped together under the family systems umbrella and acknowledged a debt to the thinking of key individuals such as Bateson (1972, 1979). These approaches were characterised by a view that mental health problems were best understood and worked with by seeing the person in the context of family and social relationships. It was assumed that problems were embedded in patterns of relationship and these patterns required change for problems to be resolved. The practice of these forms of therapy required

the therapist to shift towards seeing meanings or realities as being shaped by and shaping in turn these significant relationships. Therefore, there were different 'realities' or aspects of reality according to the unique sense each individual and family made of their lives.

I found this approach met with my own interests and provided me with ways of practising which allowed me to feel more therapeutic and effective in working with clients and the dilemmas they faced in their lives. It also lent some ideas to the day to day challenge of delivering mental health services which were relevant and accessible to clients.

Over the years I had come to respect social and cultural as well as individual dimensions to mental health. This had led me to working in voluntary and statutory organisations and with different cultural groups, looking for opportunities to expand my knowledge and expertise and at the same time develop services which met need in a more flexible way. I had also developed the idea that there was a social change dimension to addressing mental health problems, as increasingly the connections with poor housing, social isolation and unemployment became clearer over the course of the 1970's and 80's in New Zealand. I also saw that social change was needed within services as they were required to adapt in order to meet the needs of their target groups. This was particularly so in the move away from mental health services being provided solely in hospitals towards being increasingly provided in the communities in which people lived.

I had increasingly found myself paying a good deal of attention to the interface between clients and the agencies I worked for. How we as health workers interacted with each other seemed inextricably related to how we interacted with our clients and the local communities so that change could be facilitated. I became increasingly interested in the possibilities for partnership as I learned through experience how volunteer workers and both formal and informal networks in local communities could contribute powerfully to helping individuals and families in crisis. This meant in practice that I paid attention to how I related to colleagues and how we as a group related to clients. I found it difficult to turn a 'blind eye' to team problems or incongruities between espoused values and practice, and would work hard to resolve these. I was not aware of the degree to which this was apparent to colleagues I had worked with until I came to leave New Zealand. All of the written references I received commented on this as a role valued by others.

This growing interest lead me to changing jobs about every two years, moving to take what I saw as opportunities for developing new services, or changing existing ones, so that the needs of people with mental health problems in the larger community in which I lived could be met in more relevant and accessible ways. I took on roles as family therapist, trainer, consultant, service manager and project leader, in addition to also providing some of the more traditional roles expected of a clinical psychologist. In doing this I departed from the usual roles my psychologist colleagues played and together with the shift in theoretical orientation I found myself in an ambivalent relationship with psychology. On the one hand I came from psychology and gained privilege from this in terms of gaining jobs and a certain status. I also had to acknowledge that I had learned a set of skills that prepared me to be an effective problem solver within certain domains.

On the other hand, I felt uncomfortable at its narrow focus and its overall unwillingness as I saw it to embrace the social world. While I maintained professional relationships with psychology colleagues and was professionally active in contributing in small ways to teaching and training of Clinical Psychologist trainees, I felt I had to look outside the profession for colleagues who thought similarly

Allied to this shift in practice focus was a shift in how I saw research. In moving away from the more traditional and individually focused models for practice, I had also moved myself away from the more traditional models for research and evaluation. The experimental or applied experimental models for research were still held as the ideal, but they had never left me feeling particularly comfortable. The methods neither seemed to be able to answer the questions I wanted to ask, nor did they seem to offer a way of relating to 'subjects' which valued their contributions or contributed directly to their particular need. My only formal endeavour in research was for a dissertation for my Master's degree. This was an applied experimental approach with a control group which investigated 'cognitive deficits' in young people diagnosed Schizophrenic. I can still recall the discomfort and sense of shame I felt at my inability to adequately or convincingly answer the questions they asked about the experimental tasks,

and about the 'why' of the research and what the findings would mean for them. The research helped me qualify but I doubt it helped the 'subjects' in any way.

