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Birkbeck College, University of London

&

Institute of Family Therapy

**General Adult Psychiatrists' experiences of Systemic  
Family Therapy: An Interpretative  
Phenomenological Analysis**

Programme Title:  
Doctorate in Family and Systemic Psychotherapy

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Date: April 2016

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Amanda Austen

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# Abstract

Does Systemic Family Therapy (SFT) make sense to general adult psychiatrists? SFT is both a theoretical position and a form of psychotherapy. It has been evolving within mental health practice in the UK since the 1950's. Though it is now to be found more often in child and adolescent mental health services, it has its roots in adult mental health.

This in-depth qualitative study is an investigation of how registered psychiatrists working in adult services in the UK make sense of SFT. As the training and experiences of SFT vary for psychiatrists working in adult mental health services, this study explores those experiences, and the meaning psychiatrists have of them, including what they have taken into current working practice. This study therefore attempts to contribute to our understanding of the relation between the disciplines of psychiatry and SFT, and how psychiatrists use SFT in their practice.

The research used semi-structured interviews with six qualified psychiatrists working in adult services within a London Mental Health Trust to explore the lived experiences each had of SFT. These interviews were recorded, transcribed and then analysed using Interpretative Phenomenological Analysis (IPA).

The participants welcomed the opportunity to share and think about SFT in their practice and experience. The four main themes that emerged from the analysis were The Past in the Present and the Future, the impact and relevance of SFT training; Proximity and distance, exploring the range and limits of accessing SFT concepts and provision; Anxiety and Uncertainty; Position of SFT in mental health services. These master themes explore the participant's recall of their experience of SFT both in their psychiatric training and in their subsequent working practice. They illuminate how these experiences relate to psychiatrists' sense of SFT as a broader set of theories about human relations and mental health. The findings highlight the different ways psychiatrists made sense of, and utilized, SFT in their practice. The analysis of the interviews also reveals support for the trend towards incorporation of systemic thinking in mental health practice and training more generally.

The discussion focuses on the aspects of nostalgic remembrance of experiences that no longer feel accessible within psychiatric practice; the experience of learning as a mental health practitioner; and the embeddedness of SFT in present work and the workplace, in relation to existing literature and theory. The conclusion offers reflections on the research process and insights into the applicability of the findings to mental health training, service development, and particularly how SFT thinking

and skills can be taught in a more accessible way to other mental health professionals.

**Keywords:** Psychiatry, IPA, Training, Nostalgia, Systemic Family Therapy, Psychotherapy.

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# Chapter 1 Introduction

This study comes from my interest in trying to understand why, after more than half a century, systemic family therapy has a relatively small role in the treatment of adults with mental health problems. I come to this question through my own clinical experience and practice within various settings including adult mental health services. In this introduction I outline my history with this question, give an overview of how Systemic Family Therapy (SFT)<sup>1</sup> is conceptualised, how it has been positively evaluated, and how the relevance of family to health has been accepted within a political and social framework. The questions raised at the end will be contextualised in Chapter 2 – The Literature Review.

In particular, this study is interested in the interaction between SFT and psychiatry - looking at the relevance or importance of context, the interpersonal in mental health and the processes of choice that occur within mental health services between SFT and psychiatry.

“[...] let me state my belief that such matters as the bilateral symmetry of an animal, the patterned arrangement of leaves in a plant, the escalation of an armament race, the processes of courtship, the nature of play, the grammar of a sentence, the mystery of biological evolution, and the contemporary crises in man’s relationship to his environment, can only be understood in terms of such an ecology of ideas as I propose. The questions that the book raises are ecological: ‘How do ideas interact? Is there some sort of natural selection which determines the survival of some ideas and the extinction or death of others? What sort of economics limits the multiplicity of ideas in a given region of the mind? What are the necessary conditions for stability (or survival) of such as system or subsystem?’” (Bateson, 2000, p. xxiii).

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<sup>1</sup> I will use SFT throughout as an abbreviation for Systemic Family Therapy and all the therapeutic models that are within this group.

Gregory Bateson's (2000) 'ecology of mind' is embedded in the philosophy of systemic thinking, and he demonstrates that to think systemically is to be able to consider phenomena from different and unconventional perspectives. However, Berman & Heru (2005) raise the spectre of psychiatry avoiding these ways of thinking, generating information and ideas, as described by Bateson, in the way it envisages psychological functioning.

"Despite the paradigm conflict, there is a general agreement, both from research and practice, that psychiatric illness is shaped by, and in turn shapes, the immediate family and social environment. The critical issue is how we can encourage an enlarged vision of psychological functioning that includes the person-in-the-system, and how to teach this vision within a formalized psychiatric training structure"

(Berman & Heru, 2005,p.321).

The above views reflect the difficulty that psychiatry appears to have in working with the interactive nature of mental health.

This study examines from an interpretative phenomenological perspective the lived experiences of psychiatrists working in adult mental health services who come into contact with SFT. This aims to better understand psychiatrists' relationship with systemic family therapy, and why SFT may continue to play such a small role in adult mental health treatment. It aims to explore psychiatrists' experiences of SFT, the meanings they make of experiences, and what remains with them in their current practice. The study attempts to add to our understanding of the relationship between the disciplines of psychiatry and SFT, and how psychiatrists use SFT in their practice. Through being better informed about this relationship, one can consider what would impact on the relationship between the disciplines and also on patient care.

My relationship to this study comes from a working life within mental health services - both social care and the NHS (in- and outpatient services) with adults and children. When I studied SFT in the 1980's, it was actively used in the adult mental

health service in which I worked. The outpatient psychology department used the Milan model of Family Therapy, and I saw in- and outpatients in that clinic. Additionally, I was part of the team assessing patients under the Mental Health Act 1983, which used a Crisis Intervention model that was SFT orientated (Scott, 1981). In this way, SFT had a voice within the adult mental health assessment and treatment provisions. My more recent experience working in adult services saw a reduced involvement of SFT in patient care, and this interested me as it was clear that SFT remains a beneficial treatment option.

I have worked in different mental health contexts and returned to mainstream adult mental health services in 2008, where I provided SFT training for psychiatrists and psychiatrists training in psychotherapy, that included a SFT live supervision clinic. At the end of 18 months I, with that training group, conducted a focus group to discuss the training experience. This group highlighted both the wish to explore SFT within adult psychiatry as well as ideas about how it had been possible to engage with SFT and embrace it as a different way of thinking about mental health. They grappled and enthused about the idea embedded in the structure of the clinic - that of a polyphony of voices across modalities and languages - both personal and professional and how this had enriched their understanding. They had engaged with SFT, its processes and incorporated it into their practice of psychiatry. This reflection of the live supervision clinic sparked my curiosity to explore in depth the relationship between psychiatry and SFT. What appears to be absent is an understanding of the limited role of SFT in adult psychiatry. This study addresses that gap.

## Broad definition and use of the term SFT

Since the 1950s, systemic ways of thinking about mental health have been taking shape and developing, initially within adult services then moving into child and adolescent services in Europe and America (Dallois et al., 2002). Yet currently in Britain most services in general adult psychiatry are orientated towards the individual with varying involvement with, and consideration of, the patient's social

networks or family. This study thinks about the relationship that psychiatrists working in adult services have with SFT. It aims to gain an understanding of what influences and enables that relationship, and how this affects the delivery of psychiatric services to that population, particularly as SFT evolved from beginnings in adult psychiatry. As a professional working with both in- and outpatients and their families as part of a multi-professional team in the 1980s, I believe we tried to work in a manner which embodied Peter Stratton's (2011) definition of systemic family therapy:

“[...] systemic family therapy is an approach to helping people with psychological difficulties which is radically different from other therapies. It does not see its work as being to cure mental illnesses that reside within individuals, but to help people to mobilise the strengths of their relationships so as to make disturbing symptoms unnecessary or less problematic.” (Stratton, 2011, p.5).

The systemic perspective is one that offers ‘a different view, language, and range of techniques to tackle the problems that face the helping professions’ and patients and families (Burnham, 1986, p.3). It offers ‘a view of problems and ‘pathology’ as fundamentally interpersonal as opposed to individual’ (Dallos et al., 2000, p.23).

These are the definitions of SFT, which I am using in this study. It is one that includes the range of different schools of systemic approaches that have developed over the last 60 plus years. It is critical to highlight that SFT has a distinct way of thinking. It is not simply about technique or tools, but how information is perceived, gathered and interpreted. SFT requires the gatherer to think in a particular way that is relational and interactive (Cullen, 2014). The shift to therapeutically meeting with more than one person brings different perspectives into the therapeutic space and with it a need to rethink our explanations of problematic behaviour.

The reviews of the evidence base and efficacy of SFT in both adult and child services support involvement of the family in treatment (Stratton, 2011; Carr, 2014a; Carr, 2014b). These reviews include family based interventions from a pure

systemic psychotherapy model, but also interventions that recognise that individual lives and experiences are experienced in the world through relationships. However a meta-analysis of RCTs by Von Sydow et al. (2010) that specifically included systemic based therapeutic interventions found there is sound evidence of the efficacy of SFT across a minimum of 5 diagnostic categories.

Additionally, public policy would appear to support a greater involvement of whole family approaches, such as the *Think Family* document (Cabinet Office, 2008). This document reviews a wide range of literature including mental health service delivery, and states the following:

“[...] whole family approaches are seen to offer opportunities to focus on shared needs, develop strengths and address risk factors that could not be dealt with through a focus on family members as individual [...] Whilst we suggest a momentum towards whole family approaches, our review has also illustrated that many such interventions are still in their infancy and require further evaluation. Professional and agency competency in delivering whole family approaches also merits review.” (Morris, 2008, p.88).

This study particularly focuses on the experience psychiatrists have of SFT. Mental health services are increasingly using NICE<sup>2</sup> guidelines for their service provision. In order for a person to receive treatment for mental health difficulties in the NHS it has become necessary for them to have a diagnosis. The NICE guidelines review research and evidence concerning the efficacy of treatment against diagnostic categories. Although mental health professionals contribute to the formulation of a diagnosis, a diagnosis takes into account both physical and mental health and as such is formally provided by a medical doctor. Therefore, only a psychiatrist has the authority to provide the diagnosis and thus governs and needs to know about appropriate treatment and treatment pathway. How a psychiatrist relates to other ways of thinking and treatment theories, such as SFT, is instrumental and important

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<sup>2</sup> NICE National Institute for Clinical Excellence

even though treatment pathways are based on NICE guidelines. Therefore, their understanding and experience of SFT is important in appreciating use of SFT in their psychiatric practice. In light of this, this study explores psychiatrists' understanding and experience of SFT to better understand why SFT is not used to a greater extent in adult psychiatric services, despite research evidence that it is an effective treatment modality for many mental health difficulties (Stratton, 2011; Carr, 2014a; Carr, 2014b).

SFT has a limited presence in adult services, in contrast to child and adolescent services, especially when taking into account that adult services are larger and provide for a bigger population. This is the case even though there is a positive evidence base, and a presence in literature produced by SFT within mental health debates (explored in Chapter 2). In child and adolescent services, there is an expectation that SFT will or should comprise part of a multi-disciplinary approach to treatment. This may simply reflect that children and adolescents are seen as juveniles and therefore parental figures need to be included. Alternatively, it may be taking into account that the mental health of children and adolescents is influenced by relationships as well as social and educational contexts. Given that the theorising that evolved into SFT came out of work with adult mental health patients, it is important to understand why its presence in adult services has changed and what relevance this has for psychiatrists, psychiatry, and SFT. Moreover, from a psychiatry perspective it is important to understand this relevance for patients – particularly those who have experienced SFT in child and adolescent services and wish to continue with this form of treatment.

This study addresses how psychiatrists' make sense of their experiences of SFT and have incorporated them into their practice. The focus of existing research in the United Kingdom (UK), as shown in Chapter 2, has been on the applicability of SFT to diagnostic categories, and evaluation and development of whole team approaches using SFT thinking and skills. No literature could be found that explores the relevance of the experience of psychiatrists in relation to SFT, or the implication this has for clinical practice and service delivery. This study attempts to address this gap.

## *Outline of the Thesis*

**Chapter Two Literature Review:** positions the research questions within the existing literature by identifying the range of ways SFT and psychiatry are engaged with each other over time, and exploring the limitations of existing literature with regard to the limited use of SFT in adult psychiatric services.

**Chapter Three Methodology:** describes the aim of the study, the research design, the rationale for the methodology, ethical considerations and the target group.

**Chapter Four Findings:** presents the findings, in the form of themes illustrated by verbatim transcripts, which emerged through interpretative analysis.

**Chapter Five Discussion:** discusses the findings in relation to the literature review and relevant new literature.

**Chapter Six Clinical Implications, future research and limitations:** provides a summary of the findings and considers the significance of the findings with regard to the research question, clinical practice and future research.

**Chapter Seven Reflexivity and conclusion:** reflects on the process of research and the process on the researcher.



## Chapter 2 Literature review

This chapter considers the historic relationship between SFT and psychiatry, the contexts of work that may impact on the relationship between SFT and psychiatry, and the current collaboration between SFT and psychiatry. It presents a review of the relevant literature concerning psychiatry, psychiatry and SFT and their engagement with each other. The chapter will explore research concerned with psychiatrists working systemically within psychiatry, and demonstrate the limitations of this literature in relation to the research question. The review, firstly, explores the relevant literature about SFT and the mental health context. Secondly, it reviews the expectations and position of psychiatry in the mental health context and ends with the literature on the experience of psychiatry of SFT.

### 2.1 The Systemic perspective and its connection with mental health and psychiatry

Systemic ideas developed in America, Europe and the UK from the 1950s, coming from a range of directions, including general systems theory as well as cybernetics and communication theory (Watzlawick et al., 1967; von Bertalanffy, 1969; Bateson, 1972; Dallos & Draper, 2002). It was part of psychiatry and mental health research. The focus was initially on schizophrenia, with papers like *Towards a Theory of Schizophrenia* (Bateson et al., 1956), and remained so in to the 1960s. In America, Carl Whitaker, Lyman Wynne, Murray Bowen and Ivan Boszomenyi-Nagy, and Ronald Laing in the UK were researching schizophrenia through the lens of family relationships. By the end of the 1960s the Mental Research Institute (MRI) in Palo Alto, the Family Institute in New York, The Family Institute Cardiff, John Bowlby in London (Tavistock), and Salvador Minuchin (Philadelphia Child Guidance clinic) in America were all working therapeutically with families rather than only with the 'identified patient'. By the 1970s different 'schools' of family therapy had emerged. In America, the Structural approach was associated with Salvador Minuchin's work (Minuchin, 1975), whilst Jay Haley developed the Strategic approach (Haley, 1976), and in Italy psychiatrists Mara Selvini Palazzoli and Luigi Boscolo were exploring

ways other than through psychoanalytic thinking to conceptualise the dynamics in anorexia and schizophrenia which became known as the Milan school (Palazzoli, 1974; Palazzoli & Boscolo, 1978).

Looking into the history of systemic psychotherapy with its roots in adult mental health services, both in Europe and in America, Dallos and Draper (2002) state:

“The seeds for the evolution of systemic and family therapy probably germinated simultaneously but at first relatively independently in a number of different settings. Significantly though, the emergence of family therapy, its guiding theories and practice, was rooted in mental health research. The failure of psychoanalytic and other psychological treatments for serious conditions, such as schizophrenia, led to funding for research into its causation. In turn this research suggested that communication played a strong role in its aetiology and this led to explorations of therapy with families to provide further research data” (Dallos & Draper, 2002, p. 22).

The initial focus of the 1950's on the ill adult had moved by the 1960s, both in America and Europe, to include a focus on illness and problems experienced by families and children. During the 1970-90's in Britain, adult services offered systemic psychotherapy whilst also developing systemically orientated services such as Crisis Intervention, and services with specific interventions for families around the concept of High Expressed Emotion (EE) in families and its effects on a family member with a diagnosis of schizophrenia (Scott & Starr, 1981; Leff et al., 1985; Leff et al., 1989; Bott Spillius, 1990; Kuipers et al., 1992).

Bloch et al. (1991) discuss the value of SFT in psychiatry. Despite this being an early study, they demonstrate the relevance of diagnostic categories in addressing treatment options. In their view, the variation of usefulness of SFT in their results was, to some extent, attributable to diagnosis. They grouped the diagnostic category against their perception of a systemic issue, so for example a neurotic diagnosis

featured as a primary systemic issue across categories of separation/individuation, marital problems, unresolved grief, structural problem. They found that SFT was useful for most of the patients who had a diagnosis of an eating disorder, neurosis, or adjustment disorder. Additionally, their study noted that half of those with a diagnosis of personality disorder also benefited. The relevance of diagnostic category has been explored further in subsequent research. Interestingly, their study, unlike later studies, included in their evaluation whether the other members of the family, not only the identified patient, had experienced change. They note that the identified patient may positively change whilst the family may not. It was concluded that SFT enabled identified patients to shift in their thinking towards their own needs and wellbeing and thus engage with therapeutic processes. The initial frame of reference, regarding efficacy, required change to have occurred for all members of the family. They rethought this to consider the nature and relevance of change from the identified patient's perspective.

Theoretical developments in the 1970s and 1980s explored the nature of change and the role of therapists. The theorising by feminist thinkers and narrative therapy concerned the impact on individuals and families of values and culture embedded in context (Hare-Mustin, 1978; Goldner, 1988; Perelberg & Miller, 1990; White et al., 1990; Carr, 1998). This enabled SFT to re-engage with the relevance of the wider social system. Since then SFT has explored more social constructionist perspectives, how problems are constructed and expressed as well as acknowledging the role of outside factors not within the family's control (Burr, 1995; Cronen, 1994; Pearce, 1994).

SFT developed throughout this period and became a discrete form of psychotherapy. However, since the 1990s it has become more located in child and family mental health and social services than in adult mental health services in the UK. Writing in 2005, Berman and Heru (2005) describe the difficulty of perceiving the social aspects of symptoms, this being part of the current psychiatric model, suggesting that there is a preference to locate social aspects of symptoms in the social work domain. They note that there is an inter-disciplinary struggle as to what is relevant

and who is trained to deal with it. This manifests itself further in training within the professions and the separation of the context from the individual, medical to social work or vice versa (ibid.). How psychiatrists experience this separation and how it has affected their work is not apparent in the literature.

In contrast, following a death of a child known to social care, the child protection review - *The Munro Report* (2011) - recommended that social services look again at the clinical aspects of their provision for children and families. It suggested inclusion of SFT thinking in social care training to improve the ability to think holistically and across disciplines when presented with possible abuse (Cross, 2010).

In adult services, the relationship between SFT and psychiatry varies. A literature search revealed that psychiatrists contributing to the SFT literature mainly work in America, Germany, Scandinavia, New Zealand, Australia and India (Shah et al., 2000; Celano et al., 2002; Wendel, 2005; Seikkula et al., 2006; Schweitzer, 2007; Schweitzer, 2007a; Seikkula et al., 2011; Bøe et al., 2015). The literature concerning psychiatrists' training and exposure to SFT over time and in other countries raises common points: the psychiatry training requirement is to gain competence and experience but SFT is seen as a peripheral modality thus limiting what is experienced (Schmidt et al., 1995; Shah et al., 2000; Celano et al., 2002; Schweitzer, 2007; Rait et al., 2008; Josephson, 2008;). They see the purpose of including SFT in psychiatry training to enhance clinical skills and appreciation of the patient's context of treatment. This then enables them to be 'true generalists' (Schmidt et al., 1995, p.74). Whether psychiatry wants to take a more systemic approach with its concomitant engagement with uncertainty is captured by Schmidt et al. (1995) when citing Griffin et al.'s (1990) view:

“[...] a true systemic approach to psychophysiological disorders could help psychiatrists avoid being caught in the trap of mind-body duality and thus provide a better integrated basis for treatment. As one explanation for psychiatrists' avoidance of such an approach, they (Griffin et al., 1990) noted that participation in and observation

of family systems requires a high tolerance of uncertainty.”  
(Schmidt et al., 1995, p.74).

Josephson (2008) suggests another reason for the reduction of psychological thinking in psychiatry. He uses the phrase ‘biologic era’, in relation to the current educational environment of psychiatry with its ‘dramatic developments in the neurosciences’ (Josephson, 2008, p.404). This, he sees as diminishing the time available for psychological knowledge in the teaching of psychiatry:

“[...] perhaps the biggest challenge in teaching family therapy is that (psychiatric) residents being trained in the current ‘biologic era’ struggle with integrating psychosocial interventions, such as family therapy, into their psychiatric practice. These practical challenges accompany dramatic developments in the neurosciences which have competed with teaching time for psychosocial therapies and unwittingly given rise to the notion that psychosocial therapies are not the province of psychiatrists.” (Josephson, 2008, p.405).

