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

6. Finding a focus for research and initiating a cooperative inquiry

Introduction

At this point in the research my intentions were to invite interested colleagues from different professional disciplines to join me in a Cooperative Inquiry in order to research into aspects of multidisciplinary team work. Although I had my own broad questions I wished to explore, within my understanding of Cooperative Inquiry I would need to hold these somewhat lightly at the outset, in order that the inquiry group once formed could then negotiate collaboratively with each other what the focus for research would be. However, I felt I needed to have more of a focus for inviting people into a research venture than a loose set of questions. 'Teamwork' as such did not feel as though it had much 'bite', and nor did it seem congruent with what the agendas were in the department at the time.

The department was still in the early stages of the making the massive changes I outlined in Chapter One. Many of the longer-term staff were finding the changes in roles and relationships had left them feeling de-skilled and unsupported. There were differing views across the department about how we should implement the changes we had agreed upon in a series of planning days. And there were conflicts of interest, particularly between the two consultants.

We had agreed a structure for communication and decision-making for the department and part of that had been the formation of a Core Group which worked with the Clinical Director (William) and Service Manager (Jan) in taking responsibility for the overall direction the services should take. Stewart (the second consultant), a social worker and I made up that group. Together we represented the different disciplines and each had some responsibility for how the budgets and resources were used.

We then had a larger operational group which made decisions about day to day running of the service, and membership of that comprised those people who had responsibility for providing the different components of the services. Membership included the Core Group and leaders of the various small teams providing services within the department.

My clinical practice roles were centred in the hospital-based services, supporting the development of new outpatient clinics and supporting in-patient services where clients were admitted for assessment and detoxification from drugs and alcohol.

Within the context of my hopes, aspirations and intentions with which I had joined the department, I was seeking to join with people, to support the changes by working alongside individuals and teams, and to find where my particular set of skills could be best used. Within the context of the relationship between the two consultants and their relationships with the rest of the staff, I felt that I had to mask my skills and experiences. I had already witnessed head-on and unproductive clashes between the consultants and others over 'how things should be done'. I wished to avoid these if possible and seek to promote cooperation. I had no wish to repeat my early experiences in the acute psychiatric ward of taking the public position of 'this is the way to do things'. I was a lot more respectful of the different ways the professional disciplines saw their roles and the nature of the problems we were all dealing with. I knew that if I was to be successful in supporting change I had both 'go with people' and 'take people with me'.

Within this setting then, I was preparing to set up a research 'project'. This chapter is about:

- 'Testing the water' for a Cooperative Inquiry.
- Finding a focus for such an inquiry which would hold my interests and engage interested colleagues in joining me.
- Initiating a Cooperative Inquiry, and finding myself stumbling.

Testing the Water.

My first testing of the water, tentatively inquiring into how receptive my colleagues would be to both working with me and to working within an unfamiliar research paradigm, was through a weekly departmental seminar. I was asked to contribute a topic, so offered to talk about "New Ideas in Qualitative Research". I presented ideas from my readings to date, talking about the transition to a new paradigm, the key assumptions underlying it and the old paradigm, then moving to a description of Cooperative Inquiry and Collaborative Inquiry.

The two consultants were the main participants in the discussion. Each was keen on doing research and Stewart held a part-time research position in the medical school. William attempted to understand how research could be done without a starting hypothesis to test out. Stewart was considerably more challenging, doubting the relevance of any concern with epistemology or ontology, and questioning some of the terms and language I was using. I felt him to be sceptical and although I was not surprised by this, I nonetheless felt a little on the back foot. However I 'held my own' in this encounter, although by the end of it Stewart concluded that this way of doing research was not really a radical departure from standard social science research, it was merely articulating the softer end of it in unnecessarily complicated language.

I felt a mixture of reactions to this. I was intrigued that I had probably witnessed what Guba and Lincoln (1990) had described as a 'post-positivist response', a reframing of new paradigm ideas back into the epistemological and ontological framework of the traditional paradigm. I wondered if in fact I had not 'held my own' but rather had colluded with this in some way in the face of the challenge. But most importantly, I was left feeling vulnerable and uncertain about the degree to which I could proceed with a research project on multi-disciplinary teamwork with people who evidently did not share my frameworks. How could I engage in open and authentic collaboration? If I was to reveal the ways I conceptualised my work, would I receive the same reception? As a practitioner I was used to the contradiction of working with people despite the differing frameworks held, but how could I bridge this gap as a researcher within this paradigm?

I was sure that Cooperative Inquiry was the most suitable framework. It had a bias for action, and it provided for direct involvement of colleagues in a collaborative venture which would allow us all to own the outcome and increase our commitment to the products of the inquiry. The process would allow for the negotiation of differences and similarities in world-views about teamwork and about practice. Yet I felt very apprehensive about my ability to convene and lead one. The seminar had surfaced my doubts and vulnerabilities. I did not see that the method was perhaps not the best approach for the circumstances, it was more the case that I was not up to it, had not got the nerve to take risks as a researcher. I was not prepared for the rejection I foresaw might happen.

Following this I went through a period of self-doubt and confusion as to how I could proceed with a Cooperative Inquiry into multi-disciplinary team work. In supervision I was offered the alternatives of staying with the confusion for a bit to see where it lead, or alternatively, broadening my focus to look at the broader organisation within a systems model - linking two themes I had expressed some interest in.