If I was to engage in research it would have to be congruent with my changing world view. I had moved to assuming that people's thoughts and actions could be made sense of in a variety of ways by taking into account their individual histories and their family, social and cultural contexts. I believed that if I could understand or gain access to the contexts in which mental health problems were located, then I could find ways of working which by-passed guilt or blame, affirmed competence, and promoted an understanding that each person was doing their best within the limits of their experience, their social setting and the resources available to them. Researching from this perspective with the models I was aware of seemed impossibly difficult. This was not always consciously held but occupied a position at the edge of my awareness and took centre ground whenever I thought of myself doing research. I seemed to be in the midst of a tangle of questions about my practice which merely led to more questions, and I felt easily overwhelmed and defeated when contemplating research. In addition, I had learned to work across a variety of theoretical and practice frameworks and I could not account to myself at any one time which had been the determining factors in either success or failures. Such an approach did not fit with the research approaches I was aware of. I had a small network of colleagues who worked in the same broad territory, but none of us were researchers. I did not have access to a research community which could help with these dilemmas and so my doubts and vulnerability about doing research remained private.

Further restraints on 'researcher self'.

It is important to note at this point that research was low on my agenda during these years for other reasons, both personal and social. As I felt strongly about service delivery I tended to see research as a luxury in the midst of scarce resources. I felt strongly about research projects started by others which seemed to become the 'tail which wagged the dog' and cut across what I saw as good practice. For example, in job earlier in my career in New Zealand, a consultant psychiatrist colleague insisted on admitting to hospital all women who presented for help to the service with depression. He had recently arrived to work in a ward on which I worked half-time. The other half of my time was spent in the community mental health centre which served the same catchment area and which was set up to prevent, as far as was possible and appropriate, admissions to hospital. The staff in this centre saw social factors as playing a strong role in mental health problems and prided themselves in setting up crisis services and local support networks which had halved the number of women admitted to psychiatric hospitals with depression over the preceding three years. The consultant, by contrast, believed that depression was biologically determined and had set up a research trial to investigate it which required women to be admitted to hospital in order to be available to take part. It took a considerable time to develop a viable working relationship with him in which research decisions did not dictate how clients needs were best met.

At a wider social level, I found it difficult to engage in research because of a powerful cross-cultural dialogue which had emerged in New Zealand society. The indigenous Maori people had developed an increasingly powerful voice which said that the most important item on the health agenda in New Zealand was the survival of them as a race. Although they comprised only ten percent of the population they were hugely over-represented in prisons, in social services care homes, in first admissions to psychiatric hospitals, in road accidents, in illness and mortality statistics. They were a dying race, on the verge of losing their language, their health, their spirituality and extended family and tribal structures. These were all connected fundamentally to the land, which they had substantially lost in the last century. They argued convincingly (to me) that health care would only work for them if provided in culturally relevant and acceptable ways by people who were competent in that culture. Their argument was that they should be given their share of resources and the necessary decision-making power to develop their own services in the context of their own beliefs. Any involvement of Pakeha (European) health professionals would only be acceptable on a partnership basis.

I felt this to be an enormous challenge which I could not in good faith avoid, and so, with a small group of other Pakeha colleagues, became very fully involved in working with Maori people in developing services which were meaningful to them. I will illustrate some of the issues this raised for me in terms of becoming a researcher later. But for the moment, I wish to make the point that these events provided for me a further constraint on doing research as I understood it to be. Providing relevant services in the

face of such urgency and competition for scarce resources pushed research to the bottom of my personal agenda.

Indeed, in that setting research would have been seen as counter to the spirit of the partnership. As the more radical Maori groups developed an increasingly sophisticated political analysis of their situation, they were clear it was their job to work with their own people, whereas it was the Pakeha's job to work with their own and raise consciousness about institutional racism. Their purpose was to regain sovereignty over their own culture, and regaining health was inextricably related to this. Against this background, and given my values and understandings about what constituted research, I effectively ruled myself out from being a researcher.

Beginning to see myself as a potential researcher

On arriving in England, my views about research changed. Firstly, I felt freer in a new cultural context to be more curious about my role as a researcher. Here I was a member of the 'host' culture, no longer a member of a visiting dominant culture which was hosted by the 'people of the land' who were physically and metaphorically at risk of dying.