There has been a growth in what is described by Celano et al. (2010) as a ‘competences approach’, i.e. to ability to identify key competencies and assessment of those skills. This enables both differentiation between therapeutic approaches and clarity about what the knowledge is. The competences approach in the evaluations of intensive clinical training experiences in India (Shah, 2000), and in the USA (Celano et al., 2002; Wendel et al., 2005), highlight that this is about a need to have shared knowledge and skills across mental health practitioners.

However, there has been a shift towards a whole team approach utilizing SFT in assessment and treatment. This is discussed in the UK and Finland contexts by Burbach et al. (1998; 2002) and Seikkula et al. (2003) and considered in the American context by Rait and Glick (2008) and in Germany (Schweitzer et al., 2007a; Schweitzer et al., 2007b). More recent papers discuss the evolution of dialogical practices within psychiatry (Ulland et al., 2014; Brown et al., 2015a).

These practices engage with the identified patient, their symptoms and with the social context in which they are occurring; viewing them as the mechanisms with which to make sense of the experiences/ symptoms of the patient and the social network, and to bring the patient back into connection with others. These writers describe and place emphasis on the positive difference that occurs in clinical skill when the training in SFT is embedded in a designated context, where the rest of the professional team are also working with systemic psychotherapy skills, thinking and knowledge. The effect of losing the context of symptoms within more recent diagnostic manuals for psychiatry (Maj, 2012) and on maintaining systemic thinking and practice within psychiatry (Bertrando, 2009) is discussed later in this chapter.

The last time the UK-based Journal of Family Therapy focused on adult family therapy services was in 2007. Contributing psychiatrists were not UK based, though some have collaborated with systemic family psychotherapists in the UK. It included a review of the whole team training and building experience by the developers of the UK approach - a systemic psychotherapist and a psychologist. They had used a combination of SFT and CBT approaches in the training (inclusive of psychiatry) for in-patient wards within the Somerset mental health service (Stanbridge & Burbach, 2007; Stanbridge et al., 2009). They describe the many layers of involvement necessary, including that with senior management and the clinical team, for a shift in practices to be enabled. For the clinical team to make that shift they were required to engage with and work through both positive and negative aspects of doing things differently in whole team training. Webster, in that volume, provides a commentary on the two strands of systemic work (and whole team approaches) evolving within adult services- the Somerset model and the Dialogical model that developed in Finland (Webster, 2007). She explores whether training provides the mechanism for coordinated organisational change within the mental health culture, at a time when resources are ever more stretched. She further wonders whether it is time to be 'irreverent' about government guidance, e.g. NICE guidelines, in order to develop service provision (Webster, 2007.).

The development of these approaches overlap with the family inclusive approaches in India and Germany (Shah, 2000; Schweitzer et al., 2007a; Schweitzer et al., 2007b). Also, the Somerset approach and the Finnish Open Dialogue approach have subsequently been evaluated and documented further (Seikkula et al., 2006; Stanbridge et al., 2009; Seikkula et al., 2011; Bøe et al., 2015). In the UK, the Somerset approach has been embraced by a London mental health trust. A clinical research project of the Finnish model of Dialogical practices in SFT is currently underway in the UK, and it is embedded in mainstream mental health services (Jackson, 2015). This literature documents a movement of SFT within adult psychiatry of whole team and/or manualised approaches reflecting an emphasis on both the Recovery and Community Care models<sup>3</sup>. These models demonstrate ways in which SFT is finding a role in adult mental health services. It also highlights Berman and Heru's (2005) ideas of shifts in the frame of reference of psychiatry, such as changes in research goals, and philosophical, political, social and economic ideas of mental health. The literature does not reflect on psychiatrists' experiences of absorbing these shifts of emphasis into their thinking and ways of working.

The literature reveals that SFT and psychiatry have collaborated for many years. It has changed in emphasis, from researching the effect of SFT for patients in services to evaluating the training programmes and identifying specific areas (influenced by shifts in service models) to use SFT.

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<sup>3</sup> Community Care Models were developed in response to the drive to expand comprehensive care in the community and to cease having large psychiatric asylums providing psychiatric care and treatment with Assertive outreach, Crisis intervention and Early intervention teams. 'Service innovations have continued in recent years. User-led and recovery-oriented community services, many of which have developed independently within the third sector, have not only highlighted the possibility of service users taking increasing control of their lives, but have provided commissioners with the potential for developing mental health provision beyond the core roles of post-NSF services that focus on patient experience.' (Gilburt et al., 2014)

## **2.2 Nature of psychiatry training: Diagnosis, Training, Influences on Training**

The breadth and depth of psychiatric knowledge is important. Psychiatrists are trained to be diagnosticians and diagnosis influences treatments. In addition, training intends to provide psychiatrists with knowledge and experience of a range of interventions. The literature here wants to orientate the reader to what the psychiatrist is expected to gain from their training with respect to psychotherapy in general. The position of psychotherapy within the trainings varies. The training of a psychiatrist in the UK starts at undergraduate level prescribed by the Royal College of Psychiatry. The core curriculum taught to all medical undergraduates considers the prevalence of mental illness and the influencing factors. It further aims to generate an awareness of the differences between life adjustments and mental illness and provide an understanding of treatment, risk and abuse, and levels of service intervention (Royal College of Psychiatry, 2010).

### *Diagnosis*

Learning to be a diagnostician is very much a part of the medical approach to psychiatry and the role of a psychiatrist. Craddock and Mynors-Wallis (2014) put forward the position that:

“[...] the role of psychiatrist as diagnostician enables a collaboration with patients about their care as well as expediting access to effective help and knowledge.” (Craddock & Mynors-Wallis, 2014, p.94-5).

They refer to the Royal College of Psychiatrists’ Good Psychiatric Practice guide:

“Good psychiatric practice involves providing the best level of clinical care that is commensurate with training, experience and the resources available. It involves the ability to formulate a diagnosis and management plan based on often complex evidence from a variety of sources’ (R.C.Psych., 2009. p. 9). ‘In making the diagnosis and differential diagnosis, a psychiatrist should use a



widely accepted diagnostic system' (ibid. p.10)" (Craddock et al., 2014,p.95).

Craddock et al. (2014) conclude that, as a professional responsibility, it is not a choice but part of the role. Implicit in this is that diagnosis brings a degree of certainty to something that may appear uncertain or chaotic and can then provide a prognosis and treatment.

In addition, the Royal College's guide does not address the impact of ever shifting resources. Its focus is on an environment where a psychiatrist has a range of resources available and where optimum care becomes a possible goal. The statement of professionalism does not engage with the uncertainty experienced by the clinicians concerning the role of psychiatry in a culturally diverse and economically unstable environment. Without a diagnosis, a defined course of treatment according to the NICE guidelines (with all its flaws) cannot be prescribed. The risk attached to any diagnosis is whether it becomes fixed, as human distress can change as can the perception of it. Craddock et al. (2014), perceived this as potentially unhelpful; a change of diagnosis has implications for the patient's treatment pathway and, consequently, implications for service delivery.

This risk is explored further by Maj (2012). Who describes his profession being seen as 'unduly pathologising ordinary life' with diagnosis as a mechanism to expand influence:

"[...] there is a call for dealing with 'mental health problems' which are not proper mental disorders, such as the serious psychological distress occurring as a consequence of a natural disaster or of the on-going economic crisis. Furthermore, psychiatrists are being pressured to diagnose and manage proper mental disorders as early as possible, which means dealing with a variety of conditions that may be 'precursors' or 'prodromes' of those disorders, but more frequently are not, with the unavoidable risk to, again, pathologize situations that are within the range of normality." (Maj, 2012, p.137).

Diagnosis in these descriptions is a role separated from the changing and uncertain territory of psychiatry. Maj (2012) asks whether it can be separate from daily life and context, and considers reviewing the role and validity of diagnosis, for example is depression as the appropriate frame of reference for those committing suicide in the current economic crisis (Maj, 2012).

### *Training*

Rather than addressing the experiences and comprehension of training, the Royal College of Psychiatrists describes training in psychiatry in practical concrete terms, with broad areas of psychotherapy as part of the training. The prescribed training neither engages with changes in thinking within psychiatry, nor does it consider how this might impact on clinicians. It defines how those who specialise in General Psychiatry should build these skills. Training in psychotherapy is developed in the Core and Specialist training, stating:

“The aim of psychotherapy training is to contribute to the training of future consultant psychiatrists, skills include referring patients appropriately for formal psychotherapies and delivering basic psychotherapeutic treatments and strategies where appropriate.”  
(Royal College of Psychiatrists, 2015, p.102-103).

This aim continues into specialist training. Learning Outcome 5 specifies the following goal for psychiatrists:

“Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews: that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions.” (Royal College of Psychiatry, February 2010, p.24).

With these skills they are then able to:

“Evaluate the outcome of psychological treatments delivered either by self or others and organise subsequent management appropriately  
-Explain, initiate, conduct and complete a range of psychological therapies, with appropriate supervision -Display the ability to provide expert advice to other health and social care professionals on psychological treatment and care.” (Royal College of Psychiatry, February 2010, p.34).

The psychotherapy skills training is achieved through supervision of a short case of 12-20 sessions and a long case of over 20 sessions. The modalities of which depend very much on what is available in the service wherein the training rotation is located.

### *Influences on training*

However, the training requirements and how they are taught is reviewed by Craddock et al. (2008) and Oyeboode and Humphreys (2011). They say that external forces, such as service changes, influence training more than academic or clinical developments (Craddock et al., 2008; Oyeboode & Humphreys, 2011). This position about the direction of psychiatry is part of an on-going discussion in the British Journal of Psychiatry and Oyeboode and Humphreys (2011) point out that:

“The template that guides training to date was set in place in 1971 when the Royal College of Psychiatrists was formed. The academic content and particularly the structure of clinical placements have not been radically altered in 40 years.” (Oyeboode & Humphreys, 2011, p.439).

For them, this evidences the risk made by medicine in the assumption that medicine will always exist, and psychiatry within it. They, and others, explore from different vantage points the ideas, risks and concerns for psychiatry as a profession not addressing the challenges of the de-medicalization of mental health and its crisis over the nature of psychiatric disorders. The academic and clinical argument spans

biological and neurological causation - including the role of pharmacology, which is addressed in more detail later -through to contextual, social, psychological and economic factors (Kingdon et al., 2007; Craddock et al., 2008; Bullmore, et al, 2009; Bracken, et al., 2012; Das, 2013; Moncrieff, 2013; Moncrieff, 2014).

Psychiatry training is subject to the vagaries of change in mental health services which in turn, are influenced by further range of forces. Different forces have influenced services over time, including the shift towards evidence based practice (NICE guidelines) including ever more economic ways to deliver services.

Randomised Control Trials (RCTs) have been put forward as the 'gold standard' of evidence for treatments. This has made those treatments that fit this form of evidence gain greater influence (Bentall, 2009). Thomas et al. (2012) discuss literature challenging the results of evidence-based studies, who does them and which treatments are trialled. Also, whether the trials represent treatments that can be replicated in the clinical environment, alongside the concern as to who influences which treatments are given pride of place in NICE guidelines. One of the parameters in evaluating treatments is the cost of delivery in relation to benefit. The NICE guidelines therefore, are influential in determining how services are developed. This impacts on the range of therapeutic modalities available for psychiatry trainees to experience and be trained in (Abed & Teodorczuk, 2015). There is a paucity of literature exploring the experience of delivering psychiatric services, with ever-changing theories of what mental illness is, as well as the experience of how to help patients and social networks manage these illnesses.

The literature reviewed above provides the context in which expectations of psychiatry and psychiatrists are operationalized; through the definition of the role, the processes of training and service provision that do not exist in isolation from the service and society. This context provides an understanding of the professional position from which psychiatrists navigate the range of perspectives and ideas within psychiatry and mental health and find useful methods of intervention, including SFT.

## **2.3 The current perspectives in psychiatry: Psychiatry is not static**

### *Overview*

Psychiatry is reliant on diagnostic decisions, the emphasis for which comes from its medical basis. Current psychiatry places emphasis on the biological and hence pharmacological interventions, with increasing interest and emphasis on neuropsychiatry. This positions psychological, social and cultural interpretations of mental disorder as theoretical perspectives with limited evidence to substantiate theory (Bullmore et al., 2009). Looking back to the 1960s, psychiatry and the anti-psychiatry movement were interested in the individual in context. Talking therapy was seen as an alternative to medication or surgery. The Social Therapy model has continued in interventions such as Open Dialogue, which is concerned with the function and nature of dialogue when a person presents in what is called a psychotic state (Anderson, 2002; Seikkula et al., 2003; Seikkula et al., 2006; Seikkula & Arnkil, 2006). However, the current dominant focus is on the individual. There are different perspectives on how modern psychiatric thinking has arrived at this individually orientated place.

The literature discussing the need for more than biological psychiatry has been growing since the turn of the 21<sup>st</sup> century. The difficulty of finding a way forward from traditionally polarised academic positions is evidenced in a debate in the British Journal of Psychiatry between Professors Kingdon and Young (2007), in which Kingdon states:

“Research into biological mechanisms of mental and behavioural responses has failed to deliver anything of value to clinical psychiatrists and is very unlikely to do so in the future” (Kingdon & Young, 2007, p.286).

Kleinman (2012) also reflects on the limitations of this polarised stance, noting that academic posts and research funds are still focused on biological research, yet the complexity of mental health needs research which “complement(s) the best

biological research effort with equally strong and well supported research in global mental health and clinical psychiatry practice” (Kleinman, 2012, p.421).

*Psychopharmacology, Pathology and Biomedicine, ‘Psych’ Professions, Biomedicine and the cult of the individual, Cross-cultural psychiatry, Critical Psychiatry*

Psychiatry has increasingly looked towards pharmacology as a collaborator in the biomedical understanding of psychiatric disorder. Psychopharmacology has effectively positioned itself as part of the treatment and management of mental health problems, although the evidence on which it bases its value has recently begun to be challenged. The development of a critique of the efficacy of drugs in psychiatry comes from various quarters (Whitaker, 2002; Bentall, 2009; Kirsch, 2009; Angell, 2011; Kleinman, 2012; Moncrieff, 2013; Moncrieff, 2014). These have exposed the limitations and errors of causality claimed by biological psychiatry and the pharmacology industry. Kleinman (2012) notes that drug companies have started to refocus their interests on medication for neuro-degenerative disorders and away from those for mental disorders. He raises the concern that after some decades of research in biological academic psychiatry, producing some useful findings but no definitive test mechanism for mental disorders, psychiatry continues as though biological psychiatry alone will eventually find the causes of schizophrenia, depression and anxiety (ibid.). The evidence does not support the belief that psychiatry stands solely on biomedical science. Additionally, by retaining this biological focus, in Kleinman’s (2012) view academic psychiatry is in a corner with limited relevance to day-to-day clinical psychiatry and of limited interest within academia.

Medicine itself has questioned the way medicine is delivered, seeing the dilemma facing psychiatry as an ‘either/ or’ situation. Bullmore et al. (2009), as academic psychiatrists, voice the view that psychiatry risks being ‘neurophobic’ unless it adds more medical aspects its psychiatry curriculum. Whilst others ask whether the disease has become the focus rather than the sick person, Baron (1985) writes about

the need for medicine to address the lived experience of illness and argues that it is insufficient to follow a diagnostic pathology seeking approach, saying:

“ ‘Non medical’ descriptions of illness show we can reorient our thinking to encompass both our traditional paradigm and one that takes human experience as seriously as anatomy” (Baron, 1985, p.606).

As a doctor he is concerned that medicine has become lost in ‘objectivity’ in its enquiry into pathology thus separating the person from the illness. James Marcum (2004) considers the same point, but from the patient’s perspective. He discusses the biomechanical nature of the Western medical model that identifies illness within separate parts of the body. His suggestion is that this non-empathetic model has led to a crisis of care, as the patient wants to be treated by someone who is interested in the effect of illness on the person as a whole (ibid.).

The difficult, uncertain territory of whom and what is being treated in psychiatry is discussed within sociology, psychology and cross-cultural psychiatry. Looking specifically at literature addressing mental health, Clarke (2003) uses the term ‘biomedicalization’ to denote the second aspect of a shift since the Second World War in the expansion of medical influence- jurisdiction, authority and practices - across all aspects of life. She describes the movement to biomedicalization as “one from control over biomedical phenomena to transformations of them” (ibid. p.161). She suggests that it is by making health a commodity, both jurisdiction over it and the shift to individual responsibility is possible (ibid.).

Pilgrim and Rogers (2005) look at the change in relationship between sociology and social psychiatry, and hence the clinical relevance of the patient’s social world. They see an estrangement between the fields emerging in the 1970s and attribute this, within psychiatry, to the desire for greater medical respectability and emphasis on the bio medical approach. This moved social psychiatry to the margins of psychiatry and academic psychiatry. At the same time sociology became absorbed in social theory and qualitative research which did not fit easily into the ‘scientific’ discourse.

The combination resulted, firstly, in the loss of collaboration, and secondly the social aspects of mental health were left in the resultant void (ibid.). The relevance of the individual's context to their mental wellbeing and how professionals make sense of this has increasingly been put to one side. For example, recently in the UK when new services were developed such as Improving Access to Psychological Therapy (IAPT), notwithstanding the NICE evidence for couple interventions for depression, services initially focused on individual interventions (Department of Health, 2010). The emphasis in Western psychiatry on the concept of 'self' and the centrality of this to a person's mental wellbeing exists not only in neuro-psychiatry and psycho-pharmacology but also within general psychiatry, psychology and psychotherapy theory (Rose, 1998).

Lupton (2012, p. vii) discusses how Western scientific medicine is "a product of social and cultural processes", reminding us that we all are part of a culture. She also is concerned that this current scientific culture of medicine does not always make sense to the non-medical person and that there is an absence of common meanings. She describes two strands: the postmodern analysis of power and a disillusionment and dissatisfaction within broader society with the scientific description of our world and experiences. She is interested in our own participation in both the creation of this form of medicine and our ability to challenge it within society (ibid.). The user movements, which are now part of health systems, are empowered by the notion of health as a commodity. This results in a questioning of whether this commodity is appropriate and wanted by the consumer and matches their understanding of health.

Pilgrim and Rogers (2005), Clarke (2003) and Lupton (2012), describe the social processes of the shift towards medicalization. Rose (1998) proposes that this emphasis on medicalization and pathology defines the idea of normality and gives us ways to describe behaviour seen as troublesome or dangerous. What he calls "the psych disciplines" (psychiatry, psychology, psychoanalysis and psychotherapies), are services which provide a vocabulary, explanations of behaviour, techniques to measure, record, and educate individuals and society in a certain way of understanding, of relating to others and of meeting the needs of the individual (Rose, 1998). These disciplines elaborate on ideas such as identity, selfhood, autonomy,



and individuality. They provide a regulatory ideal which he calls ‘the regime of self’, which compares all aspects of human existence and variation. In his view the nature of being human has become individualised, expressed through specific forms of measurement and diagnosis developed as ‘technologies’ by the ‘psych’ disciplines (ibid.).

Recently Rose (2007) has addressed the effect of biomedicine on how we think about life. He views the impact of the ability to manipulate molecules in search of preventative health, as shifting the focus away from the treatment of disease. Using Foucault’s term of ‘subjectification’, he sees this development as potentially reducing a human being to an array of individual molecules that can be seen in isolation from one another (ibid.). He is drawing attention to the importance of the wider health arena in the shaping of how we think about our bodies, minds, and health. It is a European and North American approach to health; however, it has influence throughout the global pharmacological industry.

Like Lupton (2012), Borch-Jacobsen (2009) discusses understandings of illness, and identifies there is variation of understandings of it between and within society. He considers how a society’s relationship with being more or less concerned with the individual, and more or less with interpersonal relationships, affects how we understand illness and treatment. There is a risk that this is ignored in the drive to identify and quantify illness. This separation is present in the development of the neuro-physiological ideas of mental illness within pharmaceutical developments, which may or may not address symptom management and treatment. The self and individual behaviours are presented as separate from the interpersonal domain.