I resisted the former. Research to me was primarily a social process, therefore to focus on myself, as I heard it, at this stage felt self-indulgent. I read some social psychological literature around the latter possibility but it seemed to go to the other extreme, placing the researcher outside the action as an observer. Neither seemed to fit my requirements.

I decided to continue 'noticing' in a more conscious way as I went about my work, looking for openings or possibilities. As a practitioner I felt accepted and affirmed by colleagues, but as a researcher felt I was not 'getting off the ground' unless I could find a way of starting a Cooperative Inquiry group. I wondered if there was another way of getting colleagues to join with me. Although teamwork certainly was an issue as far as I saw it in the developing service, it felt lacking as a focus of interest for other people and I was beginning to wonder if it held the essence of what I was really interested in.

Finding a Focus

After some time of paying more conscious attention to my practice, keeping reflective diaries and journals and notes, I realised there was an emerging pattern in how certain clients were dealt with in the in-patient unit . In my noticings I became aware that in each of these episodes I played similar roles, and there had been patterns within connecting them to elements of my work across a variety of settings in the past.

These episodes engaged my interest for several reasons. They were characterised by crises which seemed to stress both client and staff, but which did not seem to lead to any reflection about how to resolve differently next time. All the different disciplines were involved at some stage but there did not seem to be any clear direction in care planning or clarification of who was in charge of the case. I found myself drawn in by these characteristics, to try and remedy the situation because I believed the chances of a more successful outcome would be increased if they were addressed.

Such episodes beckoned as a possible focus for inquiry. They engaged me as a practitioner and they seemed to be a site which connected with many of the questions I was considering for research and seeking to understand with more rigour. Perhaps colleagues would find this an interesting and important aspect of practise and teamwork to investigate and improve upon through an inquiry group.

I wrote accounts of several of these episodes, and in doing so used several lenses from research theory, as well as several from clinical practice. I did not see this as inquiry at the time. I saw it as preparation for the research 'proper', in which I was exploring some of the criteria for quality of knowing from the research methodologies.

I have several purposes in presenting one of those account at this point. It is an example of my beginning engagement with writing and with use of storied form as research account. The writing of it was informed by the various warrants described in the previous chapter. At the time of writing I was noticing in practice how I developed critical subjectivity and how I moved between Heron's four different ways of knowing. I was noticing the extent to which I used reflection in action, and for action.

In writing the account I sought to describe these processes to myself and others in a way that was alive and which incorporated some of the warrants I took from Naturalistic Inquiry - I wanted to begin making explicit some of the various framings, values and constructions I held in practice. I was also wanting to record descriptions of the setting, the characters in it and the developing relationships with the sense I made of them. At the same time I was still seeking for 'niches' in the department where there was a degree of fit, or mutual adaptation, between what I was seeking and what was needed or accepted. Through the process of writing such an account I discovered how resonances between the present and the past surfaced, and how this informed my actions. The following episode surfaced how I brought with me ideas about the role crises can play in change; ideas from therapy about the importance of meeting people 'where they were at'; and ideas from experience in the Whare Paia about 'holding' people and providing a 'place to stand' when they were in states of alienation from self and others. (The NZ Maori have a term 'Turanga wai wai', roughly translated as 'having a place to stand' - this was an essential component of mental health, referring to spirituality through connectedness with the earth as well as a specific tribal location for belonging).

I include this story here as I wrote it in its original form, including some small changes in response to comments on drafts made at that time. I used various 'voices' for the participants: those of myself variously as narrator, as reflecting on the action, and as commentator about theoretical perspectives; and those of other participants in the action in dialogue form. The dialogue is my reconstruction, taken from case notes, reflective diary entries written at the time and from my notepad which accompanies me everywhere and in which I make notes in the midst of conversations, therapy sessions, meetings and so on.

I used this form out of an intuitive sense of how best to convey to myself and others as audience how it was I engaged in action, how I paid attention to dialogue (both internal and external), how I used metaphor (presentational knowing) and how I reflected for action. I see it in retrospect as a marker point for tentatively and unawarely using 'noticing practice' and 'story telling' as forms of inquiry. Through the framework of Narrative Inquiry and its attendant assumptions, I now feel more comfortable as presenting it as 'my story' which may well differ from the 'story' told by other participants.

Link to: http://www.bath.ac.uk/carpp/publications/doc_theses_links/d_quinlan.html

Story telling as tentative inquiry

The story begins here.

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'Cushioning the Fall'

I visited the nursing office on the ward one morning to find a small group of staff looking out through the window at a man sitting on a nearby roof, several storeys from the ground. He was holding on to a chimney with one hand and to a bottle with the other, apparently drunk, and yelling a tirade of abuse at the ward staff. He had been discharged from being a patient on the ward earlier that morning and, amongst other things, was saying that unless he was allowed back in he would throw himself off the roof.

The staff were discussing how they should respond to this incident, apart from the routine crisis procedure for such situations which had already been initiated and which involved calling ambulance and fire services. A member of staff from another ward in the hospital, who was designated to respond to situations such as these, was on the spot ready to co-ordinate activities.