Secondly, in my first job in England I worked with colleagues who had a more embracing notion of research as being part of professional practice, albeit still predominantly within the prevailing traditional scientific paradigm. My first boss persistently challenged me to begin a small research project on some aspect of my practice in order to 'break the ice'. I felt able for the first time in my life to confront research on my own terms. I also wondered if I could feel more a part of the Psychology community.

At that time, Clinical Psychology in Britain was going through an exercise of reviewing itself in relation to new directions in the NHS, looking at 'manpower' issues such as supply and demand, and future trends for the profession. Critical commentators on this exercise (e.g. Pilgrim and Treacher, 1992) saw this as an unashamed marketing exercise in the face of likely competition from other professionals and non-professional workers in the new 'Health care as an internal market-place' orientation being promoted by central government. However this review was seen, it proposed a model for practice which was widely adopted. The model comprised three levels of expertise. Level one described a level of psychological competence required by all who worked face to face with clients/patients. Level two described a level of skill and knowledge acquired by other health professionals under the tutelage of Clinical Psychologists in order to deliver circumscribed treatments and interventions for targeted problems. Level three was a level of expertise owned only by fully trained and experienced Clinical Psychologists who had a broad range of theory and methodology to draw upon to design interventions at the level of individual clients/patients, teams and organisations. This level was called a 'Consultancy' level and the review advocated that Psychologists needed to develop this more fully in order to 'survive' cuts in services and increasing restrictions on 'manpower' in health.

Whilst I was sceptical that Clinical Psychologists would be capable of this on the basis of their original training and the Scientist Practitioner model, I could see merits in some psychologist developing this Level Three competency. Against this background I saw myself as needing to develop my researcher role in order to become more fully rounded professionally.

Finding a starting point

In thinking about where to start, I kept returning to a prevailing question which had trailed along with me through my work. I had often had the experience of doing work which was effective in producing change of some sort, but which left me thinking along the following lines.

> That was successful, but I am not exactly sure why. My view of it will most likely be different from each person involved. It has something to do with entering how others see the world and with providing different ways of seeing things. But I do not feel as if I have the tools to evaluated this as each case/situation is different. I am curious about what it is that I do because I believe that my involvement is part of

things shifting in different direction. Yet, I cannot claim credit for this any more than the others involved. I am also wary about being too public about what I do as I feel I may, in some unaccountable way, give away 'power'.

So, I came into the research looking for an approach which fitted my beliefs and values and which helped me to understand in a more rigorous way what it was that "I" did when I worked. I came not only with an interest in the personal, but also the social. Alongside this I carried some questions about making public what I did and some questions about my relationship with Clinical Psychology and with the teams and agencies with whom I worked. I will return to these questions in more detail after describing my work/research setting.

The research setting.

At this point I would like to provide an initial description of my work setting and my motivations on joining it by way of sketching a backdrop for later developments in my research enterprise.

My hopes and fears.

The parent organisation I joined at the outset of beginning the research was an NHS Mental Health Unit which provided comprehensive services to people with mental health and mental illness problems. Within this unit I belonged to a small department of about forty staff members specialising in addictive behaviour. At that stage, I was the sole psychologist with responsibility for specialist psychological services within the department. We served not only the local health district but also the surrounding health region. Our department was the smallest of five within the unit and at that stage we were all being prepared to become a Trust within the NHS reforms, with the change in management arrangements that entailed.

The other four departments, which at a later stage I was to have some involvement with, were organised around provision of mental health services to children and adolescents, the elderly, and adults.

I had several motives in taking up this job. I needed to work closer to home and regain lost time from daily commuting as I had spent the previous two years working in a neighbouring county. I needed to both live and work in the same locality to establish a stronger sense of interconnectedness within my new chosen country. But professionally, I needed to be a part of a work organisation which was more alive to itself and to the possibility of continuous change and development. This position had been newly created along with several others in recognition of the need for change and development and I was attracted to the idea of being in on the ground floor.