In cross-cultural psychiatry literature there is recognition that mental health is not seen in the same way across the globe. Cross-cultural psychiatry examines the imposition of normative values and the limited acknowledgment of the patient as living within a family and society. Fernando (2014), using the lens of transcultural psychiatry, challenges the appropriateness of Western psychiatric models of mental health and services. He puts forward that the globalization of psychiatry is in itself a

barrier to mental health development (Fernando, 2014) and notes that the validity of diagnosis across cultures and even within the West is ‘questionable’, saying:

“The fundamental problem in using western psychiatric categories in non western cultural contexts stems from what Kleinman (1977) calls ‘category fallacy’ - the error in taking a category of (mental) illness that may have some use in one cultural and social setting (say the UK or the USA) and using it in a very different location and sociocultural context (say Africa or Asia).” (ibid. p.552).

He briefly reviews other systems of medicine which integrate body and mind, and notes that:

“[...] there is no evidence that colonised non –Europeans in Asia and Africa accepted psychiatry as a useful or appropriate system for alleviating emotional distress, madness or problems seen as spiritual and/or socio-psychological.” (ibid. p.553).

To create a single understanding appears to be the goal. Fernando (2014, p.554) describes the World Health Organisation’s (WHO) approach of ‘emphasizing the absence of diagnosed ‘mental illness’ as indicative of mental health’ as fulfilling this Western conceptualisation of illness. Summerfield (2012) echoes this. He reports that the WHO identify mental health as a largely hidden disease, with up to 30% of the world’s population each year developing a mental health disorder, thus making the case for increasing community mental health interventions. These interventions tend to follow Western diagnostic categorisation and biomedical pharmacological interventions. Summerfield (2012) highlights the absence in this policy of the voices of the general public and patient.

The Critical Psychiatry Network retains some scepticism about the biomedical model. Double (2006) challenges its positivist paradigm, and asks whether this is the best way to think about illness, diagnose and help. Bracken et al. (2012) take the

view that this is all part of the same ‘technological paradigm’ of a biomedical stance, which aspect is emphasised is not the issue as the result is:

“[...] mental health problems can be mapped and categorised with the same causal logic used in the rest of medicine, and our interventions can be understood as a series of discrete treatments targeted at specific symptoms or syndromes.” (ibid. p.421).

Critical Psychiatry is clear that it does not reject the relevance of the physical aspects of mental ill health; rather it is part of what needs to be considered when we are trying to make sense of human distress. Critical Psychiatry like Cross Cultural Psychiatry and Medical Sociology is interested in the engagement with the experience of the patient/service user.

In summary, the different aspects of psychiatry briefly reviewed here explore the crisis of identity and meaning in which psychiatry finds itself. From the recent literature on the direction of travel for psychiatry it is clear that the future is far from a shared certainty. Psychiatry continues to experience debates about its direction and identity, reflecting the differing theoretical views about the nature of mental illness (Baron, 1985; Double, 2006; Kingdon et al., 2007; Kleinman, 2012; Bracken et al., 2012; Fernando, 2014). These ideas - loss of medicalization of psychiatry, which theoretical idea is valid, which knowledge paradigm is valid – as well the view that it has become highly medicalised (Baron, 1985; Rose, 1998; Marcum, 2004; Rose 2007; Lupton, 2012), have pushed aside a more social understanding of mental health, within a specific cultural paradigm of mental health (Borch-Jacobsen, 2009; Fernando, 2014). It all contributes to a varied but vulnerable picture for those working and training in psychiatry. The service driven model of psychiatry, Abed and Teodorczuk (2015) suggest, is at risk of limiting essential aspects of knowledge and learning in psychiatry. Psychiatry has different layers of information, interpretation and meaning with which to manage the complexity of the task. This is what distinguishes it from physical medicine and Bracken (2014) reflects that it needs to do all. This study and its participants are situated on this uncertain terrain, and is the one from which they engage with SFT.

## 2.4 Psychiatrists, Psychotherapy and SFT

### *Psychiatrists writing about psychotherapy*

The UK literature concerning psychiatry and psychotherapy is sparse and in common with literature from other countries focuses on trainee experience of trainings rather than on experiences of registered psychiatrists. A paper from 1994 reflects on the teaching of systemic ideas to psychiatric registrars (McFadyen and Roberts, 1994). The authors identified that trainees found that due to time constraints for learning, role-play and the use of videoed material was most useful. A later paper used a survey undertaken in 2004 with child and adolescent psychiatrists which explored the impact of additional SFT training on their current practice as consultant psychiatrists (Lindsey et al., 2013). The training institution believed that the course was needed to introduce other professionals to systemic ideas and to add an important therapeutic paradigm to their core professional skills. The survey revealed that small group work and live supervision were held as challenging but beneficial and empowering aspects of the course. Overall they were clear that they had taken SFT concepts into their current work and some had taken up further training. A respondent stated, ‘it is a useful framework that compliments the essential bio psychosocial model that we have been trained to use. It is helpful in formulation of cases and identifying interventions. Less useful when considering diagnosis or risk but certainly useful for risk management’ (ibid. p.101). Both papers note that adult psychiatry has shown little interest in such training.

Pretorius and Goldbeck (2006) examine whether the general adult psychiatrists training in psychotherapy as required by the Royal College of Psychiatrists is being met, and surveyed the experience of psychiatric specialist registrars working in Scotland. They did not distinguish between group therapy and systemic family therapy, but did distinguish between transference based, cognitive and integrative therapies. The participants experienced themselves as largely failing to meet the Royal College of Psychiatrists training requirements in psychotherapy, and reported a desire for greater depth in and wider experience of psychotherapies in their

training. Pretorius and Goldbeck (2006) suggest that this is related to organisational and practical obstacles which limit access to psychotherapies and appropriate supervision.

Psychoanalysis as a 'parent' of psychotherapies, was originally a medical domain which moved on to share psychotherapy as a whole with non-medically trained therapists. At the same time, psychiatry has become more interested in biological and pharmacological medicine - this seems to have made doing both an oddity. Psychoanalyst and psychiatrist Holmes (2000), makes the case of a continued integration of the patients' narrative within psychiatry. He takes the view that psychiatry can bridge the interpersonal and the neuroscience positions and as a consequence have a specific role in helping mental distress. He sees the developments within neuroscience as supporting the ideas within psychotherapy (ibid.).

Holmes' position would appear to be supported by the experiences of the six trainee psychiatrists who describe their experiences of dual training in medical psychotherapy and psychiatry (Luthra et al., 2013). This is an interesting paper in relation to the current study in that it provides a rare glimpse of psychiatry's experience of psychotherapy and of a medical psychotherapist's experience of psychiatry. It does not describe experiences of each psychotherapy, but rather the overall relationship between medical psychotherapist and psychiatry.

Luthra et al. (2013) discuss the medical psychotherapist's task of developing an identity within a general psychiatry or forensic environment. They describe finding the medical psychotherapist role within an environment with its acutely disturbed patients and pressure to respond as a biologically orientated medic, as challenging and it required thought. They see the effect on their practice in terms of being able to "pay more attention not only to what (their) patients are saying but also to how they are saying it" (ibid. p.251). They discuss training in group psychotherapy and psychoanalytic psychotherapy but only two writers reference access to training in SFT (Luthra et al., 2013). The working week is split between general or forensic

psychiatry and medical psychotherapy placements. This form of training provides them with knowledge and experience of both specialities. With two additional placements and longer placements, they saw themselves enabled to develop professionally - noting that they now are in a position to appreciate both specialities without idealisation or denigration (ibid. p.254). They describe themselves as bringing additional competencies to any future post including personal development arising from personal psychotherapy which was a course requirement. The dual training provided them with “a developmental model in which to assimilate and metabolise (their) experiences as a trainee” (ibid. p.251).

Kerr et al. (2007) discuss the delivery of psychotherapy within generic psychiatry teams. They describe the necessary difference in that delivery by generic mental health practitioners including psychiatrists, to psychotherapy delivered by specialist psychotherapy teams. They argue that psychotherapy models practised in generic settings need to include a relational component, such as SFT, in order to be able to work with the complex and challenging patients using those services. Yet in their review of the literature they conclude that:

“Although training and supervision in effective, coherent, evidence-based and, especially, relational models of mental disorder is a fundamental requirement for the successful function of such teams and their members, it is one which is currently distinguished, in most settings, largely by its neglect.” (Kerr et al., 2007 p.65).

This literature demonstrates that psychiatrists in adult services want and value psychotherapy within their practice, even if training organisations experience adult services as disinterested. It highlights the lack of depth and range of psychotherapy knowledge available to them in training and service provision, particularly that of SFT.

### *Psychiatrists and SFT*

This part of the literature review identifies the different ways psychiatrists have engaged with SFT thinking and practice. The initial writing, theorizing and practice

came out of research and dissatisfaction with the limits of a psychoanalytic perspective when working psychotherapeutically with families. The literature reviewed here explores how SFT and psychiatry have continued their relationship. Although the study is concerned with the experiences of psychiatrists in adult services with regard to SFT, the searches reveal where psychiatry has sought to use SFT in mainstream services, rather than qualitative research exploring the experience of psychiatrists working in adult services regarding SFT. The gap between how some psychiatrists have found ways to utilize SFT knowledge and the experience of SFT in this context appears to be unexplored. The search was broadened to include child and adolescent psychiatry to gain an appreciation of how SFT is made sense of in those fields. The review now identifies developments in adult psychiatry and child and adolescent psychiatry when they overlap with adult psychiatry.

Kraemer and Asen are child and adolescent psychiatrists practising and writing about systemic psychotherapy in the UK. Kraemer (2001) is concerned with the prevailing view taken by psychiatry and academic psychiatry, that psychiatric illnesses have organic origins, that psychotherapy is not scientific and therefore of limited value and to be placed aside. He, as does Donovan, a psychoanalytically trained psychotherapist and systemic and family psychotherapist, discusses SFT and psychoanalysis with regards to the difficulty the two models have in valuing the other (Kraemer, 2001; Donovan, 2004). Kraemer (2001), Donovan (2004) and Asen (1999) all comment on the need for differentiation by SFT from earlier psychotherapeutic models, they liken this to an adolescent who, emerging into herself, dismisses the influence of the parent, but then later engages in reflection and appreciation of where they came from. This is also evidenced in the writings of Flaskas (2009) and others, who note that the reflection about and appreciation of the contribution by SFT to other therapies is not so evident (Asen, 1999; Kraemer, 2000; Donovan, 2004).

One of the difficulties in grappling with SFT seems to be in the techniques used, the more ‘conversational’ approach, as well as the overt consideration of power within

therapy, families and social constructs. Kraemer says a crucial difference is that SFT engages with:

“[...] an active, restless group of people like a family in trouble. A family is a more primitive organism than an individual. This is an ethological, not a moral, statement. Humans are, like many other group living mammals, intensely social creatures under constant pressures both towards conformity and rivalry. Family and systems therapists have had to devise new maps to guide them through chaos. Most of these depend on the understanding that, unlike the individual mind, a family is an organization with little capacity for thought.” (Kraemer, 2001, p.5).

The nature of the engagement needs to be different. Nonetheless, he contends that outside of therapeutic circles the differences are less evident:

“Our disagreements can be ascribed to ‘the narcissism of minor differences’ – to use Freud’s (1930) apt phrase – but they are, like sectarian religious or tribal ones, necessary anthropological processes. These are disputes not only about therapy but about human nature itself” (ibid. p. 9).

Kraemer is concerned about the integration of therapies, which:

“[...] risks leaving the practitioners with no convictions at all, except an exaggerated belief in their own capacity to help everyone.” (Kraemer, 2001, p.10).

Solid theoretical foundations do not mean being dogmatic but allow the limitations of a model to exist (ibid. p.10). If psychotherapies are concerned with the differences between the therapy models they risk not engaging with the dilemma of how to make sense of mental health and ill health (Kraemer, 2001). This perhaps could be applied to psychiatry as well.



### *Working with and within research, SFT and Psychiatry*

The literature from psychiatrists about the involvement of SFT in their work comes from psychiatrists who have had more training in SFT, and how they have found a range of ways to make it part of their practice of psychiatry. It could be argued that this reflects a determination to practice psychiatry in a manner that reflects a belief in the social nature of mental health. Their engagement with the biological psychiatry is mediated by the context in which they work. Their work brings SFT into particular parts of psychiatry, evidencing an effective contribution.

Asen is a psychiatrist working within a context, which is neither exclusively child nor adult orientated. Writing in the *Journal of Family Therapy*, Asen (2004) is concerned about how family therapists ‘fit’ themselves into services. He asks whether they risk being too accommodating and lose sight of what SFT brings to other therapies. This is in keeping with Kraemer’s (2001) concern about integrative approaches in psychotherapy, each approach is distinct and brings something useful and psychotherapy does not need to amalgamate into one approach. Asen’s (2004) approach to psychiatry and SFT has been to consider how to evidence the role of SFT in the treatment of the existing diagnostic categories. This is in keeping with the trend in mental health to view evidence-based practice as a mechanism to improve quality and consistency of provision. He has chosen to engage with the epistemological difference between the systemic paradigm and practices of modern research in order that SFT be able to demonstrate its contribution to mental health and survive (Asen, 2002).

Asen (2002) looks at SFT across specific diagnostic categories. He collaborated in the London Depression Trial (Leff et al., 2000), which initially sought to compare three treatments for depression, CBT, drugs and SFT with couples where one partner was struggling with depression. The trial found SFT to be both an acceptable and effective treatment for clinical depression, although one limitation was it ultimately only compared pharmacology and SFT, as there proved to be an initial high dropout rate from the CBT arm.

Another aspect of Asen's work has been to use Multifamily Systemic Therapy with a mainstream psychiatric presentation, psychosis. Asen and Schuff (2006) endeavoured to explore the use of SFT in the treatment of psychosis in psychiatry, highlighting that it is limited notwithstanding a positive evidence base. They discuss a combination treatment approach in the treatment of psychosis. The provision of multiple family groups concurrently with other treatments (medication, CBT, single family therapy) positively engages and enables families in the treatment and recovery of a family member suffering with psychosis (ibid.).

Asen has examined the place of multifamily groups in the treatment of psychosis and written a guide for professionals in using Multifamily groups with different psychiatric presentations (Asen & Scholtz, 2010). Asen and Scholz (2010) sought to bring a systemic understanding to the practice of multifamily groups. Bringing different families together in a therapeutic context enables them to work together to address specific and particular problems, as families with similar difficulties can provide thoughtful and sensitive 'outsider' views, and hopes of change to other families. Such reflection can be hard to make; the setting allows these families to explore other perspectives when not directly thinking about their own difficulties, and contributes to self-belief, and enhances self-worth (ibid.).

More recently, Asen has contributed to the concept of mentalization, and its application to working with people who have a diagnosis of borderline personality disorder. Mentalization, with its feet in psychoanalytic thinking, initially focused on the individual but drew on clear influences from systemic thinking. The systemic thread was made clearer when the model explicitly focused on a family version describing itself as:

“[...] systemic in essence, deriving its ideas and practices from a variety of diverse systemic approaches, yet enriching family work by adding mentalizing ingredients.” (Asen & Fonagy, 2012, p.347).

Mentalization asks individuals to look at themselves from the outside and to consider the outsider's stance from the inside rather than outside looking on. The

Asen question asks is whether this is new or an addition to SFT. He explores whether mentalization could be seen as a psychoanalytic engagement with the contribution of SFT concerned with the mutually influencing nature of social interaction, in the same way that SFT has been discussing the value of links between the intra and interpersonal worlds accessed through idea of the ‘self’ of the therapist (Rober, 1999; Rober, 2002; Flaskas, 2009). The relationship of mentalization with mainstream psychiatry has been enabled by the involvement of Anthony Bateman who leads psychotherapy within the Royal College of Psychiatry.

### *SFT and relational diagnosis*

Another contributor to the active relationship between mainstream psychiatry and SFT is Tomm, a Canadian. He has been concerned for some decades with the North American emphasis on diagnosis. His approach has been to accept, as Asen does, that evidence is a necessary component in the dialogue with mainstream psychiatry. However, he has chosen to address the epistemological issue directly, though the mechanism of categorisation. Nearly thirty years ago he put forward a systemic approach concerned with ‘interventive interviewing’ of families (Tomm, 1987a; Tomm, 1987b; Tomm, 1988), with its aim to help “clients co create different views and practices with respect to the problem through co-creating distinctions” (Carr, 1997, p.15). His “core assumption is that the distinction of the problem is always the central problem” (Carr, 1997, p.13).

Tomm (1991) recounts how the request to use a DSM-III diagnostic framework when assessing children and adolescents brought him to develop an alternative method, as he was concerned “about the potential pathologising effects of psychiatric ‘labelling’ on children and adolescents” (Tomm, 1991, p.1). Tomm gained support to develop a:

“[...] more therapeutic means to determine eligibility for public services... drawing upon the systemic understanding of mental

problems that was emerging in the field of family therapy.” (ibid. p.1).

The result of the collaborative project between therapists and trainees in his institution was the Interpersonal Patterns Scope (or IPScope), which attends to the recurrent interpersonal patterns of interaction and its influence on experiences and mental health. This is a systemically informed relational approach to identifying, describing and categorising behaviours in contrast to the core assumption, within biological psychiatry, of a disease process as the problem (Tomm, 1991). The system codes mental health presentations through familial relational patterns. Being able to demonstrate its reliability and validity as a coding system, the Department of Psychiatry at the University of Calgary accepted its use as a diagnostic tool. Wamboldt et al. (2015), writing in the journal *Family Process*, describe Tomm as ‘Bucking the DSM’, with the IPScope as he provided an alternative way to consider mental presentations.

This work on therapeutic classification sits within both interpersonal psychology and Bateson’s system of symmetrical or complimentary core types of relationship patterns (Carr, 1997; Bateson, G. 2000). Carr (1997) also describes this work as sitting within the tradition of Critical Psychiatry in that it is interested in the ways we create and use knowledge within psychiatry. Although Tomm’s (1991) focus is on child and adolescent psychiatry, it nonetheless challenges the emphasis on the individual person and pathology, within diagnostic systems such as the DSM which obscures the social nature of human behaviour. This is an evidenced alternative SFT approach that has not been widely adopted. There seems to be something missing between evidence and wider understanding and use of SFT.

### *Narrative Psychiatry*

Part of these developments within psychiatry is Narrative Psychiatry, which draws on the Narrative Therapy Systemic tradition and situates a person’s experience and symptoms within a wider narrative (Hamkins, 2005; Lewis, 2011a; Hamkins, 2014). Hamkins and Lewis describe the manner in which this systemic perspective is present in American psychiatry practice through their use of Narrative Psychiatry.

They see it as building on a holistic approach to physical medicine, on the Critical Psychiatry discussion about the foundations of psychiatry and the postmodern discourse regarding power and use of self. They take the view that the patient is more than the symptoms of illness (Hamkins, 2005; Lewis, 2011a; Lewis, 2011b; Hamkins, 2014). Narrative Psychiatry draws its theoretical strength from Narrative Therapy that is part of the SFT family. They say that it differs from Narrative Therapy by the clear inclusion within its theoretical stance of biological influences on the individual's experiences, which it can then be curious about (Hamkins, 2005). Hamkins (2005) views Narrative Psychiatry as changing her initial consultation questions to generate another experience of the patient's story. She is interested in their historical account and stories which explore their 'resistance' to the identified problem (ibid.).

Hamkins (2014) describes narrative psychiatry as akin to narrative therapy in that it:

“[...] is animated by the idea that we experience our lives and our identities through the stories we tell about ourselves and the world. It combines the understandings that meaning is socially created, that we can question the narratives that influence us, that we are embodied creatures fortified by and beholden to our biology, and that when these ideas are gracefully combined in compassionate practice, tremendous healing is possible.” (ibid. p. xiv).

She has found a way to bring five aspects of Narrative Therapy into her work as a psychiatrist: respect for other values, collaborative working with patients, a curiosity about cultural stories and power, retaining a focus on the person rather than only the 'problem', and finally maintaining hope that healing is possible. She adds that through such practice, psychiatry can re-orientate itself between the forces of neurochemical and diagnostic categorization, thereby rebalancing it.

“[...] mechanistic neurochemical explanations of the human spirit, whilst simultaneously listening closely to the patients' experiences of the ways in which medicine has- or has not- helped them.” (ibid. p. xviii).