There was an atmosphere of tension and anxiety in the room and some people were expressing frustration and anger while others evidently saw a touch of black humour in the situation. William was joking about the patient wanting to stay with us and that we should offer endless admission. I have a dark humour which comes to the fore in such situations and for a moment I playfully joined William. I was interested that he could see the humour and paradoxical communication in a serious situation and felt there was potential to develop a good working relationship with him. But staying with the humour was not going to solve the problem and William was slipping into impatience.

- *Reflections in action*: "I can see what the anxiety is about and there is an implicit sense of melodrama, as if we are watching an old Charlie Chaplain or Keystone Cops movie. However I am puzzled by the anger being expressed toward the patient by Ms Junior nurse T who seems to be supported by Mr Senior Registrar J. This is a situation which needs careful handling if there is going to be a safe outcome. It feels as if there is a risk of loss of face and dignity for both patient and some of the staff here if this is not resolved with tact. Without this there will be continued problems, whatever the immediate outcome"

As I listened to people talking there seemed to be conflicting views on how to manage the situation.

- *Dialogue:*

[Ms. Junior Nurse T]: "We made a contract with this man on admission that he was here just for a detox and that he would be discharged today. If we let him back in it will be giving in to this manipulative behaviour. He has been a real problem and we have had to set firm limits with him throughout his stay."

[Mr. Senior Registrar J]: "I agree. This man is a personality disorder and if we back down and let him in he will 'split' the staff and he will be difficult to manage".

[William]: "This is silly. He can't stay up there, it is dangerous. We have got to get him down somehow, and besides, our job is to treat people not play silly games. Promise him anything but get him down then we can sort it out."

[Mr. Senior Nurse D]: "What I am worried about is who is going to do this. It is the Senior Nurse-On-Call's job to co-ordinate the ambulance and fire brigade but

the patient is ours and we should be the ones to negotiate with him. Already there are several people out there and it could get confusing."

It was at this point that I began to wonder whether or not to become involved in a more active sense.

- *Reflections-in-action:* "William is not actually taking charge in determining how this will be solved. It needs somebody to do this if there is to be a creative solution. William will be open to any way of getting him down and I think he would listen to me if I were to offer a way. I don't know why he doesn't take charge as it is his usual style to do so, often too readily. Perhaps he doesn't want to undermine the Senior Registrar or get into a public dispute with the nursing staff. This feels a familiar conflict and I don't want to undermine him or put him on the spot.

  On the other hand I know from discussions with Junior Nurse T that she is finding the transitions to working with drug users difficult and that her recent nursing training hasn't equipped her for this. I would like to find some way of supporting her to see this through and develop her skills and confidence. She is young in experience and tends to paint herself into corners. At the end of the day it is the nursing staff who have most to do with the patients here and I think I could play a useful role in supporting them to develop some skills they do not appear to have.

  I think that Mr. Senior Registrar is joining with the nurses in the way that doctors in training do because that is where they get most of their support.

  If I get involved here I run the risk of adding one more 'cook' and 'spoiling the broth' and that may add to the problem. They will handle it in some way and it is tempting to leave at this point. On the other hand this is a crisis which presents a good opportunity for introducing some change and testing out how well we can work together around difficult situations. It feels timely to get some teamwork going. I am not sure how this situation arose and I don't have enough information yet to know how to introduce a plan that will get some agreement. I need a few minutes getting a broader picture."

- *Comment* on 'theory and past experience lenses' I was using at this point:

  Here I was informed by a theory of crisis intervention which held that a crisis was most usefully viewed as a time of opportunity for change and that a crisis signalled that a network was facing instability because of loss of resources. This loss could be interpersonal, economic, legal, or political (influence). At times of crisis people are more open to change and accepting of intervention. It is possible for a crisis worker with this orientation to intervene in such a way as to help the network in question both solve the problem and develop more resources to solve similar problems themselves in the future. The strategy is to gain an initial concrete definition of the presenting problem with which all can agree, even if it seems minor or unrelated to apparently larger or more serious problems. The next step is to discover who is in the network, assemble the members or visit them sequentially, and clarify who and what is necessary to solve the problem. The art is to then exit as quickly and as gracefully as possible. I brought this theory and experience in practice with me into this situation.

I inquired into some of the background to the patient's being here, asking about where he came from, who had referred and why, what problems he had presented to the ward staff, what follow-up arrangements had been made and what was known of the patient's view about his current situation.

- *Comment* on 'theory and past experience lenses' I was using at this point:

  Minuchin's (1974) Structural Family Therapy model informed my inquiry here. I had found the concepts of 'sub-systems' and 'boundaries' useful in thinking

about other groups as well as families. Sub-systems are groupings of individuals according to some common characteristic (e.g. gender and age), or function. Boundaries are an invisible set of rules giving membership to a sub-system and are defined by 'who does what with whom'. Boundaries are determined both by the group or family and by the wider culture. It is clarity of boundaries that is most important for growth and development as they define the degree of differentiation from and interdependence with other sub-systems and the wider system. In Structural Family Therapy one of the therapists tasks is to help the family clarify and maintain boundaries appropriate to its stage of development and the task at hand.

It emerged that staff had found him to be very difficult to work with, viewing him as being very "demanding" and "manipulative" and as not responding to their usual ways of working. He would present the nurses with physical aches and pains with no obvious cause and demand immediate attention. If not received he would fall in a faint on the floor but always so in such a graceful manner that he never lost his glasses. They saw him as exaggerating and attention-seeking and had difficulty in taking him seriously.