My previous work pattern had been one of continuous movement, staying for no more than two years in a position in order to develop some new aspect of the service before moving on. This had meant a lot of rapid learning for me and now I wanted a different experience, of being in a service over a longer period, to be a part of a longer term development. I was curious about what skills that would take and how I would handle this. I was also wanting a base for consolidating many of the things I had learned, and I wanted to feel I 'belonged' in my chosen community. The choice of this job therefore was a mixture of pragmatism and hope.

It was also a risk and a gamble because from previous contacts with the parent organisation I had developed impressions of it as being a static one which had been slow to undertake moves towards community based services. It had a very close connection with a medical school in training psychiatrists and doing research and I recalled my earlier experiences in New Zealand and the tensions between doing research and giving a service. I was also aware that I was returning to a psychiatric hospital setting and I had some ambivalence about that. In my frequent job changes in the past there had been a pattern of seeking to escape from the confines of institutions but then being drawn back to them by the challenge of opening them up to the wider world - to make them more a part of a planned

continuum of care, open and relevant, as opposed to being closed and a repository for people for whom 'social control' was the covert agenda.

A brief history of the service.

At this stage, I need to dwell briefly on the history of the department before my arrival, as this explained for me some of the issues which arose during the initial period of change. Historically there had been two separate services, one for drug problems which was community-based and non residential, and one for alcohol which was residential and hospital-based. Some of the staff had worked in both at various times but each service ran along different lines, offered different components of treatment and care and operated from different sites. The client groups which each served shared similar problems, in terms of addictions and substance misuse, but were distinguished by the legal/illegal nature of the substances they used and the different sub-cultures which develop accordingly.

The first major change in this arrangement had occurred two years earlier upon the arrival of William, the new Clinical Director. He had rapidly dismantled the existing alcohol service and had developed one which was more responsive to the needs of referrers and clients for shorter waiting lists and a broader range of interventions. Before that the service had revolved almost entirely around a six week residential group therapy programme which had been run mainly by the nursing staff. For several years they had enjoyed high levels of autonomy in the absence of a senior medical person in the role of clinical director.

'Key Players'

This was a term I heard used by staff in my early months in the job. I read it as denoting who was seen as having potential influence in shaping the direction of the service with the impending developments. Gerry was the senior clinical nurse who had been appointed six months before my arrival. This was his first senior post and he came highly recommended by his previous employers and was keen to be seen as playing an influential role. This was a major move for him as he had relocated his family to take the job. After meeting him as part of my orientation, where we swapped backgrounds and professional interests, he remarked "I can see you are going to be a key player". I took that as a compliment but also felt it to indicate that I had been 'sized up' as to the degree of influence I was likely to have and the implications for the relationship we might have with each other. It contained a competitive edge for me that I was to feel with several other senior male colleagues who had recently joined. On the other hand I was also to experience strong bids for alliance from some of the more junior staff who had been there for some time.

Shortly after my arrival, we were joined by Stewart who was to be the second consultant psychiatrist, specialising in drug problems. This was his first job as a consultant psychiatrist (although he had experience in a general medical field previously) and he was keen to develop the drugs service which William had left untouched. Like William, Stewart had come to this job directly from a teaching position in the university. Both had an espoused interest in mainstream cognitive and behavioural treatments for problems associated with addictions, and both had researched and published in this area. Stewart particularly made clear his views that this was the 'way to go' in providing psychological services. Both had very strong opinions about how services should be organised and delivered, but neither had much experience of putting this into practice. It was evident that they were unclear about how they were going to delineate their areas of responsibility, apart from dividing their work along their separate interests in alcohol and drugs respectively. As consultants they would automatically generate referrals which then required the resources of other disciplines. They had not considered how they would negotiate this and what the implications would be for others' workloads.

We were then joined by my wife Jan who filled a new and combined post of Service manager and Assistant Director Of Nursing Services. She and I had enjoyed working together at different times in New Zealand and were looking forward to doing so again, especially as we had also enrolled together at Bath in the postgraduate group. Her responsibilities were for professional and managerial leadership to nurses within several departments, and for the management and administration of the business aspects of our department. She and I had worked together jointly with clients as family therapists in the past, before she moved on to management and organisational change roles. We shared a similar

language as professionals as well as having a personal partnership. From my experience of working with her I knew that one of her strengths was her ability to work with different professional groups in the interests of developing innovative services while still advocating strongly for nursing as a profession. In the past we had managed to use our personal partnership as a strength in our professional partnership and I had no doubts that it would be the case again. However, I wondered how we would be seen by colleagues - would they see us as a couple at the expense of our individual selves, would differences with one become differences with both, and if so would this compromise open relationships in the department?.