### *Being a Systemic Psychiatrist*

Paolo Bertrando who in 2009 wrote how he brings the systemic model into his practice. He reflects on the relationship between systemic psychotherapy and psychiatry in order to address the idea that “we (psychiatrists) should be able to stay in psychiatry without necessarily being subject to its prevailing values” (Bertrando, 2009, p.163). His voice is alone in the SFT literature in reflecting on the understanding and relationship psychiatrists have of the two domains. In terms of the research question, he provides ideas and considerations of how he, as a psychiatrist, can also be a systemic psychotherapist, and he acknowledges that he no longer works fulltime in psychiatry. He explores the nature of current psychiatric values about biology, dogma, the family, and the technological nature of the self before taking a systemic lens to psychiatry to put forward six points of cohabitation. Bertrando (2009) engages with the debates around biology, seeing it as a helpful additional perspective to be used by systemic thinking. In order to be useful, he distinguishes between ontological and methodological biological approaches. The former is preferred by biopsychiatrists as realistic and objective, but the latter is more fluid and studies the biological subject and its interaction with its environment. Taking the Popperian philosophical stance he puts forward that, “methodological biology sees biological interpretations as scientific hypotheses, which can be falsified by other hypotheses at any moment” (Bertrando, 2009, p.167). In this way systemic therapists could:

“consider a person as a biological entity in interchange with her (human and material) environment [...] help her to more realistically see possibilities for change and self- determination, avoiding both rigid determinism and illusory solutions.” (ibid. p167).

He believes that methodological biology results in a person who acknowledges what enables and disables and, therefore, the possibilities of adjustment of these factors. Diagnoses should be engaged with it as hypotheses. Related to this, he reminds us of “the aphorism by Alfred Korzbski, famously quoted by Bateson (1972) ‘the map is not the territory- ‘a diagnosis is not the person’ ” (Bertrando, 2009, p.167).

Bertrando's (2009) systemic positioning towards schizophrenia is respectful of the 'burden of care'. The different professional and personal orientations, experiences, narratives and stresses that exist for the patient, the family and the wider network, need to be considered in order to foster confidence in each other. In this way, treatment becomes a proposal which comes with trial and error. This has the accompanying reality that there has to be consensus and acceptance about the role of psychiatry - which includes the notion of it as a mechanism of social control. Lastly, he sees systemic thinking offering psychiatry a questioning attitude, "an ability to face dilemmas without needing too many certainties" (ibid. p.170).

Perhaps Bertrando (2009) is able to bring these considered reflections partly because he has significant knowledge and experience of SFT. Shortly after his specialization, Bertrando qualified in Systemic Psychotherapy at the Milan Centre for Family Therapy. His tutors, Cecchin and Boscolo, both psychiatrists, had already become known in Europe and the US for their innovative approach in systemic interventions with families. Bertrando went on to become a tutor at the same Centre. His experience as a psychiatrist whose professional development, almost from its beginning, took place within systemic practice and ideas offers us new avenues for exploration. His work is of particular interest for this study in terms of his lived experience as a psychiatrist fully trained in systemic psychotherapy, as opposed to the participants of this study who have had limited exposure to systemic ideas.

## **2.5 Other psychologically orientated disciplines writing about SFT**

I include a brief review of non-psychiatry literature to gain perspectives from psychologically orientated disciplines on the ways they make sense of their experience of SFT and understand SFT. The search brought limited results, with the focus being on techniques.

Within family psychology, Sexton with others has worked to produce manualised interventions with families (Sexton et al., 2004, Sexton, 2011). However, in the

2013 paper working with Patterson they addressed the danger of holding a 'normative' perspective, reflecting that it can restrict with whom their model can be effective (Patterson & Sexton, 2013). The paper considers how systemic thinking can be used to enable a wider concept of family and thus be incorporated into their model. This brings forth the notion of selecting the bits of systemic family psychotherapy that are potentially useful without the need to embrace the overarching philosophy.

This idea to use of aspects of SFT was discussed in two Educational Psychology papers (Blow, 1997; Pellegrini 2009), both of which like Sexton et al. (2004) wanted to embrace aspects of systemic thinking and techniques to enable effectiveness of educational psychology. Pellegrini acknowledges the limitation of this position as he considers that it would be more useful instead to have access to a fully trained systemic therapist, with that overarching systemic perspective, within the service. Writing from a clinical psychology standpoint Hill (2014) acknowledges the value of systemic thinking and practice for psychology, yet highlights as a dilemma for practitioners who want to do this, as requiring a shift from an individual pathology orientated perspective to a contextual and relational one.

Social work looks to (re)include SFT thinking in training (Cross, 2010; Munro, 2011). This is reflected in other social work literature, which identifies that social work had during the 1970's a strong systemic thread in its training and practice (Teater, 2014). Current social work theory is interested in techniques but is also interested in a philosophical position behind such techniques. This is reflected in academic social work which discusses a need to re-examine the purpose and direction of social work, to look at theory and techniques that collaborate with families. This includes systemic thinking and moves away from the approach which has evolved with its increasing focus on risk and resource management rather than relationship based work (Rogowski, 2012; Morris et al., 2012; Teater, 2014; Fook, 2016). These disciplines echo the difficulties experienced by psychiatrists of the limitations of interventions orientated to the individual.



The chapter shows a shift from an involvement by SFT in thinking about mental health constructs overall (Watzlawick et al., 1967; Minuchin, 1967; Palazzoli, 1974; Bateson, 2000), towards a more specific role as an intervention (Asen, 2000; Hamkins, 2014), or to provide an alternate way to think about mental health presentations and how to intervene (Tomm, 1991). The context of this shift is shown in the growing emphasis on the self and the movement away from social psychiatry (Rose, 1998; Pilgrim, 2005; Rose, 2007), particularly in academic psychiatry towards a biological psychiatry (Clarke, 2003; Kingdon, 2007; Kleinman, 2012). The Critical Psychiatry network and cross cultural psychiatry literature challenges the universality, applicability and value of the positivist paradigm which this biomedical approach to psychiatry puts forward (Marcum, 2004; Double, 2006; Fernando, 2014).

It is also clear is that there has been a growing emphasis in the literature on exploring the value and effectiveness of SFT content within psychiatry training programs and how else to include SFT in those programs (Schmidt et al., 1995; Josephson, 2000; Shah et al., 2000; Celano et al., 2002; Schweitzer, 2007; Rait et al., 2008;), reflecting the need to respond to the economics of health provision and ideas of evidence based practice (Dept. of Health, 2010; Carr, 2014a; Carr, 2014b). The uncertainty, which is part of what psychiatry grapples with and Bertrando (2009) discusses, sits alongside the reality that irrespective of changes in the field, the Royal College of Psychiatry has not changed its guidelines on psychotherapy training since the 1970's (Oyeboode & Humphreys, 2011).

The literature gives a definition of SFT, its origins within the mental health field, (continuing with a consideration of the nature of psychiatry), and its role and requirements in relation to psychotherapy. It describes the training and work experiences of psychiatrists regarding psychotherapy as located in individual psychotherapy. It considers how psychiatry has worked with SFT to locate it within current psychiatry and mental health thinking. The literature review shows two concurrent trends: 1) SFT in adult mental health services occupies a peripheral position in mental health services and psychiatry interventions, and 2) how SFT is

brought directly by psychiatrists into clinical work. It does not explore how psychiatrists in general adult psychiatry use or understand SFT.

## **2.6 The purpose of this research**

The literature review considered evaluations of SFT in psychiatry training and application of SFT in the clinical sphere, evidencing that SFT has a constructive role and place in current psychiatric practice; yet it continues to be narrowly used.

Identifying whether it is effective or useful has had limited impact in improving access to it for patients and professionals. It seems that effectiveness and being a constructive addition to psychiatry training is insufficient to make sense of the more peripheral role that SFT plays in adult mental health services and psychiatry.

Literature on the efficacy and benefit of SFT in adult mental health services is well evidenced; however, it is seldom used by psychiatrists as a clinical tool despite some SFT training. Therefore, it is of interest to investigate the lived experience of clinical psychiatrists in relation to SFT in the mainstream public mental health services of the UK. This study explores that experience, considers what influences the use of SFT and its thinking in psychiatry, i.e. how it has been experienced and made sense of, not just by psychiatrists who have taken further advanced training or are active in clinical research but by those practising in mainstream clinical settings. It goes on to seek how SFT is understood, comprehended and perceived by psychiatrists in order to provide another perspective and source of information about the changing use and position of SFT in adult mental health services.

The overall research question is why, after more than half a century, systemic family therapy has a relatively small role in the treatment of adults with mental health problems in the UK. Given the dearth of research on psychiatrists' views of SFT, the study aims to respond to this general question, but asks the specific qualitative questions:

How do psychiatrists make sense of SFT?

How do psychiatrists make sense of SFT in relation to psychiatric practice?

How do psychiatrists incorporate SFT into their own working lives?

## **2.7 Literature Search**

The literature search used both formal and informal methods. The informal method was to explore literature I already knew, follow up the references they produced, and suggestions from my supervisor and colleagues. The formal method consisted of a systematic search and identification of relevant literature that was done through the use of the main medical, social science and psychology databases: Medline, PsycINFO, CINAHL, EMBASE, Jane.biosemantics.org and Google Scholar. A list of key words and search terms were drawn up, emerging from the research questions and used in the search engines such as: systemic family therapy, family therapy, systemic thinking, adult, multi –disciplinary teams, diagnosis, therapy, dialogical, psychiatrist, attitude, integration, understanding, application, cross over, NHS, child psychiatry, child psychotherapy. These were combined in different combinations with “and” and “or”. The abstracts produced from these searches were reviewed to produce a list of relevant papers to be examined in more detail. Literature was chosen as being relevant to the whole thesis as well as the main themes. A combination of less new material being generated and an end time to complete the study resulted in the decision to cease searching.

The following chapter will address issues of methodology and implementation of the study.

## Chapter 3 Methodology

This chapter will address methodology and why Interpretive Phenomenological Analysis (IPA) was used to explore these research questions.

### 3.1 Qualitative Research

This is a qualitative study. Qualitative research differs from quantitative research, which is seen as part of an empirical and positivistic approach, and takes the position that it seeks to discover objective truths and that are to be found in empirical data. A qualitative approach is better suited to this study as it is “concerned with meaning”, the making sense of the world and experiences (Willig, 2008 p.9). It addresses how we understand our experiences and the processes within that understanding. It aims to understand experiences, explore descriptions, avoid looking for ‘cause and effect’ through not having predefined goals or variables, which allows room for participants to attribute meaning to the descriptions (Willig, 2008).

Qualitative methodology provides a way to explore and understand both phenomena and the complexity of experiences, taking into account the subjective nature of those accounts as well as the context in which they occur. Part of the value of qualitative research is that:

“Since the data collection procedure are less constrained, the researcher may end up in the interesting position of finding things that they were not originally looking for or expecting.” (Barker et al, 2002, p.74).

### 3.2 Validity and Quality

Quality and validity are important concerns in all forms of research but need to be established in different ways in qualitative research. Spencer and Ritchie (2011) discuss the contribution of qualitative research particularly whether it has external validity and transferability. The credibility concerns ‘how claims and conclusions have been reached’ reflecting on the recurrent idea of validity (Spencer & Ritchie, 2011, p.230). They describe that validity can be thought about in terms of methodological and interpretative validity. The former concerns the careful documentation of the research process and the latter, the quality of the interpretation in evidence produced to support it (ibid. p.230). This study has drawn on Yardley’s four principles (Yardley, 2000) cited by Smith et al. (2009) that guide qualitative research: i) Sensitivity to context; ii) Commitment and rigour; iii) Transparency and Coherence; iv) Impact and importance

The researcher has endeavoured to be sensitive to the context of the participants and to be respectful and protective of the content through appropriate use of anonymity. The rationale concerning the choice of analysis, the evidence supporting the analysis and the provision of an audit trail of the analysis (Appendices H - N) enable the quality of the study to be evaluated. The study is designed to be interesting and useful and to add to the body of knowledge concerning systemic family therapy and psychiatry.

### 3.3 Reflexivity

Qualitative research involves a communication loop between researcher and participant, therefore I also am participant in the research,

“collecting and engaging with data in a more reflexive fashion, acknowledging (and using) the intersubjective relationship between the researcher and the researched” (Thompson et al., 2012, p.6).

In trying to make sense of the meanings presented by the participants I was engaged with my own meaning making mechanisms. This comes in

“two strands: epistemological reflexivity and personal reflexivity.

Personal reflexivity concerns the influences of the researcher’s own history, whereas epistemological reflexivity concerns exploring how the assumptions of the approach taken shaped the study” (ibid. p6, their emphasis).

The purpose of qualitative research is to help make sense of experiences and events with the intention of influencing understanding or policy, and with this then “comes responsibility and for some that alone is sufficient to necessitate reflexivity” (Shaw, 2010, p.233).

Singh (2010) discusses the compatibility between qualitative approaches and systemic family psychotherapy, seeing qualitative research methods as ‘consistent with and contribut[ing] to, a systemic paradigm’ (Singh, 2011, p.230). She quotes from the foreword of Bateson’s *Steps to an Ecology of Mind* to highlight his exploration of the recursive nature of knowledge generation saying that:

“The Bateson scholar, Peter Harries-Jones described Bateson’s epistemological as ecological, which is “knowledge looping back as knowledge of an expanded self” (Bateson, 2000). This is what we now describe as self reflexivity, essential to both systemic psychotherapy and qualitative research.” (Singh, 2011, p.230).

I perceive my work as a systemic psychotherapist in various mental health settings as addressing how people make sense of their lives and experiences that may be incapacitating for them, and to explore other perceptions and solutions. I have preconceptions and ideas about mental health and these have been influenced by the populations in which I have lived, I have worked and by fellow professionals with whom I have worked. I am theoretically informed by Feminist and Marxist thinking, Critical Theory and Social Constructionist theory. My thinking along with these

theories has evolved, whilst retaining a belief that how knowledge and power is constructed effects its manifestation, its use and the mechanisms to engage with and alter it. I find useful the critical realism position which views our understanding of events as our subjective interpretation of what we know whilst accepting that there are also unobservable realities, and that our access to the world is a mediated experience with a continuous process of understanding and reflection (Ponterotto, 2005). In addition, my systemic training and approach is concerned with subjective experience, which engages with the recursive nature of understanding experience. Throughout the interpretation process I needed to be mindful of my systemic self and my own experiences in the NHS as a systemic therapist in how I interpreted what I hear and what I observe from the interviewees. Therefore, my epistemological position is broadly social constructionist, influenced by critical realism's idea that our understanding is a subjective interpretation and by critical theory that events occur within power relationships. (Ponterotto, 2005; Costley et al., 2010).

I am mindful of these aspects of myself and this informed my engagement with the participants, the relationship between us as well as my engagement with the findings. Keeping a reflective journal, and discussion with peers increased my awareness that I was an 'insider' to mental health services though not to psychiatry and needed to 'monitor research processes' and reactions (Costley et al., 2010, p.6).

I am a middle aged, middle class white professional woman, with two young adult children (the research started in their adolescence), and an ex-husband. I am also a younger sister, an aunt and a daughter. My initial training and work was within generic and psychiatric social work, which at that time had strong systemic leanings as identified in the earlier literature search. I currently work as a consultant systemic and family psychotherapist in the NHS, live in the south of England and work in London where class and ethnic demographic are very broad. I am aware that I am both seen and see from these 'descriptions', which carry assumptions and inaccuracies. I am conscious, then, of these in my daily working contact with

patients and in the context of this study of how they may influence the interview process.

I have lived in 4 different countries and have personal experience of being an incomer, being 'foreign' speaking another language and doing things differently. This is a starting point for self-reflexivity - how I am perceived and how do I perceive others? My curiosity as how to make sense of experiences both with and to others, stems from arriving in England aged 5 into a new physical, social and educational environment. I did not know the local social rules, though it was assumed that I did because of my appearance and my white British parentage. My lived experience is contrasted with others' expectations of me. As a child whenever my family moved locality in the UK, I revisited the experience of learning 'local' rules, perceptions and expectations; gaining perhaps an early training in participant observation and systemic thinking.

I was drawn to this research after years of working as a systemic psychotherapist in both adult and child focused mental health services, and previously in social work mental health services, where my interest lay in the way individuals make sense of their experience. This has been reflected in my work with asylum seeking young people, adult mental health patients, parents, with child and adolescents in outreach, in- and outpatient mental health services. Working within a range of psychiatry practices over 35 years, I experienced collaboration, ambivalence and occasional hostility from psychiatrists. I make sense of these professional relationships in terms of responsibility, risk management and varying levels of respect for what 'fits' best for the patient.

Also I was drawn to finding a way to gain an understanding of how psychiatry experiences SFT following a focus group discussion which was done at the conclusion of a training clinic in SFT which I ran between 2008 and 2010. What was clear from this group of psychiatrists, both general adult psychiatrists and those taking a further training in medical psychotherapy, that they enjoyed the clinic as a place to think, to reflect with peers, and to develop skills in SFT thinking and



techniques with regard to patient distress. Although they worked in different aspects of adult psychiatry, they found time for this alternative experience. This interested me as it fitted with my experiences in the 1980's whilst training in SFT and working in adult psychiatry services.

There has long been a conversation in mental health about patients accessing the service and what influences it. My belief is that relationships and context influence how we understand our experiences and ourselves. My interest in this study comes from a curiosity about and frustration with where SFT has found itself and where it has been positioned by psychiatry. I hold SFT as an essential way of thinking about and approaching mental health. With this investment I was mindful of my intensity and curiosity when exploring the participants' relationship to it. This study aims to explore the expectations and views of psychiatrists in their relationship to SFT. I am conscious that my experiences could potentially influence my relationship with the participants as well as with the findings.

This study was an opportunity to discover where SFT finds itself in the 21st century, and where it might go in the future. My own experience of organizational change in the NHS, of creating and recreating services to adapt to fluid social, economic and political perspectives of mental health, the struggle to value services and expertise, all increased my curiosity about the role and future of SFT. Organizational change has been a part of my working life, and the stresses that accompany it have become increasingly exhausting. In order to complete this study I elected to take an unpaid sabbatical, as I was aware at the point of write up that I was close to 'burn out'. Reflecting on this, I realize that at the time of the interviews the participants too were processing organizational change, and that this could influence interpretation of the data and their reflections of what 'was' and 'is' within psychiatry.

### 3.4 Why IPA and not another qualitative method

Qualitative methods are concerned with the lived experience of the participants. The choice of qualitative method is rooted in the research question because the method chosen needs to examine the data in order to answer the research question. I will briefly discuss four philosophical areas in which qualitative research is grounded, with regard to the research question, namely: Epistemology, Phenomenology, Hermeneutics, and Idiography. This will serve to explain my choice of IPA for this study.

#### *Epistemology* (The nature of knowledge)

Within Grounded Theory the researcher adopts a position that is on a continuum between positivistic ideas of knowledge through to constructivist ones. It aims to produce theory from the ideas within the data (Tweed et al., 2012). It is rooted in ideas of knowledge being discoverable and that theory emerges from descriptions of experience. Discourse analysis, Narrative analysis and IPA in varying ways acknowledge the hermeneutic or interpretative nature of knowledge that emerges from data (Willig, 2008). Discourse analysis, with its social constructionist stance, emphasises that knowledge is created through language, in other words, we 'language' our reality. Narrative analysis places narratives within contexts. These narratives are ways of ordering and creating meaning, so the context and interpretation, as part of the process of narrative, has an impact on the meaning. IPA is situated within critical realism and contextual constructionism and reflects on the interactive nature of knowledge through the use of the double hermeneutic (Smith et al., 2009). In this study, the experiences of the participants own stories could then be interpreted acknowledging the meaning making nature of language, of contexts, and also the researcher's interpretations of the participants recounted experiences, using the double hermeneutic. This is an additional layer of analysis acknowledging the researcher as a clinician within the mental health services.

## *Phenomenology*

This is a philosophical movement founded by Edmund Husserl and developed by later philosophers Heidegger, Merleau-Ponty and Sartre which addresses what it means to be human. It studies how we perceive and talk about human experiences, psychological and external (Smith et al., 2009). Willig (2008, p. 52) says “phenomenology focuses upon the content of consciousness and the individual’s experience of the world”.

Within the philosophical tradition of phenomenology there are different emphases. What they have in common is the focus on the experiences individuals have in their lived world, in relation with and to their culture, their concerns, thus not in isolation (Smith et al., 2009). Phenomenology is curious about those experiences “which register as significant for the participant, those which become ‘an experience’ of importance rather than remain as just ‘experience’ ” (ibid. p.188). Qualitative methodologies such as narrative analysis, discourse analysis and IPA attend to why a lived social event is important, psychologically and externally through consideration of the recounted experiences analysing language, narrative and context. They aim ‘to capture the quality and texture of individual experience’ (Willig, 2008, p.53). Narrative analysis offers a way of tracking and analysing experience through the structuring of experience in narrative form, whilst discourse analysis ‘is concerned with how particular versions of reality are manufactured, negotiated and deployed in conversation’ (Willig, 2008, p.103). IPA ‘recognises that such experience is never directly accessible to the researcher’ (ibid. p.53) and so pays particularly close attention to the meaning making that occurs in these areas, through the use of the recursive interpretative process, to consider and interpret the cognitive and affective reactions in personal accounts to try to get as close as possible to the participants’ experiences. This makes IPA applicable to the research question. IPA explores the detailed lived experience of the individual, the emotional and outer lived experiences, and is interested in the personal and particular within a homogenous group.