The patient had arranged to enter a long term rehabilitation centre in several weeks time following his discharge today, but in the meantime had no accommodation to return to. This apparently had been smashed up by his drug dealer to whom he owed money and he was facing a number of legal and financial problems. Little of this was known at time of referral but emerged during his stay. As he had come from another Health District there had been confusion about who would take responsibility for co-ordinating his follow-up care with the result that no one had been clearly nominated.

This was another pattern within the services I had glimpsed previously. Within this context the patient's behaviour began to seem a little more understandable.

- *Reflections-in-action*: "I think enough of a consensus has emerged in this conversation that we might possibly be able to reach an agreement about where to go from here. I think everybody accepts that there has been a lack of initial agreement between the patient, the referrer and our service about what was wanted from the admission to our ward. It is clearer that we have been participants in this confusion and therefore have some responsibility to help solve it. So I think it will seem reasonable to offer an extended stay while follow-up is sorted out.

  Junior Nurse T and Mr Senior Registrar appear sceptical that he will behave himself if we have him back, so some way is needed of toning down the conflict and getting some co-operation going. I will need to stay in this and work with them if this is to happen, particularly if I argue for having him back. They will not feel heard and the conflict will escalate again if his contributions to the problems are ignored and the difficulties in working with him not acknowledged.

  Also, I don't know this patient and he may be someone who is well practised in using these strategies to gain entry to psychiatric facilities and to stay there indefinitely. We need to reframe his behaviour in some way that connotes co-operation with us."

I agreed with William that the patient should be offered re-admission and suggested that we should reframe his behaviour as helpful to us in pointing out that we had dramatically missed the seriousness of his situation and that we had not yet completed our work with him in helping him prepare for the next step in his recovery.

I next offered to convene a meeting with the patient and relevant staff to clarify what further work was needed and to work with the nursing staff in finding some ways of managing the rest of the patient's stay which lessened the likelihood of past problems recurring. I affirmed the ward rules that nobody who had a breath-alcohol reading be allowed in the in-patients area and that this must be pointed out to him. Someone suggested he be offered the waiting area for the rest of the day and I took this as a small but significant sign that we were 'moving in the right direction'.

- *Comment* on 'theory and past experience lenses' I was using at this point:

  Here I brought in experience developed around ideas form the Brief Therapy school (Watzlawick, Weakland and Fisch, 1974). 'Reframing' means "To change the conceptual and/or emotional setting in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better and thereby changes its entire meaning" (P95). Reframing opens up the possibility of new solutions.

The next day I attended the weekly in-patient case review and found that the patient had been re-admitted as planned. No mention was made of our agreement of yesterday to meet with the patient. I was surprised as I had anticipated they would be keen for it to happen in order to prevent further problems. This left me wondering if I had overestimated the degree of concern and whether this signalled a reactive as opposed to pro-active problem solving style among the staff. Was this a 'wait until something happens' approach? Was this part of a sequence of interactions where one party distances and the other party pursues? If so I could see what might have been maintaining problems between P and the staff. I reminded people of the plan to meet with P and clarified who needed to attend.

- *Comment* on 'theory and past experience lenses' I was using at this point:

  Jackson (1968) coined the term 'distancing pursuing sequences' to describe how family members negotiated intimacy. This emerged from early research into families with a schizophrenic member, using Communications Theory and incorporating Bateson's notions of complementary and symmetrical relationships. These sequences were observed to escalate until either violence or separation were threatened. They could begin again after a pause with the roles reversed. Jackson developed a classification of marriage types, including this pattern which he described as 'tied together by a ten foot barge pole'. While I find this a limited and partial explanation/description, I find it useful to alert me to certain possible outcomes when I discern this pattern occurring in relationships.

I met initially with Ms. Junior Nurse T, his key nurse, and Mr Registrar Dr S. who had been giving him direct medical care during the past two weeks.

- *Dialogue:*

  [Me]: "I thought we needed to meet together beforehand just to be clear about how we are going to run this meeting and to make sure we are in agreement. I see the purpose of this meeting as giving P the opportunity of telling us what he would like from us for the rest of the stay, and for us to decide what we can and can't do to meet this. I think it is very important that whatever is agreed is something we can all work with and that we get clear what each is going to do otherwise I think there is a strong chance with this guy that we'll end up back in the same situation as before. I am happy to start the meeting off with each of you chipping in as you wish. What do you think ?

  [Nurse T and Dr S]: (Nods of agreement but each looks uncomfortable).

  [Me]: "You don't look comfortable about this."

  [Nurse T]: "I don't feel very optimistic about this at all. He is so histrionic and difficult to work with. No matter what I do or what limits I set it doesn't work. I've been through this with him already and have made contracts with him which he has broken. He is manipulative and will cause trouble by splitting the staff against each other."

[Dr S]: (Nods in agreement)

[Me]: "Yes I agree he had the potential to split the staff, but that's exactly why we are here now, to ensure that at least the people who are involved with him will be working together. Given that we have agreed to keep him, it is important to at least minimise the chance for confusion and chaos, don't you think ?"

[Nurse T and Dr S]: (Both agree)

[Me]: "By the way, how has he been since being back on the ward. Have there been any problems so far?"

[Dr S.]: (Pause) "Not that I've been aware of, he has kept a low profile."