With the arrival of all the new senior staff we were able to begin the task of integrating into a combined and comprehensive clinical service which served not only the local Health District but also the surrounding health Region.

Intimations of things to come.

The changes required were massive and at all levels. There were changes in roles, in professional and power relationships, and in management and decision-making structures, not only within the department but between the department and its parent, the Mental health Unit. With the changes came times of crisis and instability. For some this meant welcome challenge, for others unwelcome stress as their jobs had changed in ways they had neither predicted nor wanted.

For those staff who had worked on the alcohol side in the residential hospital base, this meant doing less long term counselling, more crisis work and detoxification, and dealing for the first time with clients/patients who had drug problems and very chaotic lives. This left staff at times feeling de-skilled, lacking in new skills and unsupported.

For those staff who had worked in the drugs side, the changes meant more resources available, less autonomy and more interdependence. There was a heightened role conflict around clinical responsibility which was generated by the introduction of substitute prescribing of legal drugs for opiate dependent and injecting drug users. While doctors prescribed these drugs, it was mostly left to the nurses and counsellors to take responsibility for negotiating changes with the users who frequently sought changes in both the level of drugs and the prescribing arrangements in order to fit in with the frequent chaos in their lives.

A thread running through this fabric was the conflict of interests and styles between the two consultants and it became a major influence on how the changes were managed.

Myself as a 'Key Player'.

I began the job wanting to give myself time to get to know the history of the organisation and how it worked, who the staff were and what their vision of their work was. It was important for me to find out who I could work with easily and at what points could I 'fit' with the staff. I looked for the strengths and the areas of flexibility because I believed these would be important to link with in making change. I decided not to commit myself in the early stages to particular sorts of work, but to involve myself as the opportunity arose in whatever came up in order to do the sort of reconnaissance I was wanting. I circulated a memo advising what I would be doing and what I was available for. I kept a reflective diary to help guide me through this stage.

I was aware that it would be easy at the outset to set myself up as doing psychological treatments in the mainstream tradition of Cognitive-Behaviour therapy, responding to the agenda of the two consultants. However, at that stage, I was the only psychologist, and to take up this invitation would mean I could easily devote myself full-time to seeing long queues of clients and working in relative isolation as a result. I was more interested in how psychological skills and knowledge could be made available to clients in the broadest sense through interactions with all the staff, as well as in the specific and more narrow specialist sense of sessions in psychological treatment. Although I could provide the sorts of psychological treatments advocated by the consultants, I did not wish to confine myself to them. I also believed that other disciplines could be taught many of the more straightforward treatment techniques In short, I was wanting to see what opportunities were available across the services as they developed,

and what roles I felt it best to play in order to meet my own aims and also the collective aims of the service as they emerged.

I discovered that there were many different visions of what the changes would mean and that there were conflicts around leadership and power between senior male staff who had more recently joined the department. There was also a tension between longer term staff and more recently appointed staff, and between medical and nursing staff.

In order to be open to possibilities I had to be careful to avoid covert coalitions. I had more clinical experience than the other senior clinicians and in previous jobs had taken a lead role in developing a service, but I felt I had to mask my experience and skills in order to join with them. I did not feel my inquiry into other's views was often reciprocated, particularly by the more senior of my colleagues - there seemed little curiosity in the experiences I had brought with me as a professional.

So I began the research at the same time as finding my own way in working with people to create a climate which valued co-operation and supported growth and change. Despite the value I place on collaboration and looking for strengths, the reader may note a degree of wariness and scepticism in my descriptions of colleagues. This is how I felt at the time. My characteristic style is to enter new experiences cautiously and avoid getting too heavily engaged with others until I am sure of where they stand and how they view the world. In looking back now, I realise I was picking up on some of the tensions which were later to cause conflict. For example, the senior nurse had been selected by the clinical director against the wishes of other nurses. Neither of the two consultants thought the post of Assistant Director of nursing should have been created. The clinical director did not believe a second consultant post was necessary in such a small department. Some of these issues and my understanding of them will weave their way through the remainder of the research account.