*Hermeneutics*  
(the theory of interpretation)

What is central to this study is how the participants make sense of their experiences. In order to do this IPA, through the use of the double hermeneutic, places more emphasis on the researcher's own meaning making process, than narrative analysis, discourse analysis or grounded theory. IPA is informed by the philosophy of hermeneutics and views as crucial the researcher's own interpretative layers of understanding which are explored through self-reflexivity, so enabling them to be distinguished from the participants' contributions. By 'bracketing' or putting to one side the researcher's own assumptions and experiences (metaphorically), they can be brought into the analysis later through the use of the double hermeneutic, so providing the opportunity to notice new aspects of the same phenomena. IPA places particular emphasis on this double hermeneutic. This is important in this study, because the researcher too works in the mental health services described by the participants. Using IPA, the researcher has to try to make sense of the participants' attempt to understand their experience. The researcher has a subjective approach to the data and holds her own perspective on ideas and the research questions. Therefore, the researcher explores and discusses the experiences given by the participants, but uses only part of the material generated, that which from the researcher's perspective is relevant to the research questions (Smith et al., 2009). Although IPA has critical realist/social constructionist foundations, the use of the double hermeneutic enables one to consider the influences on the researcher and their interpretation of the data. This interpretation is subject to reflection on its interpretation, which is the double hermeneutic. This use of hermeneutic theory by IPA provides possible perspectives on the data that "are not directly apparent in the text" (Willig, 2008, p.53).

Hermeneutics emphasises the recursive nature of understanding, the hermeneutic circle, in order to "understand any given part, you look at the whole: to understand the whole, you look at the parts" (Smith et al., 2009, p.28). This theoretical stance for the IPA researcher, through detailed and systematic analysis produces

connections “which emerge through having oversight of a larger data set, and some of it may come from dialogue with psychological theory” (ibid. p.23). It will involve moving in and around the data at different levels of meaning (Smith et al., 2009). As noted above, in the double hermeneutic the researcher is making sense of the participant making sense of their experiences, accessed through the participants’ recall, thus the meaning making for the participant is of a first order nature and the researchers of a second order (ibid. p. 36).

### *Idiographic*

The last major influence on choice of methodology with regards to the research question is whether to focus on particular individual meaning (idiographic) or universal group orientated understanding concerned with human behaviour (nomothetic). The idiographic stance is used in qualitative methodology. IPA is idiographic as it first looks at the meaning of the experience for the individual, offering “detailed, nuanced analyses of particular instances of lived experience” (Smith et al., 2009, p.37). It is idiographic in attending to a particular set of experiences and in the nature of the detailed analysis. If generalisations are made from the idiographic analysis it is done with reference to the particular (ibid. p.38).

This study is concerned with the individual not group experiences. Although it is a homogenous sample, it is concerned with exploring the detail of that individual experience psychologically and practically. The hermeneutic nature of IPA works with the idiographic to explore meaning and process in the unique individual experience.

IPA offers a methodologically rigorous qualitative approach. It is not focused on outcomes but on the lived experience, which is the focus of this study. It provides the opportunity to explore individual’s experiences, as it explores the meaning experiences are given and the individual’s interaction with them (Biggerstaff & Thompson, 2008). It is interested in the nature and fabric of that experience and in the specific uniqueness of that experience for that person (Willig, 2008; Smith et al., 2009).

In this study, the researcher is part of the same mental health services and the methodology of IPA acknowledges and works with this in an interactive manner. The methodology of IPA recognises that the researcher brings something of their worldview to the nature of the study, the interaction between the researcher and participants, and the analysis; in consequence “the phenomenological analysis produced by the researcher is always an interpretation of the participant’s experience” (Willig, 2008, p.53). Therefore IPA’s interpretative stance of the double hermeneutic, where “the researcher is making sense of the participant, who is making sense of x”, is an important methodological component to the interpretation of the data (Smith et al, 2009, p.35).

### **3.5 The sample**

#### *Size, type of sample, inclusion criteria*

The idiographic stance within IPA enables the sample size to be smaller, because it is concerned to produce detailed and in depth data. The sample was purposely rather than randomly selected, with a degree of homogeneity to enable the participants to be a defined sample for whom the research question would be relevant and meaningful (Willig, 2008). To this end, I recruited the sample from one Mental Health Trust in London, working in adult services - all of whom had completed their medical and further training in psychiatry and were members of the Royal College of Psychiatry. I accessed all psychiatrists in the trust via email; the participants were the ones who responded.

### **3.6 Recruitment**

The participants were clinicians working in a NHS Mental Health Trust in London. They were recruited after the Medical Education and Resources Department had

confirmed research and ethical approval and had accepted the advertisement for participants (Appendix A). This sheet contained my contact details and asked for interested subjects to contact me directly. At this point, the Medical Education and Resources Department emailed my recruitment advertisement and information sheet (Appendices A and B) to all the doctors in the Trust, providing adult mental health services in 3 London Boroughs. Ethical clearance came from a consortium to which this trust belongs. My choice to interview psychiatrists in the same Trust in which I work was governed by time; they would be nearer so reducing my travelling time. This influenced who came forward.

The participants were self-selecting. Those that offered to be interviewed appeared to be curious about a different kind of conversation, one that was clinically orientated rather than service audit related. I interpreted this in these terms as within the NHS context audit has become a dominant discourse. Once I had been contacted, respondents were given additional information if required and were asked to arrange an interview time where prior to interview the consent form could be completed.

From the initial recruitment drive I received 3 responses. This was disappointing as this is a large Trust, but at the time there were many organizational changes and a recruitment email was not a priority. After resending one more expression of interest was received, taking the total to 4 participants. Although IPA favours small sample sizes I thought a bigger sample would be constructive and after a second recruitment drive gained 2 further participants.

### *Dates*

Initial recruitment drive - December 2011

Resultant interviews - December 2011 and April 2012

Second recruitment drive - September 2013

Interviews - November and December 2013

### *The Interviews*

Each interview was conducted in the workplace of the interviewee, at a convenient time. Each interview was based on the semi-structured interview (See Appendix C for interview schedule). The participants were interested in the completed research and accessing it. I agreed to inform them when it was completed and available from the university.

### *Ethical considerations*

Both Birkbeck College University of London Ethics Committee (Appendix D) and the North Central London research consortium NHS (Appendix E) granted approval for this study.

As a researcher, it is important to give voice to some of the ideas that influence those who treat mental ill health. Society in general struggles to make sense of mental health, and we seem to increasingly portray those with mental health difficulties as outside of mainstream life or unlikely to return to it. Mental health, good or ill, is as much about how society makes sense of it and provides treatment, as a question of how the individual makes sense of it. There are ethical issues in how to enable these voices whilst protecting them from censure and threat.

The researcher's obligation to protect participants from harm remains and as such confidentiality, anonymity and protection of any clinical references were issues that the researcher was sensitive to (Willig, 2008). The participants have been given aliases to provide anonymity. The participants' working environment is busy and stressful. The fact that the interviewed psychiatrists are active clinically with real people in real contexts is important as they are working in an environment that is influenced by many forces. The opportunity to talk about their lived experience of systemic psychotherapy gives voice to a range of ideas concerning psychiatric thinking and mental health. However, both professionals and patients need to be protected. The interviews involved discussion of the current work context and practice, professional support or lack of, past training, and could be intrusive or distressing. Being aware of this, and that we all work in the same Trust, I was



mindful in the interviews, supportive to participants, and safeguarded inadvertent references to patients to avoid any potential impact on future working relationships. The participants, engaging in a study where they may be asked to discuss issues directly relating to their work, may be placed them in a bind concerning what is professionally acceptable, to which I needed to be sensitive.

### *Informed consent*

The participants were given the participant information sheet (Appendix B) prior to meeting with me, for them to consider any issues that may arise from their participation. This was reviewed at the beginning of the interview and any additional queries received a response, including: concerns about the purpose of the study, who was involved, advantages and disadvantages of participating, issues of confidentiality and use of patient information (to be avoided, if used then generalised and made anonymous). Their right to withdraw at any time was reiterated. They were asked to sign 2 consent forms (Appendix F) countersigned by the researcher, and given one copy for their records.

### *Confidentiality*

The consent and information sheets established the use of the data and the extent of confidentiality. This was further discussed and confirmed by the researcher before written consent was requested. It was confirmed that if any patient references were inadvertently made, they would be anonymised in any written transcripts. Furthermore, all data would be kept securely and in a locked environment in the researcher's house. It was confirmed to the participants that any identifying information in the data would be removed and all quotations would use an alias.

### *Potential distress*

As discussed above, the researcher was aware that the study may raise issues about the participants' current work. However, the researcher was aware that she should be a thoughtful and considerate interviewer, particularly because the nature of the study

required the recollection of events, including emotional responses. Considering that the participants are professionals working in busy stressful environments, the researcher needed to be aware of any impact and be supportive should any issues arise during the interview. The participants were aware that the interview could be stopped for any reason at any time.

#### *Access to the completed research*

The participants were told that they would be informed when the study was available for them to access the completed research thesis from the University.

### **3.7 Influences on the data collection and analysis**

The participants were six registered psychiatrists. I had hoped that they would reflect different grades, i.e. those who had very recently completed their training as well as established consultants, however the participants were all consultant psychiatrists, working for adult mental health services in the Mental Health NHS Trust. This is a mental health trust in a large and diverse city which services a diverse population across all demographics. The semi-structured interviews were analysed manually using IPA.

#### *Information about the participants*

Appendix O shows participant demographic characteristics with information on gender, age, clinical training and current work environment. The participants varied across these axes. The participants were self-selected, as they chose to respond to the advertisement and this in itself indicated an interest in some way in the research. To main confidentiality all names are pseudonyms.

## **William**

### ***Transcript 1***

William is a white man from southern England, who trained in London and is a consultant psychiatrist in a community support and recovery team. Prior to reorganisation, he worked in a community mental health team which provided assessment as well as on-going treatment and care. The team was newly formed, with different experience and expertise for this particular patient group, including my interviewee. William had responded very promptly to my first advert. We agreed to meet in the quiet days following the winter bank holidays, and met after lunch at his office, an unfamiliar but very peaceful location, where he was courteous and welcoming.

William was the first participant, as he had responded very quickly to the email advertisement. As I had not tried out the interview schedule previously, I was slightly unsure of how the interview would work. William seemed quite concerned to get things right, and also not be perceived as being negative about his employer. He was very thoughtful about the questions, was very polite and gracious, and as the interview progressed and we relaxed, we shared a gentle humour. He then became more confident about sharing his thoughts. He explained that recently the adult mental health service had significantly changed service delivery. This reorganisation had altered his patient group and the team with whom he worked. He felt he was at a point of significant readjustment in his career. He recounted his experience of ‘family therapy/systemic psychotherapy’ whilst also being clear that he was not trained in it. But it was clear that he had retained ideas and thinking from his exposure as a trainee. These ideas sat alongside other psychotherapy experiences in his day-to-day thinking and work and he enjoyed thinking about his experience and practice, reflecting he would perhaps address some of the ideas that had emerged.

I was struck by William’s use of the first and third person singular within the interview. On reflection this shift occurred when he was more or less certain about an answer, and when placing himself within a wider psychiatric context. The third person singular was used when talking about the system, i.e. not quite part of him.

His first person usage was emotionally charged, whilst his manner of speech was gracious. His language was careful and cautious concerning thoughts about the NHS Trust, conveying a sense of trying to not get it wrong. As the interview progressed he increasingly began to use dry humour and metaphorical language to convey - what I experienced as - concern, anger and distress about psychiatry and delivery of mental health services.

During this interview, I was conscious that the process opened up different perspectives and ideas for William, almost as though I had consulted to him about his team. I was mindful of this and careful not to be directive in any way and, from an ethical position, to be considerate of the impact of raising these perspectives in terms of his returning to work. This highlighted that the interpretation of the data needed also to have regard for how William engaged with me as an interviewer and as professional within the same Trust.

## **Jane**

### ***Transcript 2***

The interview with Jane was very different. I was more familiar with my interview schedule and it was in a venue I knew, conducted in the time before lunch but nonetheless we had to look for an available room. Jane was interested in the research idea due to her own experience and exposure as a trainee. She had participated in a live supervision clinic during training and had found it helpfully challenging to her psychiatric thinking, and saw it as important to her learning process, which continues to influence her now. Additionally, she was leaving the Trust shortly to work abroad which contributed to her coming across as relaxed.

Jane is white British woman, from southern England, in her early 40's, who trained in London with one year in Australia. She saw this as an important year in developing her ideas about psychiatry, and the relationship with other disciplines. She works in a specialist team, early intervention in psychosis (EIS), with both in- and outpatients. I was more comfortable with the process of interviewing and setting up the context and my interviewee was keen to be interviewed, which combined to

make a relaxed atmosphere. Being interested in the research topic she wanted to reflect on her experience and her manner of speech was calm and she was curious throughout. As the youngest participant, her past was less distant and references to it warm and intimate; whereas the language concerning the present was eager, descriptive and conveyed an awareness of the magnitude of the psychiatric task. It was hard to conclude the interview, which reflected both curiosity but perhaps the ending she was navigating.

## **Amir**

### ***Transcript 3***

I went to meet Amir in an outpatient unit unfamiliar to me. I was comfortable with the location and my interview schedule and it was early in the morning before other staff arrived. He was welcoming, yet formal and the interview was conducted in his cramped office. We spoke about this and how the lack of space impacts on his clinical work, as it did initially on our interaction before we were able to reflect on it together. Amir is originally from the Asian subcontinent. During the interview we reflected on what this brought to his current work, in terms of language and approach. His medical training was in his homeland and his psychiatry training in London. Amir was clear that these 2 contexts had influenced his development as a psychiatrist, and continues to do so. In his psychiatry training he had chosen to include direct work in a live supervised systemic psychotherapy clinic, as he believed he needed to have knowledge and experience of therapies in order to be a good consultant psychiatrist. He was aware of the wider Trust context of reorganization, aware that this had altered the delivery of the service, and referred to it whilst reviewing how systemic thinking influenced him.

It seemed important for him to confirm that the interview did not require preparation. Amir spoke with a hospitable air, appearing relaxed and interested in research and was keen to offer his perceptions. Throughout the interview his language was personal even when talking about work contexts and he was self-deprecating. His tone did not have the urgency of the others, but there was perhaps a sadness when reflecting on the experiences of his patients.

Amir more than the others referenced the wider context of mental health, and the interview was wide ranging due to his familiarity and training in systemic psychotherapy as he explored ideas around application including organisational ones. He brought consciously to the interview ideas about the use of language and culture in psychiatry. These areas, organisation and culture were carefully navigated until we established safe and respectful positions; these being done the interview relaxed further and interested us both.

## **James**

### ***Transcript 4***

I was late starting the interview, having been stuck in traffic, which made for a rushed and slightly uncomfortable start. I was apologetic, but also conscious that we needed to start, as James' time was limited. My sense of limited time was compounded by the time it took to get to his team's office space where we conducted the interview, as the general hospital inhabits a tall multi-storey building. The interview started with a sense of urgency and need for time management. During the interview I was conscious that both James' manner and the context -that of a busy general hospital not a mental health clinic or psychiatry unit- contributed to this pressured experience. The interview was conducted in his team's office space. He is a white British male in his early 40's, from southern England, who had worked and trained in London though initially as a physician. His work in liaison psychiatry involved considerable flexibility, and motivation to engage his fellow professionals within other branches of medicine. This is a challenging context for a lone psychiatrist, needing to make links with medical colleagues who need his interventions when having difficulties with patients, but who have no professional role with making sense of human behaviour. His earlier work as a physician has influenced his understanding of human behaviour and this had been instrumental in him pursuing both psychiatry and systemic psychotherapy training. He saw both a philosophical as well as a clinical thread to systemic psychotherapy. James was committed to systemic thinking and intervention, as he found it useful. He has done some initial systemic training and has toyed with taking this further. James has a fast

moving style yet his speech was thoughtful, present, and in the first person. He was reflective with quite a serious tone, and as the interview progressed included some light humour. His language initially was precise and short, e.g. ‘headline thoughts’ (line 11), and conveyed a desire to get going. This shifted to being more discursive though remaining still quite pithy.

The interview was enjoyable as I found myself talking with someone who understood systemic principles and was managing to apply them in a somewhat isolated context; it also drew my interest to his determination to apply systemic principles. He generated many ideas about the clinical applicability of systemic ideas in general medicine and psychiatry.

## **Elizabeth**

### ***Transcript 5***

Elizabeth is a white British middle-aged woman, from southern England, who had trained in London. The interview was 23 months after first interview, so I was less familiar with the process. This initial concern faded as the interview schedule was an effective guide and memory aid. We met in her office in the inpatient ward of the psychiatric hospital. Her work is on a male inpatient unit. When I met with Elizabeth it was at the end of a long day of work for us both and so time seemed less of a constraint and we both settled quickly into an interested dialogue. The interview was difficult to conclude as we both were interested in meaning making within the mental health context. Elizabeth is very much engaged with how psychiatry also needs to be able to have enough time to work psycho-therapeutically in inpatient settings, when bed space is constantly under pressure and the drive is to treat in the community. Elizabeth was thoughtful about the relevance of a patient’s social context and experiences in life. She was concerned that in mental health there is a risk of ignoring patients’ social circumstances to the detriment of making sense with a patient and to treatment provision. Elizabeth thought about the space limitations of the ward on the patients’ treatment as well as the diminished range of staff and interventions particularly occupation therapy, which made recovery harder. She came across as curious and yet compassionate about human distress. Elizabeth

was aware that her own exposure to SFT had been limited, but saw links within psychotherapeutic stances. What did interest her was that in her experience the current trainees appeared to have no knowledge of or exposure to SFT, in contrast to her own training that had been rich in psychotherapeutic learning.

Elizabeth spoke throughout the interview very quickly, and the interview was hard to conclude. The speed of her speech scarcely varied throughout the interview. I experienced her as conveying a commitment to being a psychiatrist and her patients by her intensity of speech. Throughout the interview Elizabeth used emotive language, although her tone was never violent her words were, e.g. hit, bash. The intensity of feeling was present through the interview.

## **Richard**

### ***Transcript 6***

This was the last of the second set of interviews, conducted 24 months after the initial interview. This interview was our second attempt. Richard had cancelled the first one when I arrived due to an unexpected Mental Health Tribunal that he needed to prepare for. The inpatient ward on which Richard works is located within a hospital complex, which has both general medicine and psychiatry. The ward was busy and it took a little time to find a vacant room in which to conduct the interview. The interview was conducted mid-morning, with a clear time constraint for Richard, nonetheless he was thoughtful although there was an overall sense of rushing.

Richard is in his 40s from northern England, who trained in London. He was aware of the difference when he came to London. I was aware of differences in language and nuance from southern English usage, which I found refreshing. He works in an inpatient unit, focussed on assessment. He described his path within psychiatry as one where he needed to think about what his first consultant post would be, and had chosen his placements with a view to what was current thinking in psychiatry at that time. Richard has been exposed to different models of delivery, particularly in the community based treatment ideas, and found them to be interesting and enriching of his practice. He talked very engagingly about home treatment models and his experiences of involving families in assessment. Richard was conscious of how psychiatry had moved away from this kind of home base assessment and



intervention. He was clear that families are part of his assessment process and should also be for treatment. Although these models have strong influences from systemic thinking, they were not identified by him as such in this interview or at the point of learning about them. He, like some of the other participants, saw his systemic exposure as informal rather than formal training. From a reflexive perspective, I was conscious in the interview of thinking about how he was systemic in his approach, but did not 'label' it as such and that I needed to be careful in exploring this.

The interview with Richard had a sense of being wanted but rushed. There was endless background noise from the ward, noise bells, whistles, air moving, and people in general. Richard himself, though level in his delivery, had a busy air about him, the interview had had to be postponed and he was very busy even at the new appointment time. However, as the interview progressed, he moved from factual responses to warm, talkative reminiscence.

### **3.8 Data**

#### *Data collection*

Smith et al. (2009, p.56) see IPA in common with other established approaches as having "certain requirements, limitations or preferences for methods of data collection". They see in depth interviews as a way to access 'rich' data by which they mean "participants should have been granted the opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns" (ibid. p.56). In keeping with the qualitative stance, the interviews were conducted in real life settings (the work place of the participants) and arranged to fit into the work schedule of the participants.