[Me]: "Does this seem any different from the usual day to day encounters staff have with him?"

[Nurse T]: (Hesitantly) "Yes it possibly is, usually we would have heard from him in some dramatic fashion by now."

[Dr S]: "Look, I think we should get on with the meeting and set some time limited for it. I don't want to spend too long with this."

- *Reflections-in-action:* "These two do not find it easy to look for new patterns and pay attention to them. S looks uncharacteristically severe and this is so unlike him to set time limits. He is usually so delightfully unhurried and thorough. I can see that this is not going to be easy and that I am going to have to monitor this whole process carefully. I can't succeed without S's involvement as doctor, so I will have to be careful to keep him engaged. I know that T will stay in there with my encouragement but she seems rather demoralised and unable to see P's behaviour in any other light. I am going to have to spend time on this with her without disempowering her.

  I have doubts about how open these two will be to hearing what P will be asking for. It will be more difficult than I thought and I will need to keep a close eye on the process of the interview so that we come out of it with some understanding of how P is seeing his current situation, together with some concrete requests to work on."

- *Dialogue:*

[Me] : "You are right and as I am particularly bad at time keeping I would appreciate your keeping a close eye on it. How long should we give it?"

We then met with the client. He was a tall careworn man in his thirties with an east London accent, straw-like blond hair, gold-rimmed glasses and a loping gait. He wore an almost constant grin and his mannerisms were very boyish. He presented himself as someone who had reached the end of his tether and with little prompting he told a story of many years of chaotic living, drug abuse, death of close friends, loss and victimisation. He saw himself as having lost everything. Yet at the same time his boyish grin added an incongruously playful dimension and I was reminded of those same two dimensions being present during his crisis on the roof the previous day. At one point he recounted how under hypnosis he had recalled a memory of his mother attempting to smother him with a pillow as a young child.

- *Reflections-in-action*: "Hmm! I'm quite enjoying this man. There is a playfulness and ability to almost laugh at himself as he tells this dreadful tale. I feel I can work with that in some way. However, the story is starting to sound a bit

rehearsed and I am not sure what I believe about memories retrieved under hypnosis, but I can readily accept this as one of the 'truths' he holds about himself. T and S are looking doubtful at this point and I can see why they have had so much trouble knowing how seriously to take P."

After hearing his story for ten or fifteen minutes I began to inquire what his more immediate problems were. He was very clear about several practical ones and what he wanted done about them. There were several of a more emotional nature to which he had no solutions. I was careful to make sure I fully understood the problems in as tangible a form as possible, then suggested we a staff group should retire for ten minutes to consider how we might meet his requests.

During our break it was easy to agree how to meet some of his more practical needs which required a doctor to look at a grazed and sprained knee, a social worker to take him back to his flat to rescue some legal papers, and some activities to keep him occupied during the remainder of his time here.

But it was less easy to agree how we would meet those emotional needs which required closer interaction with him. He had said he was bothered by repeated thoughts about his dead girlfriend and all the negative things about the past.

T talked about still feeling quite defeated by him and hurt by the criticisms he had made of the service. She felt she had tried hard to respond to him when he had made requests and then been critical of the staff for not meeting them.

- *Reflections-in-action*: "There is more evidence here that P and the staff have been locked into 'distancing - pursuing sequences' which have moved to and fro, leaving all dissatisfied. The staff have not found a way of reaching out to meet him. If they could, my guess is that they could interrupt these unhelpful sequences of interaction. I wonder if gender has something to do with this. Can it be that P is wanting a closer relationship with T as a woman and the way he goes about it is received as some form of power-over tactic? Maybe a male key-nurse would be more appropriate at this time. On the other hand I don't feel I know T well enough to broach this subject directly and she may feel undermined if I was to suggest a change of key nurse. I need to start reframing things even more and to suggest some ways of interacting with P differently.

  For me the metaphors that our conversation has suggested are 'Child-like', 'Playful', 'In the grip of his past', 'Story telling', 'Grief', 'Fear of the future'. If I could devise some reframing and activities around these metaphors which met his requests, got him involved in activities which kept him busy, and which restructured the staffs interactions so that they had regular and planned times with him at their initiation, they might have more rewarding experiences of each other and themselves. The most important task is to reframe the situation for T in such a way that it is not too far from her frame of reference but gives her a more workable and co-operative view of him."

I reframed him as 'developmentally very young' (as opposed to 'mad' or 'bad'), as someone who was 'stalled' because of his childhood experiences and his long years of drug abuse and associated chaos. If we were to understand his behaviour in this way then it would suggest certain ways of managing it and helping him. A starting point would be helping him structure his time and give him some activities such as artwork.

Secondly he was likely to be experiencing a delayed grief reaction now that he was drug free and we would provide some counselling for him to look at bereavement issues.

Thirdly, now that he was drug free it was likely he would be experiencing a good deal of anticipatory anxiety about managing the future. But at the moment he seemed to need to make sense of the past first, and perhaps we could help him with this by getting him to tell his life story and reflect on this as a preparation for entering the rehabilitation centre in several weeks.