Early Research Questions.

By this time I had made the first links with Bath University, having identified it as a place which offered an approach to research which seemed to fit with my views and interests. My first task was to narrow down the broad questions I was carrying with me. I did not have one clear burning question, nor did I have a clear idea about a project with a clear focus. There seemed to be a certain territory in which my research needed to be located - questions about multidisciplinary teams in a health setting and questions about my role as a psychologist.

The *initial broad questions* I posed for myself were:

- "How do multidisciplinary teams in a mental health setting interact together in the best interests of their clients.
- Can a map be constructed that will guide the development of effective teamwork?;
- What roles, skills ,knowledge and strategies do I as a clinical psychologist bring to bear on presenting client problems being considered by the team?"

To aid my thinking I reflected about my beliefs, assumptions and principles at the time concerning individuals and teamwork. I wrote these down and shared with supervisors and fellow researchers at Bath as part of our early discussions in orienting ourselves in research. Following is a summary written at the time.

Core principles:

I believe it is desirable that team members take time to develop trust and honesty so that conflict can be resolved constructively and responsibilities shared in an appropriate way. Central to my interest in teamwork is the belief that well-working teams enhance individual effectiveness.

Assumptions about teams:

Teams are likely to function best when:

- Members listen to and support each other, and affirm strengths regardless of status.

- Members share personal goals which are then incorporated into group goals, and these are reviewed regularly.

- Roles are clarified and role boundaries are negotiated.

- There is a shared philosophical base which informs decision-making.

- Decision-making and communication structures are developed which support and ensure each member functions according to their ability.

My reflections and internal dialogue about these statements:

Given that members of different professional disciplines have separate bodies of knowledge and world views, are afforded different status, and have different types of formal power and influence, it is questionable whether multidisciplinary-disciplinary teams can work effectively. However, the potential value of multidisciplinary-disciplinary teams lies in these differences, where different perspectives can enhance the problem-solving and decision-making processes. Therefore, finding ways to enhance the interactions so that positive outcomes are more likely is a worthwhile endeavour - it might clarify the dilemma of 'Is it worth the effort, given the inherent conflict of interests and loyalties?'. If I am to research the possibilities of developing effective multidisciplinary teamwork, then I need to start with clarifying the questions for myself.

The most important questions for myself at this stage are:

- Without formal authority to lead, how do I function effectively to make the process work?

- If I am an equal member of the team, then how can I participate so that teamwork is promoted and we collectively come to understand the process that has occurred?

- What tools do I need to develop so that accurate information can be gathered from all points of view that will lead to the identification and solving of team problems?

- Can I isolate critical incidents or significant parts of the process that lead to a shift in the effectiveness of team-work?

- Can the processes that I and other team members regard as significant be replicated and affirmed as significant by other successful teams?

- How can I present the findings from this team's experience so that new knowledge can be generated?"

This was broad territory indeed. Although I did not recognise it at the time, there was an implicit assumption in these statements and questions that I would be a member of a 'multidisciplinary team' which would be sufficiently identifiable as such, and sufficiently cohesive over time as to allow these processes to occur. There is a tension between these assumptions and the approach I took in the early stages of seeking to work broadly across the department, looking for opportunities to make psychological skills and knowledge available to staff and clients alike in a variety of ways. This is one of several tensions which remained implicit for some time in the research and I will comment on these as I go.

In a subsequent chapter I will present several 'stories' about past experiences which I carried with me into the research. I will use these to illustrate in analogical or metaphorical form some of the frames I was carrying with me into the research and which provide an experiential grounding for the questions I was asking.

In the meantime, having set the scene for my research venture, I will in the next chapter turn to a theoretical and methodological perspective which provides a broad frame for writing the remainder of this research account. It not only informs the final form which this research account takes, but it also informs some of the research activity reported herein.