The interviews varied in length from 54 minutes to an hour and 23 minutes. The speed at which the participants talked varied considerably - this did not necessarily reflect a scarcity of actual time - but as noted in the reflections on each interview reflected something of the interviewee.

The interviews were based on a semi structured interview schedule (Appendix C), using relevant literature and appropriate model schedules. The schedule was to help steer the interview rather than be rigidly adhered to, to enable their stories to be told (Smith et al, 2009). The researcher noted her thoughts and reflections, concerning the interview, after each interview. The interviews were conducted in 2 time periods, and reflections on this have been discussed in the consideration of each participant.

### *Data Analysis*

Each interview was digitally audio recorded, with consent obtained prior to the interview and confirmed at the beginning of the interview. The interviews were transcribed verbatim and then analysed using Interpretative Phenomenological Analysis (IPA), informed by the process guidelines as described by Smith et al, Willig, and the experiences of Gee (Willig, 2008; Smith et al., 2009; Gee, 2011).

The first 4 interviews were transcribed and reviewed. Once the second set of interviews had been recorded, the interviews were then attended to one by one.

By re-listening to and re-reading the transcript several times, to become immersed and familiar with the text as well as the tone of the interview, the first transcript was put into columns as suggested by Willig (2008) and Smith et al. (2009). This was done to enable initial responses, on an emotional level, a linguistic level and conceptual level to be captured on one side and later emergent themes at a meta level to the initial responses, on the other.

Themes were developed from these emergent themes and put into groups. At this point managing the data in this way was found to be difficult - even when printed out it was hard maintain an overall picture - and a colleague suggested that a spreadsheet be used to organise the data. This made it possible to 'look' across the data without getting lost, and to start to be more interpretative. This spreadsheet approach enabled the researcher to gather and explore possible themes through using key words and phrases from the emergent themes and then check these themes

against the words of the participants. The looking backwards forwards and across is part of the recursive and iterative nature of IPA as described by Smith et al. (2009).

These emergent themes were grouped and regrouped until an initial set of subthemes were produced.

The spreadsheet method was applied to the analysis of the subsequent transcripts, and permitting integration to form “an inclusive list of master themes that reflects the experiences of the group of participants as a whole” (Willig, 2008, p.58). The subthemes and master theme grouping was reviewed, and another layer of interpretation was needed. From this a final grouping of master themes was formed. A table for each master theme was then constructed (see Chapter4).

### **3.9 The written findings**

The themes will be presented in the next chapter in the form of a narrative, which is structured around the master themes. The subthemes and master themes are written into a narrative using illustrative quotations from the participants to provide “a convincing account of the nature and quality of the participant’s’ experience” concerning the research question (Willig, 2008, p.60).

## Chapter 4 Findings

I present here the Interpretative Phenomenological analysis of the accounts given by 6 psychiatrists. This is a dance across six psychiatrists' narratives about how SFT is part of their experience as psychiatrists. Verbatim extracts from the transcribed interviews are used to illustrate the themes. A consequence is that the themes that are taken forward by the researcher are those which have subjective meaning and relevance to the researcher. Therefore, the themes explored in this study are not exhaustive of the experience of the psychiatrists but have been chosen as most relevant to the research question.

As seen in Appendix P many subthemes were identified, through initial analysis of the interviews. They were colour coded to enable them to be grouped in potential master themes. Appendix Q shows initial master themes (right) and final master themes (left). The process of grouping and movement to final themes initially followed grouping similar ideas, whilst taking into consideration the experience of the researcher. The frequency of theme was a consideration but also the importance given by the participant as experienced by the researcher to the ideas within the theme. The initial master themes were reviewed and on reflection were thought to be concrete or descriptive. Another layer of iterative interpretative analysis was done to identify meaning expressed through these descriptions.

So for example the participants all talked about their training experiences. I was more interested in how they recalled and made sense of those experiences rather than exploring the technical aspects of the training.

I expected more recall of how they experienced SFT but their descriptions were more concrete, suggesting that theoretical ideas were less meaningful until they were seen in action. My iterative process was to examine the meanings embedded in these descriptions, partly to put to one side the description, but also to think about why the

description was important. This resulted in the shift to understanding and meanings over time rather than specific descriptions.

The participants' relationship with psychiatry came through in their description of expectations of them as psychiatrists, how focused they were on that current immediate experience of loss and uncertainty rather than a specific psychiatry dialogue. The wistfulness was surprising, though related to the difficulty in engaging with their own power, which was reflected in their experience of being seen as having power (diagnosis) but not experiencing power in terms of how services and treatments can be delivered. In their role within current services, they are positioned and perceived as having power as diagnosticians, yet they experience that role as not powerful. I was expecting a more active engagement with academic psychiatry and the dilemmas it poses, where as they described problems as NHS based rather than considering psychiatry's role.

My own experience as a senior clinician, not a psychiatrist but in a context of frequent changes and adjustments to service provision and delivery, led to me not to be surprised by their expression of frustration, which reflects both my exhaustion at the time of data collection and analysis but also their experience. The analysis explores how this experience of power and powerlessness is experienced in relation to SFT.

Within the transcripts, (...) denotes sections removed for ease of reading, ... without brackets denotes pauses, words or letters in bold denote emphasis by the speaker, punctuation follows the spoken punctuation, poor sentence coherence is also transcribed verbatim and word repetitions are included when they convey uncertainty or hesitation. Each quotation is followed by the initial of the speaker and the line number from the transcript.

### Summary of Themes

Tables 1,2,3,4 summarise the 4 Master themes and their subthemes

**TABLE 1**

THEME	ELABORATION	RELEVANT QUOTATION
<b>Master Theme ONE</b> The past in the present and the future	<b>1</b>  The impact and relevance of SFT training; particular experiences which remain relevant over time	
<b>Subtheme 1.1</b>  Hope that SFT is more than a set of techniques	<b>1.1</b> Exploring their knowledge, experiences and influences of SFT in their work	<i>'one would have had hopes of it'</i> William
<b>Subtheme 1.2</b>  Ideas and Hopes of SFT in making sense of symptoms	<b>1.2</b> Memories of SFT in practice; the context, culture, the relevance of a team and team functioning in the process of making sense of symptoms	<i>'A sort of welcomed sense of context'</i> William
<b>Subtheme 1.3</b>  The presence or absence of the family, in mind or reality.	<b>1.3</b> In what way is the family in mind for psychiatry	<i>'you don't quite see it'?</i> Jane

**TABLE 2**

THEME	ELABORATION	RELEVANT QUOTATION
<b>Master theme TWO</b> Proximity and distance exploring the range and limits of accessing SFT concepts and provision	<b>2</b>  The ease or difficulty in engaging with SFT theory and accessing and working with SFT services	
<b>Subtheme 2.1</b>  How accessible (to professionals) is SFT. Literally and figuratively	<b>2.1</b> Experiences of making sense of and using SFT, and SFT services	<i>'please ring me if you want any kind of any ideas about what I think might help'</i> James
<b>Subtheme 2.2</b>  Perception of accessibility for families literally and figuratively	<b>2.2</b> The participants view of families' understanding and use of SFT	<i>'it was interesting in that kind of setting because people were coming from kind of miles and miles around to do this'</i> Jane

TABLE 3

THEME	ELABORATION	RELEVANT QUOTATION
<b>Master theme THREE</b> <b>Anxiety and un/certainty in role of psychiatrist</b>	<b>3</b>  How the experience of working with anxiety and un/certainty in psychiatry	
<b>Subtheme 3.1</b>  Holding risk when the knowledge is less certain than it would have you believe	<b>3.1</b>  Expressing doubts about the efficacy of pharmacology, being able to pick up and use the medical model but not accept it as entirely accurate and thinking about the alternative- - psychotherapy- as attractive but mysterious	<i>Think too many difficult thoughts... (...) it's very challenging because we are walking on quicksand in terms of evidence'</i>  Jane
<b>Subtheme 3.1</b>  Managing uncertainty (diagnosis and treatment) with families	<b>3.2</b> The influence of SFT in managing risk, and uncertainty, with patients and their families	<i>'systemic lends itself to that kind of thought it tolerates that kind of questioning and uncertainty...' James</i>

TABLE 4

THEME	ELABORATION	RELEVANT QUOTATION
<b>Master theme FOUR</b> Position of SFT in mental health services	<b>4</b> Position of SFT in mental health thinking, and within the NHS. Exploring what influences promulgation of which treatments	
<b>Subtheme 4.1</b>  What influences when SFT is used	<b>4.1</b>  Ideas about Knowledge, experiences, and influences, identifies their experience of how mental health is understood by the NHS, resulting in a diagnosis-led and rationed service delivery	<i>'something that goes in fashions'</i>  Elizabeth
<b>Subtheme 4.2</b>  How good a fit is SFT for the NHS	<b>4.2</b>  What drives change; the role of individuals and evidence	

Four master themes were chosen. The first, *The past in the present and the future, the impact and relevance of SFT training*, explores the manner in which participants recall what they remember of SFT from their training in psychiatry. This master theme evokes remembering the intensity of what was, what was hoped for, and what has come into the present because it was intense and intimate. The second master theme addresses the accessibility of SFT in their experience, in terms of thinking as well as service provision, and is called *Proximity and distance, exploring the range and limits of accessing both SFT concepts and service provision*. The third master theme, *anxiety and uncertainty*, using the focus of SFT identifies their lack of clarity and confidence in SFT within a broader discussion about their experience of anxiety and uncertainty regarding the validity of treatment options- both psychological and pharmacological- and expectations of psychiatry following diagnosis. The final and fourth master theme is their experience of *the position of SFT in mental health thinking, and within the NHS*.

Interacting with these master themes are subthemes.

- 1) Knowledge, experience and influences,
- 2) Making sense of symptoms, use of language, team thinking and functioning, culture
- 3) To include or not to include the family

#### **4.1 Master Theme 1: The past in the present and the future, the impact and relevance of SFT training.**

This master theme aims to capture the participants' remembrance of psychiatry contrasting it with the present. As consultant psychiatrists in adult services, they describe previous selves that expected to have the breadth of thinking and the experience, to think of the person as a whole being and in the whole context. Now they find themselves working within a much-reduced environment both in terms of resources but also in terms of service capacity to think about the patients' contexts and needs. Asking them about their experience of SFT resulted in themes emerging about this seemingly lost psychiatric land. The Master Theme tries to capture an



overarching idea of ‘of having hopes’ suggesting that something is lost; the place to think, and a good enough place to work.

This Master theme is explored through 3 subthemes:

#### 1.1 - Hope that SFT is more than a set of techniques.

The master theme is explored firstly through their recollection of what they hoped SFT offered their psychiatric practice. The subtheme explores a sense that psychiatry and the psychological was once more intertwined than separate, with the idea that psychiatry could think more than  $a + b = c$ , in an apparent medical model of delivery.

#### 1.2 - Ideas and Hopes of SFT that made sense of symptoms, context, language, team.

This subtheme reviews their memories of SFT in practice; the context, the relevance of a team in the process of making sense of symptoms.

#### 1.3 - The presence or absence of the family, in mind or reality. This subtheme recalls when, how and where ideas of family come into their practical work.

#### *1.1 - Hope that SFT is more than a set of techniques*

This subtheme explores the psychiatrists' lived practical experience of SFT. The range of thought and description regarding their experiences of SFT clustered around three positions: more than a set of Techniques, Outreach, and a way of Thinking. The first and second recollections seem to reference the hoped for possibilities, and what they experienced as the use and interpretation of SFT. The last response recalls an active connection with not just the practice but also the thinking. The lived experience is both nostalgic of that learning period, yet is connected to the active present.

When speaking about their training experiences they all became emotionally engaged and thoughtful. Their language tinged with emotion.

What comes through in their descriptions of SFT training as part of their core psychiatric training was of observation, theoretical experiences and diagnosis, though with little ‘hands-on’ SFT. The usual access to SFT was in child and adolescent psychiatry, though there was reference to specific, usually adult diagnoses, such as schizophrenia.

This initial training left some of them with awareness of the usefulness of SFT, but without a belief that they had specific knowledge. Other therapy trainings they describe seem to have been clearer, leaving them more confident about what they had learnt and skills they possessed.

They reference SFT techniques, recognising them as such but are less certain about theoretical knowledge. William and Elizabeth recalled their core training, with learning largely recalled in terms of techniques. There was a sense of something that was useful but frustratingly not realised. In contrast, the training experiences in general hospital settings for James, for Amir in CAMHs<sup>4</sup>, and eating disorders and adult outreach for Jane and Richard, were ones where SFT was more defined and taught, though for Jane remained tantalisingly insufficient. Jane and Richard had had experience of working in specialist teams that used SFT in their approach. They describe other worlds of work, one abroad and the other no longer practised in the UK<sup>5</sup>. Jane yearns sufficiently for this to have taken a job abroad to re-immers herself in what she recalls as a more integrated psychiatry and psychotherapy setting. Richard recalls his learning and is aware that bringing that way of working onto his current work is challenging, not impossible.

*‘(...) do a slight a relatively similar thing (...) when a patient is admitted to the ward within 72 (...) hours we have what is called a formulation meeting (...) we invite the care coordinator and we invite family members to the meeting erm and that meeting is basically to discuss you know what’s*

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<sup>4</sup> CAMHs- Child and Adolescent Mental Health Services

<sup>5</sup> Crisis Intervention/Home Treatment Model as described by Denis Scott et al. (1981)

*happened and for the patient to come into hospital to sort of look at where we go from here.' R L70-72*

James and Amir had both sought out and completed more SFT training. Both were drawn to SFT because of the relevance and importance of context, for them and their patients.

The unclear understanding of SFT and whether it might be more than a set of techniques emerged with Elizabeth. She recalls her own breadth of training experiences including exposure to SFT, which she remembers through a set of techniques, currently incorporated into her work. Her training in psychiatry included a therapeutic community experience within mainstream psychiatry; a psychoanalytic therapeutic frame which to her valued the context of symptoms. Elizabeth contrasts this with how she sees the experience of current trainees; her trainees have much more specific management training as well as no specific SFT training. She is clear that psychiatry should be able to draw on different tools. In her recollection of her training she conveys her belief that psychiatry should be broader than a medical approach, noting that work and training is different now.

*'(...) in one's psychiatric training we you know have experience of of all sorts of different things...and it's one one develops one's own style I guess by this sort of pick and mix , (...) but the other thing that I found I really thought was particularly great I really think that some of the... questioning styles. You know used in systemic family therapy are things that I have found incredibly useful and helpful'*

E L40

*'I have to say I don't think of it consciously as being a systemic way of thinking (...) but I guess from my own my sort of my my training (...) but it is something that I think systemic family therapy (...) puts names to things and is is more explicit about the techniques and things and I think that that is helpful actually in terms of learning'*

E L87

*‘(...) none of the trainees the higher trainees come along having done their child psychiatry at the X which is where most of them do it’ ‘(...) talk(ing) about systemic family therapy’* E L20- 22

William starts recalling SFT using the word ‘welcomed’ conveying a recollection of warmth and hope in his experience of SFT.

*‘Yes. A sort of welcomed sense of context as opposed to... bad medical model which can sort of wish that there were not a sense of context just want it to be a disease process (...)’* W L21

He recalls being intrigued, and perhaps still is, about what it offered as another way of making sense of mental health contrasting with a medical approach. He is uncertain about what SFT is, and like the others is confused by the shifts in names for SFT.

*‘(...) it seemed quite an interesting alternative whole approach actually, and quite sort of a challenge to something that certainly in medical school and increasingly since really, one was finding was inadequate which was the this medical idea that A is the problem which has led to C er B and I am going to give the treatment C which is just going to get rid of the whole thing’* W L 59

*‘(...) this may not be specifically systemic this may be more of a family therapy thing, of circular questioning and that whole approach...’* W L65

William like Elizabeth clearly states the appeal of SFT in contrast to the medical approach, in that it took a ‘whole’ approach, his careful choice of words throughout his interview came through strongly when thinking about what SFT had meant to him. Yet he remembers his hopes concerning SFT and psychiatric practice which like Richard he contrasted with his experience in later practice. He talks in the third person singular, almost to separate himself from the almost lost hope. He conveys a

sense that SFT offered something that has not been realised in psychiatric practice, as yet.

*'(...) one area where one<sup>6</sup> would have had hopes of it, initially, was (...) in schizophrenia in one's training one had heard a lot about umm the issue how the family was with the person suffering from schizophrenia and expressed emotions but also (...) behavioural family management... in clinical practice in general adult psychiatry, (...) it was just sort of really difficult and just didn't really happen in practice.'* W L74

*'I was wanting (...) family (therapy) would be available for patients with severe and enduring mental illnesses um, but we had already been told I think in training really and certainly turned out to be the case in reality that getting that into practice, in clinical practice in general adult psychiatry, is very very difficult actually getting therapists on board getting families on board ummm it was just sort of really difficult and just didn't really happen in practice'*

W L105

Something of these hopes remains with him in that they enable him to think beyond the confines of what is currently demanded of him. These hopes linger in how he uses what he remembers of SFT to bring flexibility to his thinking that also values the complexity of human behaviour.

*'Then sometimes I sort of remember systems because I think you know have a tendency to be bit stuck in the other stuff so then I sometimes remember but I mustn't. I remember as it were not to be thinking that I must find a cause and the answer- to find the problem*

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<sup>6</sup> Here William talks from the third person singular, moving in the subsequent quotes to the first person singular, to take more personal ownership of his views

*and find the cure- I can think out of that sort of box and I can think about ...the whole rest of it'* W L106-8

*'(...) systems is one of the ones that is definitely looking to have a deeper understanding of things and therefore maybe (...) to offer a more lasting sort of change or rebalancing or shifting or whatever it might be be ...um I think human behaviour is just so complex so anything anything that seems simple I think is sort um unlikely to be correct'* W L114

Richard and Jane have experience of SFT in specific contexts, eating disorders, early intervention in psychosis (EIS), and Home Treatment teams. These form an *Outreach perspective*. Their recollection of SFT was in its direct application in specific treatment contexts.

Jane specifically recalled her experiences of SFT whilst training as a place where thinking and skills were expected and incorporated into the work. Her recall of the experience was that her understanding of psychiatry was enriched. As an intern in Australia she was struck by the incorporation of psychotherapeutic thinking into the core syllabus and hence into the thinking, discussion and practice. For Jane working in EIS, the utility of taking a systemic view, to involve the lived context of the person was confirmed from her own earlier experience of Community Mental Health Teams (CMHT). Her current experience is that the context of the person is not generally involved in current psychiatric practice in adult services. Her fond recall of these formative experiences occurs as she is leaving her post to go and work in Australia where these experiences happened; she hopes it will still offer the breadth of thinking that for her is difficult to find here.

*'Very very interesting –because it was bit of a revelation to me actually at that stage of my training which was fairly early on... in my training ...that sort of opening out of sense of the trying to understand the kind of bigger picture'* J L42

*‘(...) then I came back to the UK of course I kind of and I have only realised this recently actually because I have been working in the now in the team (EIS)with (...)our psychology lead (...)how little I have ever worked with therapists and psychologists (...)in the sort of teams I have worked in’ J L54*

Richard chose to complete his training in Home Treatment teams, describing people as embedded in their families. This was an approach that he experienced as making sense.

The Home treatment team approach embraced context as informative, accepting and valuing that a different perspective on how a person presents to mental health services can emerge in a different context.

Richard had anticipated becoming a consultant psychiatrist in such a team. Now he is the consultant for an inpatient unit where he endeavours to involve a patient’s social system as soon as possible after admission. Richard talked about the thinking and skills from his training and work in home treatment teams of the 2000’s.

Richard in outreach used a social systems approach, rather than the observer and video-recording described by James or the live supervision clinics with the use of one-way mirrors as described by William, Elizabeth, Jane and Amir. Richard experienced a room full of people talking about the people and context, which he describes as helpful. For Richard, this was a different kind of apprenticeship from that later described by Amir. On the one hand it describes the vagueness of his learning experience. He connects the relevance of high expressed emotions in families with the presenting responses in the patient. He draws a distinction between this approach and clinic based SFT which is how he recalls formal training in SFT. Richard experienced SFT as a way of thinking, shared within a team, applied in different places and appreciated. Richard seemed wistful when he spoke.