- *Comment* on 'theory and past experience lenses' I was using at this point:

  Many of my ideas and metaphors for reframing come from an appreciation of the importance of the developmental life cycle of individuals and families. Most problems can be traced to some developmental transition point which the individual, in interaction with family and wider networks, failed to negotiate in such a way that they were equipped to manage the tasks of the next stage. I do not hold that developmental transition is linear and step-like, nor is it an absolute truth as each individual and family have their own unique experience of development. However I have often found it helpful to work within and share this framing of events as one which can give problems a more normalised and less noxious or blaming meaning. It also locates the problem as being in the realm of their expertise to solve.

- *Reflections-in-action*: "T and S are looking as thought they are interested in this though T still appears apprehensive. I feel as though I have taken this as far as I can at the moment. I'll suggest we sort out which one of us takes up these tasks later. I'm worried that T may have felt that I've taken over too much and she is feeling 'one-down' in relation to P and me. I'll suggest she feed back to P what we have decided which will affirm for him that she is still in the key worker role."

T and S gave their agreement to the plan. T asked P to join us and proceeded to feedback our ideas and suggestions. However she did so without imparting much sense of encouragement or enthusiasm and the feeling of energy in the interview started to decline. I immediately regretted my haste in asking T to take on this role as I felt strongly that our reframing should be positive in both content and style if we were to fully engage P and set a new pattern of relationship going. I decided that this was more of a priority at this moment than my worry about possibly undermining T further. That would have to be dealt with on another occasion. I waited for an appropriate moment to intervene and then embellished and elaborated what T had said until I could see that P was nodding in agreement and starting to comment on what I was saying.

- *Dialogue:*

  [P]: (laughing)"Well, what do you expect, I'm Polish and Catholic".

  [Me]: (laughing)"I would expect you to feel a lot more guilty about all this." (further laughter. I ended interview).

I asked my two colleagues to quickly debrief. Again, they each acknowledged continued doubts that going along with his requests would bring about any change, but they also acknowledged they could see no other reasonable alternative. I felt surprised that they could not appreciate the metaphorical aspects of P's behaviour.

We negotiated who would carry out what roles. T did not feel she could give him the time to do his life story but was interested in sitting in with me in providing bereavement counselling. The following day I arranged for another nurse to work on his life story. He was a little uncertain about what was expected so after some discussion I suggested some ways of doing this with the promise I would review progress regularly with him.

By the time I was able to see P for bereavement counselling several days later, he had already started his life story and was so engrossed with this that he felt he did not need help with grief or bothersome thoughts about his dead girlfriend.

Over the following several weeks there was no further occurrence of his bizarre or demanding behaviour and he was able to sort out his affairs sufficiently to feel he could move on to the residential rehabilitation centre. I spent little time with him apart from brief reviews. I saw T on four or five occasions and discussed some of my ideas behind what I had initiated, mostly focusing on reframing and helping her retain the 'developmentally young' frame and ways of managing P's stay within this. I

shared some ways of preventing tantrum behaviour which I had learned from working with children and families (including my own).

I saw my main task as holding the 'frame' firmly enough to guide my own and other staff's actions until we had experienced it for long enough to see what the outcome was. I did this by being available for consultation, by being around the decision-making points (both formal and informal) and by asking questions in such a way as to elicit any evidence for new patterns of relationship developing which might suggest certain solutions as being more worthy of attention than others. These could then be used to inform further action.

- *Comments* on 'theory and past experience lenses' I was using at this point:

  The concept of 'Brief Therapy as Aikido' is useful in making an intervention in situations such as these. Simply put, after circling around and testing your opponents balance, and finding a point at which you sense that an unexpected move may unbalance, then the important thing to do is to complete the move through without hesitating until it is clear whether or not the move has succeeded.

  However, I am uncomfortable with constructing others as opponents although the metaphor captures something of the essence of balance/unbalance/new balance in crisis work. More recently I have become attracted to notions of 'participation' and 'co-evolution of new realities' as another map for what occurs in therapeutic interactions.

In the meantime, P remained a colourful character and continued to strain the staff's belief in his credibility. At one point he declared his engagement to be married to an anorexic young woman in a neighbouring ward. But, he completed his stay successfully and left in a more timely way to transfer to a longer term rehabilitation centre. He was free of drugs and alcohol for the first time in his adult life, had tidied his affairs in his home town, and was ready to 'move on' with more confidence.

On leaving he thanked me for "cushioning" him during the second part of his stay and I was struck by the connection between this metaphor and his threatening to throw himself off the roof. I wondered if I might have been successful after all in helping colleagues see him differently. Several days later, a casual conversation in the ward office:

- *Dialogue*:

  [Me]: "We seemed to do OK with P don't you think? He quietened down a bit and even seemed to have made a few changes."

  [Another Ms. Junior Nurse]: "Yes, but he's still full of shit!"

As I finish this story by noting some final reflections, I am surprised by my surprise at colleagues not being able to share my frameworks. I came to this case by a very different pathway and considerably more experience. Most of the people I interacted with during the case have only recently come from, or are still within, mainstream education.

I am also interested in how much I had failed to apply my beliefs about developmental life cycles to all the actors in this drama. My reframing of P as if he were childlike constructed him as requiring parenting and us as staff as providing this. I did not consciously consider the impact of this for T as a young woman who I later learnt was struggling with the dilemma of simultaneously developing a relationship with the man she lived with while at the same time individuating from a very close relationship with a divorced mother who was ill and needing support.