*‘(...) we had a social systems meetings so we would actually invite we would identify people from the patients circle and then invite them to a meeting ...’ R L30 –L38*

*'it it was just trying to understand everybody's perspective actually'  
'basically getting everybody talking (...) and having somebody to  
facilitate that emm'* R L32-34

*'Do you think that the system found it useful?'* (Researcher) L35

*'They did yeh definitely they did there is no doubt about it and the  
and I think it was helpful clinically'* R L36

His recollection of SFT techniques, viewing them as artificial yet probably useful, identifies the tension between using a technique and making sense of it.

*'(...) we had a couple of the nurses were (...) quite knowledgeable  
about it er... er I think one of them had worked in another team  
where they had done a similar thing (...) (in)the literature they even  
talk about getting people together and even sometimes people even  
acting out roles we never did any of that, its slightly artificial'* RL62

Nevertheless, he is clear it was a period when his work was satisfying and productive. With gentle frustration, he recalls a 'can do approach' unlike the present which is constrained by diagnosis (cluster).

*'What was good about working in the home treatment was they had  
'a can do' philosophy instead of getting into arguments as to  
whether this person has this that and the other or whatever er  
whether they meet the criteria for blah blah they would just go and  
see them they would just on with it which was great er where as  
other services argue about which cluster it is (...) whereas the home  
treatment team would just go on with it and not argue about it and  
do the actual assessment and then they had actually something to  
talk about you know rather than just talking about a paper exercise'*  
R L 210

The last perspective of this subtheme recalling training experiences and hopes captures the applied SFT identified above with an active appreciation



that the application was part of an additional way of thinking about the symptoms and patients. It is expressed with warmth and positive connection from their initial engagement to the present day. All the participants could identify that the thinking was different in some way. Elizabeth, William and Jane spoke of grappling with the thinking, as something to remember to use when stuck and to try to connect to practice whilst unsure of the thinking. Richard continues to use the social systems approach but has not engaged with the theoretical thinking. The psychiatrists reflected on the experience of SFT as an opportunity to look at layers of meaning and meaning making.

James' forthright manner reflects perhaps his experience of physical medicine. He chose to leave physical medicine and move to psychiatry through curiosity about the patient engagement with treatment. He works at the interface between the two in liaison psychiatry. Like Elizabeth he was influenced and enabled by the consultant he worked under who was interested in SFT work. His talks in positive terms about the layers of thinking that were opened up to him through his experiences of SFT.

Along with Richard, both Amir and James had a clear sense of what was different in SFT thinking, and spoke particularly clearly about SFT in terms of theory and thinking. Amir and James recall wanting to know more, to grapple with the thinking and practice. Their recollections convey an intimate personal connection with SFT. They describe their encounter with SFT as more than rehearsing techniques, experiencing SFT as way of thinking applicable to their work and their work context, enriching and enabling them.

In SFT James was engaged by the interest and capacity to be actively curious, to be actively different and to invite curiosity. He recalls his own curiosity and how this was stimulated by the varied contexts of work. James remembers his first introduction to SFT, after his core training and general medicine training. When he

had started in psychiatry, his consultant was interested in family work and saw it as being relevant to understanding patients' reactions.

*'That was adult..., yeh definitely adult, that was in that was in A and E or emergency settings or on wards physical path usually... they just seemed to be helpful it seemed to be an important part of reasons why people were there or having problems um so I was exposed to that kind of thinking and people doing it so people who were quite comfortable ... talking to relatives and families and patients in that way.'*

JM L20

Along with Amir he also describes and reflects on a new personal learning process that is different in SFT, that of live supervision. How being observed and through replay of session recordings he was able to observe himself, and thus was able to reflect on the multiplicity of communications in the therapeutic space rather than only on the communication reported in conventional supervision. The idea of observing yourself to provide a different understanding of your own experience was vital to his absorption of SFT.

*'(...) well I think it made the whole thing (...) you see a patient then you can sort of post hoc justify what you do, when you brought it back it was quite hard to to accurately remember what was going on for you at the time, what you were thinking about (...) whereas in the video (...)you might see yourself interrupting people and you had not noticed, um ,all sort of things, your words that you use whereas if them report back you have generally processed them, and could take a different stance on it.'*

JM L42

Amir was clear that he had both valued and wanted the experience, which fitted with his ideas and hope of psychiatry. When speaking about the rationale to learn a clinical skill, Amir's speech slowed and he engaged pleasurably with the memory of the experience of a supervision group.

*'(...) systemic thinking and systems I think systems are important... and that they are very useful. Systemic con con constructs and concepts are very useful.'* A L10

Amir expresses both positive memory and value of the clinical SFT training through his description of himself as an 'apprentice' whilst participating in an SFT live supervision clinic (AL75). He progressed from working alongside to working independently in the mirror with supervision team scenario. For both, the recollection is also tinged with appreciation of what they experienced contrasting with the present. James is acutely aware of the difference in approach and thinking between where he trained, and where he works now.

*'(...) I think there is a big difference in what I would might like to see and what is actually like, I think there is very little local systemic practice going on outside of CAMHs, as far as I can see, so erm you as an adult you might get to see an psychologist with some systemic training perhaps in some teams um but I think there is very little provision for seeing...'*

*'I think in XXX... there is a bigger culture of systemic psychotherapy'*  
JM L87-89

Looking back to his training, in contrast with the present, Amir ruefully sees he had both different expectations in terms of his skills and of the skill available in the team.

*'I don't know, things keep on changing don't they (...) the problem is that with SpR training (...) because my understanding at that time was that the full membership its... its, you need to be very clinically (...) I mean at that time that out of my naivety I thought I would be working in a team with lots of family therapists and psychologists' 'So I thought that I need to have at least (...) some understanding of of more skilled people in that um intervention...'* A L100-03

## *1.2 Ideas and Hopes of SFT in making sense of symptoms*

This subtheme reviews their memories of SFT in practice; the context, the relevance of a team in the process of making sense of symptoms.

All of the participants were very aware that their current contexts and teams contrasted with their previous experience. Their nostalgia about ‘what was and what is’ continued when thinking about the relevance of team, of what enables therapeutic thinking and of making sense of symptoms. The participants talked about changes in team, in skills and about use of language. What comes through to varying degrees in the language they use, is the anger and frustration with the current way of working contrasting with the affectionate language and tone they all used when recalling earlier ways of working.

James’ recollection of training and the attraction of SFT is both located in a place but also the attitude of his fellow professionals which is different to his current place of work. In thinking about where he trained and first explored SFT ideas, he is conscious that patients and hence mental health was constructed differently. His tone shifts to being abrupt when describing the liaison team in which he now works, it is ‘bi –professional’, doctors and nurses, providing only those perspectives. His tone and the recollection of his experience elsewhere convey a sense of longing, a knowledge of which kinds of professions could belong to a liaison team.

*‘No. There are liaison teams that have psychologists and social workers ... graduate mental health workers, and things...we just don’t.’* JM L175

James describes his persistent efforts to bring context into his current work as a way of making sense of symptoms together with his team. To do this he uses SFT supervision. His description is respectful of their medical model approach whilst asking them to engage with something different. As he describes his work it emerges that bringing in SFT thinking requires not just the introduction of theoretical ideas but also a change in the culture in how the team works.

*'(...) so I started supervising the nurses and so one of the things was I was introducing a bit of systemic thinking ...'* JM L232

*'(...) so I wanted to offer them something that was perhaps a little bit different, that they hadn't thought about but wasn't necessarily challenging their usual work err'* JM L236

*'yeh I think it (SFT) would make us more creative and more flexible and I think it would.... probably help us as a team to be...erm a bit more confident about... not knowing, uncertainty, and some of the boundary issues and how to manage erm the difficult bits'* JM L149

Amir compares his past experience of a team's capacity to think, with the present, and is very aware that his current team struggles with clinically thinking. He and William both use gentle humour to convey a sense of dismay about the current working situation whilst describing how a lack of a shared language restricts the team and its members' thinking. He believes that a consequence of less thinking and discussion in current work is that practical interventions for patients are not happening.

*'(...) yesterday when the label was put forward it was implicit in they way it was said that the person had a very fixed view and they're not gonna be a budging around that fixed view, whereas in a high functioning team the way it's communicated (...) the person knows that they are using this label but there is a level of flexibility in this...'* A L116 -7

*'(...) they are not very skilled that is what I struggle with what you have is lots of words but no actions and this (is)actually what patients don't like, if you are a patient you don't want to be told xyz you want somebody to intervene in an effective way, ...'* A L127

Amir retains a belief that systemic thinking would enable staff to develop skills which would make a difference to how they work.

*‘(...) if there is support available in terms of systemic thinking (...) and in a non judgemental way things are processed ...’*

A L240

William thought about his current team’s ability to reflect on its use of terminology. He describes how they manage to not question and think together; conveying resignation in recognising that the team has no common ‘therapeutic’ language, and is concerned with trying to assess who they can trust within the team but are not addressing how to work together.

*‘(...) nod sagely, well no, we do not do too much serious sage nodding thankfully, but it usually passes un... unsort of questioned I think in our team, (...) at the moment it is not the sort of team where someone, sort of gets all serious about it as it were, ‘can I just check how you are using that word’* W L191

*‘But we do not really address it very head on... we sort of hope... I think we sit, work with each other for a while and work out who can be trusted to pull their weight you know, who you like working with who you don’t like to work with ... and we sort of sit and do that... sort of settled into that without attending to it you know...without actually thinking about it ...’* W L179

He reflects on what limits thinking, noting the stimulation and focus that psychological staff bring into a team, is limited by the amount of time they work in the team, as they are spread across many teams. He comments on the team’s defensive shift away from discussion through the use of humour.

*‘(...) I am a great believer in humour (...), but I think if it has a down side it can mitigate against the sort of serious thinking mode to a sort of ... you know the real sort of questioning of what one is*

*doing or what was it that one just said orrrrr -why are we all afraid  
of this one- kind of question’ W L276*

Elizabeth bluntly comments on how teams emerge rather than are created. She, like William, James and Amir, is very aware that her clinical team is not functioning as it once did and recalls her experiences of more positive teamwork, which embraced the sharing of ideas.

*‘(...) ward staff have been sort of cobbled together over years ...’*

E L246

*‘(...) but working(...) in a much more egalitarian type team is a  
much more enjoyable... thing to do and (...) sort of distributed  
leadership model (...) I think it also empowers other people to have  
ideas um and thoughts about things and often very good ideas (...) I  
think that’s a much nicer way of working really than how we work,  
now’ E L319*

Richard invokes the idea of shivering at the recollection of working within a mental health team that held a predominantly medical interpretation of mental health that did not work with the interplay between health and context. He is aware that in his current inpatient work there is a risk of a language divide between medical and nursing staff. What is crucial for him is the engagement with the context by the team to make a constructive working experience. Richard explained how being part of the home treatment team, some of whom were well informed enabled the process to make more sense than simply reading the literature. He conveyed the belief that as a team they experienced themselves as doing something useful which gave them satisfaction.

Richard clearly enjoyed talking how a home treatment team thinks and functions. The whole quality of his conversation changed, becoming animated in his storytelling about what he learnt, and recall of examples. SFT informed home treatment psychiatry and Richard describes how illness, home and meaning were integrated, and how this has changed. He describes firstly how it made sense, to staff and patients to meet at home. He then recalls and values the knowledge within the team and the importance of it to the team.

*‘some of the nurses were (...) we had a couple of the nurses were very interested in this approach (home treatment) actually and quite knowledgeable about it er... er I think one of them had worked in another team where they had done a similar thing ...’* R L 162

*‘...I think people found this...kind of work enjoyable I think in terms of your work satisfaction (...) often it felt like you... you come out of a meeting like that that you had got somewhere ...’* R L 66

When thinking about this current context, Richard describes how they have tried to bring some of this contextual thinking into the ward. Because he found it important, Richard has found a way to maintain collaboration with both community staff and the patients’ social network:

*‘well here we do...do a slight a relatively similar thing (...) a patient is admitted to the ward within 72 hours (NOISE) within 72 hours we have what is called a formulation meeting’* R L 70

*‘we invite the care coordinator and we invite family members to the meeting erm (...) basically to discuss you know what’s happened (...) where we go from here ...’* R L 72

Jane is clear about the value of psychological input into the team, as much as how fragile it is. She notes that recently the return of psychological therapy to the team has been a ‘*pleasure*’ (L60) and a boost to the team. She ruminates on how and who holds the therapeutic thinking in a team which can also be muddled and confusing.

*‘...in a good team you have a lot of people who were thoughtful about kind of processes and understanding what is going on and understanding (...) why teams are reacting the way they are to a particular kind of case (...) as to who holds it I think it depends, (...) an awful lot of kind of relatively senior people in teams of whatever background will either be doing some sort of psychotherapy training have done some erm ...and there is a lot erm... you know a lot of*



*knowledge and understanding there but from very disparate angles just depending on what people have done (...) so yes people kind of muddle on ...'* J L98-9

Thinking about context of work evokes for the participant's fond memories of team working incorporating thinking and constructive collaboration. There is a sense of being more alone in their work, which they do not see as a positive, and yet in different ways they find ways to bring context into their work.

### *1.3 - The presence or absence of the family, in mind or reality.*

The idea of whether to include the family in their work is described through their recollection of their experiences of SFT in action. For some the relationship of SFT with psychiatry is fluid; all found it enriching, and for some it is also unsettling. Elizabeth is clear that the mental health professional task is to try to make sense and SFT contributes to this. She acknowledges that SFT techniques are helpful to explore relationships in family networks but believes that it too stylised to make sense to patients, disliking a sense of '*religious ceremony*' (L51) in it. She is concerned that it would unsettle patients.

Like Elizabeth, William's memory of SFT is mixed. William initially takes the position that patients and families would be confused. The theme of confusion, his or the patients', emerges at various points and comes through in the uncertainty of language.

*'at times its seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times in a way I did not think it was always easy for the patient or the family to sort of quite know what was going on it might have seemed quite a strange process to the kind of subject'* W L33

Yet, he is clear that involving families results in seeing the person as part of a wider social network, not just a person with symptoms. He shifts between the first and third person singular; his personal response and perhaps a distancing from the patient experience.

*'(involving families) sort of reminded one that these patients don't exist in a vacuum as kind of nothing but a patient as it were... (...) other whole things that their lives are about really... as well as what it might be about when they are speaking to me...'* W L262

For the others SFT is experienced as essential in their relationship to psychiatry. Amir's language is impassioned. He identifies that SFT has a role in psychiatry when thinking about families as it makes sense of different cultural expectations. It offers information for constructive interpretation of the symptoms. He views this as required in order to be able to address the psychiatric disorders which he sees as expressions of complex social change.

*'the first generation is bottling it in and there's going to be an interesting mixture of problems when the second generation comes up and would require quite a lot of systemic thinking because they would have interacted the wider world and would have come up with new problems in terms of intermarriages...'* A L249

Jane values SFT thinking as it brings families into psychiatric practice.

*'X has been seeing some of our families (...), she has done some teaching for the team about how alliances are formed within families (...) that has been really good and we have been thinking about some of the cases, and um apart from anything else you are feeling that you are offering people a decent service as well'* J L62

Commenting that she cannot see how in her field you can work without involving families. Her language evokes the strength of belief that people are part of families.

*'... but in early intervention people are sort of utterly embedded in their families...'*

*'... and there are just huge family difficulties (...) I do think it would be so difficult to just treat the... the child in that kind of situation'*

J L67-9

Richard wanted the involvement of families in his practice. He distinguishes between past experience of seeing families and patients at home and finding ways to include families in the present. He brought case examples from the past that were vivid and energised; highlighting the value he placed on how it informed his work, and how little he knew without it. In current practice, he struggles to comprehend an individual's presentation when they are out of context, and separated from place and relationships.

*'I did enjoy it I found it that was extremely helpful seeing people at home because you saw the context in which they lived... in the end actually I came to think that the the mental state examination wasn't complete actually until you had seen person in their environment that somehow the environment was part of their mental state (...) it became all one to me erm I think that when you get a patient into the hospital and sat them in a room like this (...) they are isolated from their context and you don't really know that much about them,'*

R L133

Richard believes that the experience of working in this way taught him rather than the literature. He believes that thinking with the patient in their social environment is when everything becomes obvious, for:

*'when you start to work in that context that these things start become obvious you know that actually you do need to do (...) there is a problem here because you can see it erm whereas here (hospital) you don't quite see it.'*

R L159

He is conscious that the hospital environment offers a very different way of examining a patient that he sees as limiting.

James echoes this idea that it is obvious or nonsensical not to involve the family. This became apparent to him working in an A and E, it did not make sense to him not to include the relatives in his work, for they were both part of the problem and the solution.

*‘Often people will come with relatives and partners who are very distressed and worried (...), and it seemed kind of odd to remove them from that setting (...) very much likely to be part of both the solution and the problem.’* JM L 126

Jane, Richard and James convey a degree of absurdity in assessing and treating a patient without their family, that imparts their passion to do it differently. The value of including families was apparent to all the participants. Whether SFT was useful in doing this varied and was connected to their own experiences of SFT. It ranged from it being too stylised and unsettling to being a component in helping them understand their patients.

## **4.2 Master Theme 2: Proximity and distance, exploring the range and limits of accessing SFT concepts and provision**

This master theme aims to capture the participants’ experiences of how accessible SFT is both literally and figuratively, and how they intertwine to make referrals to SFT confusing and avoidable. The experience of proximity and distance appears to be connected to actively wanting a relationship with SFT, but finding it mysterious can be off putting as well as inviting.

This master theme is explored through 2 subthemes:

2.1 How accessible (to professionals) is SFT, literally and figuratively.

This first subtheme focuses on the psychiatrists’ lived experience of how proximal SFT is and the second subtheme reflects on their reflection on how proximal it is for

families. It explores both psychiatrists' conceptualisation of SFT ideas and services. In their descriptions they convey a mixture of lack of clarity of the theory for themselves, unless they have had access to clinical training. This is compounded by the limited physical distribution of SFT service provision.

2.2 Perception of accessibility for families literally and figuratively. Who does it not make sense to, mental health services or the family?

The second subtheme considers the experience for patients as experienced by the participants, some echo their views, yet the patients and families perhaps have other experiences.

The participants describe how involving families is complex both in terms of skill and resources. They identify as a belief or myth the logistical complexities of including family members in the treatment process. This is both a real difficulty and one that can be used as to justify only seeing the individual. They acknowledge that running a session with more than one person is difficult and requires skill. The NHS resource allocation is reflected in lack of clinical space and allocation of staff time. They acknowledge the belief that the involvement of families is regarded as time consuming to coordinate and may result in poor attendance rates. But contrast this with the belief that the family itself is a huge resource.

### *2.1 Proximity and distance, psychiatrists: How accessible literally and figuratively (to professionals) is SFT?*

William and Elizabeth are most clear about the experience of the theoretical and physical inaccessibility of SFT for themselves. They refer to confusion between overarching SFT thinking, or philosophy as James referred to it (JML 315), and the different strands or models within SFT. The physical availability is linked to how they understand SFT. Like the others they share the view that it is a limited resource, but accessing it is further mediated by being perplexed as to who the service should

include from a patient's network, what the service is called, as much as how they understand SFT.

William described the difficulty in getting close to the theoretical ideas of SFT, describing it as a game. He returns to the idea of it not being real and dismisses it as an

*'amusing game'.* W L66

This distancing tone emerged in his description of the SFT service, with its name adding to the confusion; it is not clear to William who the service would work with. This was unhelpful and went against his belief to understand who is important within a social network.

*'Well it is called a family or a couple service, you want to refer a family or a couple, it sort of puts you off a little bit for instance referring whatever else you might refer, like a someone's home and their main carer there or whatever else you might think of if you were thinking about it more broadly'* W L56

Linking the name of the service with his understanding of what SFT is and offers adds to the lack of clarity and maintains distance. The mystery around SFT schools of thought, models and techniques reappears as a distancing factor; accessing SFT becomes too complicated.

*'Not of systems we have access to what is called couple and family service sort of service within the psychology department at Z Hospital and I kind of presumed that they work in that way though I actually don't know the specifics of what particular models they might define that they are using.'* W L136

William was reflective about the rationale of lack of time being the reason not to include family members, saying that it was more about lack of resources than about time. He recognises that time is used as an excuse. William also alludes to the impact of the lack of time on the capacity to work and think, including in a SFT way.

*'I think it's, I mean one experiences it (involvement of families) as a pressure of time... (...) in practice that explains a small proportion (...). I think most of it is probably lack of money, lack of people coming from a family or systems background in the team as professionals wanting one to remember to do such and such.'*

W L268

The issue of practical accessibility is clear to Elizabeth; she comments that her trainees do not appear to have had experience of SFT, that the practice of it is not a core part of their training. That the focus is on basic literature-based knowledge, not application and understanding.