In reflecting back on this and other similar cases, together with the changes which have occurred in the department, I see that one of my roles has been producing stability and change for the client in harmony with other changes. One of the questions which arises for my practice is how to maintain the

balance between the needs of myself and colleagues for growth and change, and those of clients for growth and change.

End of story.

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Making sense of the story

So, what did I take from this story and the writing of it? It had felt difficult to engage others in the sort of decision making and reflection about the case I was interested in. Despite the success we had achieved in the short term with the client, I realised there was much work to be done in supporting colleagues in handling such cases more successfully and changing our patterns of relationship around case work.

However, there seemed potential to join more with William in developing a working relationship around these sort of cases as a focus. He showed flexibility and humour and was willing to consider alternative viewpoints. There was also potential to work more with junior nursing staff. Shortly after this case, T asked me to help her with several more cases where she was struggling with the considerable complexity she was encountering. I was seeing now, at first hand, how junior staff were often left unsupervised and unsupported with work beyond their skills and experience. The matching of skills and resources with need was a haphazard process.

This story alerted me to how I had probably cut across the prevailing culture in advocating for the client to be readmitted to the ward. This could be a partial explanation for the degree of energy it required for me to facilitate a new care plan and 'make it stick'. However, it was also satisfying to do this and see a more productive outcome. I saw the potential to develop this role in working with the more complex cases - it harnessed my skills and interests, and it seemed it could be one focus or fulcrum around which change could occur. Correspondingly, this also seemed an engaging and interesting focus for research.

In thinking about the criteria for rigour I had laid out for myself, one factor considerably occupied the foreground, obscuring the others - that of authentic collaboration with others in the research field. I was still seeing research as separate from practice, as a bounded field of activity under the banner 'this is research' which was 'about practice' and 'on practice, not 'in-practice'. This cognitive dissonance generated anxiety for me which I resolved at that stage by deciding the only way forward was to attempt a Cooperative Inquiry. I was unable to see the analogue communications which were suggesting that collaboration in that particular form was an unlikely prospect in the current climate. I was construing collaboration within research as being characterised by all participants opting in to a research project, fully informed and fully in agreement. This would be the only way we could together 'map the territory' and fully inquire into our individual and collective sense making. Anything short of that could not be collaboration. This construct also blinded me to the degrees of collaboration which had occurred in the story. There would have been no story, or a different story, without a degree of mutual collaboration.

The writing of this story surfaced for me how many frames, skills, theories and experiences I had available to me at any one time - more than I had previously been aware of. This awareness compounded my dissonance about research. If I was to explore these and share these with others, as I intended to do in research, then how could this possibly happen in moment to moment engagement. It could only be done in the bounded setting of a group set up for that purpose. On the other hand, I felt unaccountably vulnerable and exposed at the idea of sharing this sense making. It was all very well to feel legitimised by Heron's epistemology, that experiential knowing is 'OK', but it was a very different matter offering this to colleagues who seemed to see the world very differently.

In terms of Rowan's research cycle, I was not sure where I was. In overall terms, I saw myself as preparing to move from *thinking* to *project*, taking a risk in involving others. Yet in an obscure sense it felt as if I had done this already in practice. Taking on this case had involved project, encounter and

making sense. Was this what Rowan meant by small cycles within larger cycles? This, however, was background. I told myself that all this would be of more significance when the 'research proper' started.

I was also interested to discover through writing how much I was influenced by the more structural and strategic aspects of family systems therapy as providing frameworks for action with colleagues around case work. The systemic epistemology of Cronen and Pearce links with a series of practice frameworks which involves a stance of 'neutrality' towards inquiry. This is not a neutrality of values, but a neutrality towards the particular form of resolution a system finds for its dilemmas. This is transacted through a series of carefully selected questions with the aim of establishing patterns connecting belief, behaviour and relationships with the presenting problems and dilemmas. It does not lend itself to the sort of reflection-in-action related in the story. Even in the writing, it was difficult to apply this. As I wrote, I was aware of so many contexts informing the action, from the past and the present.

The sum effect of these reflections was that I needed to form a Cooperative Inquiry. I now felt I had a focus with 'bite' and interest , one with which I felt congruent. It was also a focus which could involve clients in the inquiry process. I needed to overcome my apprehension and doubts and set up a project .

Starting a Cooperative Inquiry group, and losing my way.

I will describe some of the steps I took and the eventual outcome. n doing so I will not be writing in as much detail as I would like in order to do justice to the experience. It did not lead to a fruitful outcome in itself, although it created a context for further development. I will tell of my experiences briefly and from this perspective.

Despite seeing this as the way forward with research, in fact I became increasingly busy developing various roles in the department. There was much to be done which required my time and energy and I continued to keep a 'noticing' eye on my practice. I was not sure I could either find sufficient colleagues within my immediate department to join me, or whether there was sufficient 'space' among all the changes and developments. Through continued reading and discussion at Bath, I realised that I wanted to select people for the group who had some interest and willingness in joining and who could provide the different professional perspectives I was looking for. I thought I might need to canvas wider than the department.

I then spent several months preparing a research project to inquire into the management of "Difficult Cases". I wrote proposals outlining my interest in this as both a researcher doing a PhD and as a practitioner working on a day to day basis. I outlined the basic theoretical ideas I would be using, the implications for those who wished to participate, and the hoped for outcomes in terms of improvements in clinical practices, local knowledge, and improved patient/client participation in treatment planning. I was uneasy about the term 'difficult cases' as it appeared blaming of clients, but I decided that it was a term which was in current implicit use and would have immediate meaning for staff members. However, in my proposal I was careful to deal with this by proposing an initial broad definition as applying not to individuals, but to the situation we often found ourselves having to deal with, namely both the client and professional networks seeing themselves as having reached the limit of their resources and therefore presenting in crisis.

I talked to various stakeholders in the organisation whose support I believed I would need. These included the Chief Executive and my professional head the District Psychologist. I set up initial meetings to present and discuss the proposal and invited colleagues from not only my immediate department but across the wider Mental Health Unit. I decided I would invite those within my department I believed would both have an interest and also represent different disciplines. These included William and my wife Jan who was engaging in her own research with nurses. In her role of manager Jan had developed a close working relationship with William and had introduced him to some of Torbert's work. We were able to have conversations together about his ideas.

My invitation across the wider unit was to heads of departments or team leaders, asking them to inform those colleagues who had an interest in this area. My intentions were twofold. I needed a wider and more heterogeneous group representing the multiple professional viewpoints than I could obtain within my immediate department. Also, there was an explicit interest across the mental health unit in dealing

with the most demanding clinical problems. Nurses were researching "challenging behaviour" in some client groups and there were discussions abroad about a new Intensive Care service for extremely disturbed patients who required more intensive nursing than could be provided in existing acute admission wards.

It therefore seemed timely and relevant to involve colleagues outside my immediate department. There seemed to be a fit between my research interests and wider concerns and I could also get a more heterogeneous group representing the differing professional perspectives. I sensed that some among them would have a more active interest than immediate colleagues.

I held an initial meeting to test this out. Over a dozen people attended, mostly nurses, several psychologists, plus Jan and William. Over the course of two hours we covered both theoretical and practical implications of a research project. I also presented my own beliefs and assumptions and told several stories about past experiences to illustrate and provide a grounding for my interest in this area. I also wanted to convey in practice some of the attention to personal process required in this way of doing research. I wanted to keep a balance between providing enough information for people to make a decision about whether this approach was 'for them', but leave sufficient openness for potential participants to feel they could take part as co-researchers in defining the project themselves.

There was a range of responses. Some saw the project as addressing "challenging behaviour" which transpired to mean dealing with aggressive and violent behaviour from men. Others seemed mystified. Some responded to the theoretical areas, several responded to my stories with similar stories. One woman expressed concern at the limited focus on challenging behaviour and told of how she found if far more difficult to deal with female clients who developed long-term dependent relationships which left her feeling drained and defeated.

My psychologist colleagues saw this research approach as a variant of their own and expressed no interest in joining. This was revealing to me as I had not known previously of their interest in qualitative research and despite their lack of interest I felt I had developed a new connection with them.

The meeting ended with several participants saying they would like to 'hear more' from me. Only one person after the meeting approached me with what seemed genuine commitment. A senior and very experienced nurse said after the meeting that he understood little about the research side of things but would very pleased to join me. For me this was the most affirming response of the afternoon. (I was to link up with him several years later in developing the new Intensive Care service).

I was left with the following impressions:

- The participants worked very separately from each other with separate working practices.

- There were very diverse interests within the group, mirroring the diverse interests apparent across the mental health unit. Implicit in this was a degree of conflict which would be difficult to resolve within the context of a research group. I could see little evidence from the meeting that there was a sufficient degree of commitment, shared goals, and openness needed for a group to learn to work cooperatively together

- I was left with one concrete offer and several expressions of interest from outside my department.

- I had a 'gut feeling' that if I were to try to take process to the next stage of forming a group of six to eight members I would not have the time or resources as the initiating researcher to support a range of inquiry across different settings.

I was left feeling doubtful and unsure of where to go from here. On the one hand I could intellectually appreciate a systemic view that 'all information is relevant' and 'if the feedback does not confirm your hypothesis, then change the hypothesis rather than ignore the feedback'. On the other hand, as a

researcher, how could I take the research forward if I could not see a way of achieving open and authentic collaboration, with the field of inquiry being defined through a process of consensus agreement. Events were not fitting my vision of how the research should be and I was unable to change my views about research to fit the events.

On a personal level, I was carrying the familiar sense of vulnerability about the degree to which I would be able to create a climate in which I could reveal how I conceptualised my work. I did not understand that vulnerability well and did not feel inclined to pursue it as it felt too painful. This examination only happened at a later stage when in crisis over the research.

My understanding at the time was that my sense of integrity was at stake. Part of this sense of integrity involved managing a contradiction between, on the one hand, a willingness to disclose according to the degree to which I felt others would be interested, versus on the other hand, a recognition from experience that disclosing viewpoints which differed too markedly from the prevailing culture risked marginalisation. I felt I could not afford to become marginalised through this process if I was to achieve my hopes and ambitions to be centrally involved in participating in change towards a more alive, open and flexible service.

From this point I could see no way of managing the inherent difficulties as I saw them in starting a Cooperative Inquiry. My plans were shelved for a prolonged period while I immersed myself in my practice. This decision inadvertently lead to the gradual emergence of the second strand of my research to which I will now turn, where practice and research become more intertwined. The next chapter sets the scene for this.