*'(...) just as much as you need to pass an MCQ exam or whatever on systemic family therapy'* E L3

She dryly describes the actual service provision of SFT in physical terms whilst expressing her theoretical uncertainty and hesitant grasp of what constitutes a SFT therapist, saying:

*'I am told that there is one (SFT psychotherapist)'*

*'(...) we have like the leg of a family (therapist)'*

*'I don't know what kind of family therapist she is'* E L100-4

On a subjective level Elizabeth explains the professional task and with it her struggle to connect theoretically. She emotively expresses her discomfort that it has a sacred or revered aspect to it, which made learning more about it uncomfortable. This tension between making sense of it herself and finding it useful came through by her limiting her embrace of SFT to techniques.

*'(...) to try and make sense of something, also in a way that is useful to somebody else, (...) that's the tricky bit, (...) whether you call it a psychiatrist or (...) a family therapist that is where the difficulty lies,*

*and I have to say in my experiences in child psychiatry was (...) when one has this approach umm (...) it's a bit too much religious ceremony around it for my liking'* E L51

*'(...) the types of questioning techniques I think are very good at (...) finding out (...) the situations who thinks what who is allied with whom and what's going on, ...'* E L71

Yet in her discussion of the inpatient task, and the lack of clarity, she intuitively finds some common ground or understanding of and with SFT, alluding not only to techniques but also thinking. In inpatient setting Elizabeth identifies the task as trying to make sense for yourself, and with and for the patient, of what is happening. She acknowledges that this is not straightforward and SFT chimes with her as a way to think about this.

*'but you know my sense of things is (...) that kind of notion that there is a a puzzle, that one is presented with a puzzle (...) that's I think a sort of, that notion is very explicit within systemic family therapy'* E L37

Like the others Jane concedes that the physical delivery is much more limited and distant from the patients, she regretfully connects this to limited resources.

*'Yeh I don't think we are going to be in a position where we can say part of the standard care that everyone gets in this team is to be seen systemically'* J L154

However, psychotherapy in general is more mysterious for Jane, she acknowledges that it lacked a presence in her core training.

*'(...) I don't think that there was ermm a very... strong kind of psychotherapy basis to actually psychiatric training at that time'*

J L6



SFT came closer when she did her internship abroad, she had weekly exposure to SFT which taught her some techniques, but she did not experience being taught the theoretical underpinnings. This further tantalised her rather than giving her a sense of SFT being accessible.

*‘...we would do this systemic...session every week erm, so there was I mean I can’t really remember what exactly we were taught, but erm, but there was obviously some teaching about techniques but I think ... but I have never been taught properly at all’* J L85-7

Through working in her current EIS team she is more conscious of families. Jane describes this as a better service. Working in this team she has experienced SFT and psychotherapy as a bit closer at least in her thinking, which she links to receiving direct SFT teaching related to the casework in which the team is involved. It remains one step removed however as she has not seen families herself, stating that SFT is difficult, and therefore not yet quite accessible.

*‘Errmmm I found it very difficult actually erm because just you know - just trying to just manage the whole thing’* J L35

The ‘doing’ of SFT came through clearly as the vital shift in accessibility. Richard put it as:

*‘...these things (theory) often only really make sense (...) if you actually do it’* R L 127

For Richard accessibility is both location and an approach. The integration of family networks into his work is now his norm. He sees this as raising the effectiveness of his work. Richard imparts though his language that it is necessary to be a bit assertive and express clearly that families are wanted and needed.

*‘(...) I think you can’t work any other way actually, that patients would just come back (...) I’m mean it was more so in home*

*treatment but also here (hospital) you need to sometimes co-opt family members'* R L 101

His experience is that the limitations on accessing SFT are straightforwardly about lack of resources.

*'... it isn't there ... and we have no one to refer to particularly, we do occasional refer people to family therapy but it is far and few between, I think there is a sense that that the resource isn't there'*  
R L 193

Like Richard, Amir sees SFT as part of his way of working, not separate. His practice as a psychiatrist very much engages with the relational nature of human existence. He has a clear sense of how it fits into his skill set and of it being essential.

*'If a psychiatrist err does not put that (SFT) hat (...) then they are not a very good psychiatrist. (...)I think it is implicit in our errrr errr training that we need to have systems focus, erm be it...relationships'*  
A L10

This integration of theory and technique occurred clinically through participation in a SFT clinic, which he actively chose to experience. Amir believes that a psychiatrist needs to have a competent understanding of SFT in order to be able to provide limited interventions but also refer on to SFT when appropriate.

*'for me (...) I had ...theoretical book knowledge (...) and what I wanted to get out was to experience it and and ...and see how (...) what its effectiveness, (...) so that I have some understanding of systemic work (...) not going to be something that I ermm would do as my main intervention I just wanted to have (...) a base line level of skills'* A L 88

SFT sits comfortably close for Amir, who describes himself as being culturally biased towards relational thinking, and therefore it is more comfortable to think systemically than not.

*'(...) I am not a typical European trained psychiatrist because I ... grew up in Pakistan (...) because of my ethnic background there is emphasis on families and wider systems and so families have a wider influence (...), that sort of background places less emphasis on the individual and more on the collective so to speak, so yes those are influences are also there which inform my practice, but training ermm also helps'*

A L261-3

But even with the proximity of SFT in his thinking Amir is frustrated by physical issues. For him the context of the delivery of his service reflects expectations of what he should deliver, so accessibility is connected to service design. He notes that location does make a difference, as he cannot deliver a service in the community at present as they do not have the staff nor the premises to accommodate more than the patient. We were sitting in his office that was largely occupied by an average sized desk. He says:

*'The time constraints in terms of systemic work, (...) I can use the thinking but systemic work and (...) the office requirements if there is a family, I mean I have seen patients with err 2 family members over here it can get cramped'*

A L349

The importance of personal relationships to the notion of how proximal or distance SFT is, was conveyed by James' recollection of his first experiences of SFT. He was influenced by one of the consultants he worked with as a trainee, who worked with families as well as exposure to staff who were comfortable working with relatives. Working on the same floor as the Family Therapy Unit, enabled a closer relationship and fuelled his curiosity and interest. He describes how this close proximity to this team and their work challenged his preconceptions of SFT. In his interpretation of SFT he had expected that work would be done only with more than one person in

the room. What he came to appreciate is that SFT is about relationships and relational processes not the number of people in the room.

*'I remember (...) they used to have psychologists at P Hospital, the GUM department and they had a bunch of psychologists who were doing individual systemic work, and I remember being surprised and saying- how do you do that and (...), them saying why not-and I thought oh yes and fair enough (...) doing family work sometimes you only get one person there.'* JM L127

The experience of reviewing his practice differently through live and video recordings enabled a huge shift in his personal relationship to SFT. He describes the impact of his reflection on his contribution to what is happening and assumptions about what he sees; it became more incorporated to his practice.

*'(...) I have not had outside of family therapy, was that instead of seeing a patient and reporting back to your supervisor what you did ... you were videoed ...(...) they were looking at a video of you did which is pretty close to what you did.'* JM L37

The experience of live supervision, self-observation and reflexivity James sees as a pivotal point in his relationship with SFT, it made sense and was available to him.

*'well I think it made the whole thing, I have always been conscious that always there are layers of processing that you do... (...) see a patient then you can sort of post hoc justify what you do, when you brought it back it was quite hard to accurately remember what was going on for you at the time, what you were thinking about.... there's things for you to be aware of, you would not be particularly aware of (...) ... you might see that you might be sort of all hunched up and defensive or sort looking bored or looking very engaged with one person and not another, um or you might see yourself interrupting people and you had not noticed, um, all sort of things, your word that you use, whereas if them report back you have*

*generally processed them, and could take a different stance on it.'*

JM L41

James is respectful that SFT is unknown to his colleagues and needs to be made accessible. However, he takes the view that when SFT appears too different it becomes distant and inaccessible. James says that he takes his cue from SFT theorists, describing his use of SFT in the hospital as a stranger from a distant land, different but careful to be not too different lest the town becomes wary of him. In consequence he tries to bridge the gap by offering ideas in various contexts, with colleagues and patients. He sees his role as bringing an:

*'informed thinking about how it might be more complicated than being mad or not mad erm (...) and sort of dropped into canteen conversations to see how it might work with patients in all sorts of different things too give the clinicians here simultaneously to some other ways of thinking about things...'* JM L184-6

What he hopes is that movement is generated, and that SFT gets closer.

*'(...) I think the systemic stuff lends itself to that kind of fluidity of positioning and thinking about positioning ... if they become more systemic I can move (laughs) further in that direction.'*

JM L221

Within the trust he has not experience SFT as nearby, rather he conveys the idea that it is too far away both literally and in terms of how they think to hear his systemic ideas.

*'I referred them to (...) the generic team and I've suggested that they do some couple work would be useful and...I'm hoping that the psychologists will be able to do that! So um I said if you know please*

*ring me if you want any kind of any ideas about what I think might help but I don't know.'* JM L105

This subtheme captures something of the dilemma of involving families that the participants experience and see others experiencing. On the one hand families are a resource for everyone. And the task of convening and working with a family is something the participants are respectful of. They also accept how clinical space, perceptions of SFT and of families, as well as perceived logistical problems contribute to rationalising away from doing it.

## *2.2 Proximity and distance: Perception of accessibility for families literally and figuratively.*

*Who does it not make sense to, mental health services or the family?*

This subtheme identifies how the participants perceive the experience of patients accessing SFT. To some extent it reflects their own position. Some of the participants believe that families must find SFT too distant, both literally and figuratively due to a poor fit concerning ideas of helpfulness, or that it is too different to be able to make sense of it and be useful. They explore the relevance of culture, local, specific and NHS in regulating access to SFT thinking. Additionally, they are conscious that they work in an area of the UK with an economically and culturally diverse population both of which affect what a patient expects and whether they access public services. Notwithstanding these ideas of distance, their experience is that family members want to be part of the treatment even if patients are initially reluctant. This is attributed to the patient's perception of relationships at that moment, not to any notion of how patients may be influenced and informed by the psychiatrist. The participants are uncomfortable with the patient's wish to have family included which sits poorly with the mechanisms of service provision.

Both Elizabeth and William express their view and poor comprehension of the processes of SFT and assume that patients will experience it in the same way. The different processes in SFT are seen as unclear rather than different. They suggest that there are a number of consequences of this experience; it distances people,

including themselves, it disorients and this is problematic and may result in psychiatric symptoms, rather than be useful. They are also concerned and protective of the unknown for their patients but also for themselves.

*‘(...) I did not think it was always easy for the patient or the family to sort of quite know what was going on it might have seemed quite a strange process ...’* W L33

*‘yeh and the sort the coming in and out<sup>7</sup>. I think it is very off-putting for for patients who generally don’t understand at all what the hell’s going on it all feels very you know, if one is a little bit paranoid to begin with I think it’s (...) you really do need to explain to people quite clearly what the the point of it all is’* E L54-6

The interwoven aspect of patient and doctor communication, which can shift in comprehension with a change in the process of enquiry or therapeutic intervention, is apparent when Richard talks about how the therapeutic relationship is affected by how a family’s involvement is enabled and construed by services.

He expresses the movement in thinking that working in the home brings in terms of insights that are not available in the hospital setting. He sees working with the relationships and context also engages with who has power, and how this affects access to and crucially use of therapeutic services.

*‘... the quality of the conversation is better actually in the person’s house because in the hospital there is a power dynamic it’s them on our territory (...) when you see somebody at home it is you on their turf and and that subtly changes things I think they can ask you to leave, they can tell you to get out (...) and here it is different (...) if they try to leave we stop them (...), that alters the quality of the dialogue that you have’* R L142

Like William he is sensitive to the way modern mental health services define relationships in families, that this language can distance families from therapeutic

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<sup>7</sup> SFT sessions may involve a break or other members of the team join the therapist.

interventions. His dismay at the depersonalising nature of service language, and his respect for patients and families as people not descriptions is expressed in the explicit way Richard says they that there are not ‘carers’, but are family members with a role, a history and an intimate relationship. He is concerned that this kind of language unhelpfully changes the relationship with family members, through not recognising as important the existing relationships and their function for the patient and family members.

*‘... you know I don’t quite like the term (carer) because patients often think they don’t have a carer they’ve got a mum they have got a whatever’*

*‘it is completely different yeh and they don’t like the idea they don’t think they need to be cared for yeh so I think language is important’*

R L109-111

The bleakness he experiences in the lack of access to SFT is underpinned by the belief that referral is purposeless as the resource is so limited and so structured as to not know who receives the referral.

*‘yeh and it isn’t there .. and we have no one to refer to particularly we do occasional refer people to family therapy but it is far and few between I think there is a sense that that the resource isn’t there.’*

R L193

Jane reiterated the theme that families want to participate. She ranged from saying that in her experience people want to be accompanied by their families, to debunking the service idea that an older adolescent in crisis would reject parental involvement, as somehow an adolescent would in the ‘adult’ manner be independent of relationships.

Jane, like Richard identified that the service difficulty of enabling patients and families to access SFT is influenced by service ideas of how a patient is perceived. She contrasted this with her experience in Australia. She recalled families making huge efforts to be included; travelling vast distances to attend family therapy



meetings. The service wanted their presence and they wanted to be there. There the proximity in terms of appreciating and wanting the process of SFT was mutual, she saw families experiencing the inclusive approach.

*'(...) erm it was interesting in that kind of setting because people were coming from kind of miles and miles around to do this because the distances are so big...'* J L25

Amir believes that the service is neither proximal literally nor figuratively to his patient population, although it is a match for some of the borough's population as a whole. He perceives a cultural mismatch, yet is hesitant about how open I am to this cultural interpretation of use or not of services and needs me to be interested to continue. He says:

*'... I look after a deprived ethnic population and errrrr but the service was very good in terms of meeting the needs the family therapy service it's my perception'*

*'I am interested'* (Researcher) L173

*'was more white middle class English yeh'* A L172-6

Stating that his patients would not use the service as:

*'it is based at Z hospital'*

*'stigma of going to a hospital mental hospital ...'*

*'(...) their whole their universe is totally different and for them to negotiate that and go over there and explain themselves is too much so something needs to be nearer to home errmmm'* A L192-8

Amir appreciates the various influences on the patient, ranging from family to the wider cultural context. He draws on both the patients' expressed needs and the constructs in which he works. He goes on to deconstruct the patient's experiences of accessing services, through a systemic lens. He thinks about how the patient might

experience the service as well as how they might think it. Amir steps into the position of the other to explain how language and culture make interaction with psychiatric services problematic. Firstly, Amir notes the need for patients to adapt their expression of distress to be culturally congruent to access services.

*‘and that drives the morbidity, so that so that and it is mostly with women er and because there is language, they are not that proficient with language they present with symptoms that...’*

*‘or a somatisation of’ (Researcher)*

*‘... currency they know that if they start hearing voices they will be taken seriously’* A L183-185

And that, secondly, perhaps this is not possible because it takes so much effort when they are already distressed. He conveys frustration and agitation with the inability of services to grasp the wider cultural aspects of service distribution and delivery,

*‘(...) when it was a couple and family service you wouldn't have referred?’ (Researcher)*

*‘no’*

*‘because your understanding of how they would meet that kind of of referral you felt they wouldn't engage with that or they wouldn't accept that referral?’ (Researcher)*

*‘a) it is based at X hospital’*

*‘yeh’ (Researcher)*

*‘distance’*

*‘yeh’ (Researcher)*

*'stigma of going to a hospital mental hospital and for them, I mean if I am a refugee from England let's just say Scottish people have bullied me about....and I'*

*'yeh' (Researcher)*

*'end up somewhere let's just say western Africa where all humans are speaking another language you know their whole their universe is totally different and for them to negotiate that and go over there and explain themselves is too much so something needs to be nearer to home'* A L189-198

Rather than seeing ideas of proximity and distance as fixed, James perceives a dance between services and what patients and families want. His experience is that by using a SFT position, he can acknowledge that situations are fluid and when he shares that with patients they benefit and participate.

*'(...) you might find yourself in a certain position or the patient might be in a certain position with their thinking and that might feel like a sort of solid final position kind of and now that we understand and the next day things have shifted again (...)'*

*'so I would have expected that to change and I (...) would talk to patients with that expectation and use words that imply that - this is where we are at now and next week things will be slightly different- and often that um that can be quite therapeutic and positive'*

JM L 67-68

James describes using SFT thinking with patients and experiencing his patients as being able to make use of his approach. He uses SFT to discuss uncertainties and change, which he sees his patients as finding therapeutic.

The 'fit' of SFT for patients comes through the relationship each psychiatrist has with SFT. As this influences their expectation of how their patients will experience

SFT. Their ideas of whether it is comprehensible move between these personal experiences through to ideas of accessibility for different cultures.

### **4.3 Master Theme 3: Anxiety and un/certainty in the role of psychiatrist**

This master theme explores aspects of the participants' experience of uncertainty and anxiety within psychiatric practice, which was accessed when discussing their experiences of SFT. The different uncertainties that they manage are explored through 2 subthemes.

3.1 Holding risk when the knowledge is less certain than it would have you believe - shifting sands and the function of guidelines.

3.2 Managing uncertainty (diagnosis and treatment) with families. The participants explore their anxiety about how to balance the capacity to stay with not knowing, and having to make decisions.

The theme considers firstly the uncertainties surrounding treatment options, the attractiveness and possible mystery of psychotherapies including SFT, as well as pharmacological treatments. Secondly, the theme reveals what these uncertainties mean in practice on a personal level in relation to patients and their families.

All the participants voiced a degree of uncertainty and anxiety about the use and limitations of the medical model. Their training helped them think about possible choices and utopias in psychiatry yet what they are working with is uncertainty. They experience society, and their patients, as seeing medicine as knowing or being about to know how illnesses function. What they talk about is trying to describe and hence treat mental ill health. They grapple with the tools at their disposal such as psychotherapy and psycho-pharmacology, whilst experiencing a lack of confidence in both psychiatry's body of knowledge and a poor fit between their clinical

experience and some of that knowledge. They have a notion of psychiatry inhabiting a place of trying to make sense and having to managing a degree of ‘not knowing’, whilst the overt professional position and societal expectation and demand is that they ‘know’.

### *3.1 Holding risk when the knowledge is less certain than it would have you believe - shifting sands and the function of guidelines*

This subtheme puts voice to their experience of the choice of interventions available, the lack of certainty about any intervention, and how they deal with this. The participants identify that they experience other peoples’ expectations and ideas of conformity whilst the territory is more fluid. The complexity of being medical practitioners who can prescribe medication sits within evidence based services that are beginning to question the validity of the evidence. They express that in their experience interventions need to take into account the complexity of human processes and experiences to be effective. The need for them to be versed in many models is clear to them though being knowledgeable and confident in these different perspectives is another matter. They are aware that access to treatment is limited by knowledge and evidence. They also are mindful that external forces intervene regarding treatment availability and choice. This comes through when they discuss evidence and national guidelines, but also in recognising wider social and political pressures.

In recognition of this uncertainty, William uses both humour and a precise, emphatic language to convey that he embraces reality and uses all the tools and ideas to which he has been exposed. Yet he also manages to convey in his phrasing that he sees that it as necessary to have a range of approaches to manage this uncertainty.

*‘Well like every psychiatrist **I would say** I was a bit eclectic...  
Definitely biology I prescribe all over the place, but Cognitive  
influences...’ W L96-98*

However, the anxiety of being a psychiatrist with the competing ideas of illness and treatment even within a medical model perspective were recounted by Jane. She puts it clearly that certainly from her vantage point, it is unstable treatment ground that psychiatrists stand on, particularly from a pharmacological perspective. She conveys the anxiety underpinned by this sense of instability, of sitting within a wider overt statement of confidence about treatment approaches. She appears to struggle with having to make a choice between supporting one evidence-based intervention over another, without being convinced of whether it is beneficial.

*‘Think too many difficult thoughts... (...) I think it’s very challenging because we are walking on quicksand in terms of evidence about what we know I mean there was a big paper recently about SSRIs which says that (...) it is not that much better than placebos’*

*‘But that is partly because that placebos are quite good...’*

*‘(...) but the things that you think that you know... are very questionable and that is you know not always a comforting position to be in’* J L514 -518

*‘Yes because it is interesting cos you get this sort of conundrum where you know that the party line that you are kind of mean to trot out well this is a long term (drug) treatment and you need to stay on this long term (...) there are so many situations where that is not the right kind of advice to give and you need to be having a far more hopeful conversation and erm’* J L474

Jane conveys not only the changing positions about treatment within psychiatry but also that the guidance on the use of such treatment is neither applicable nor appropriate, and that leaves her feeling in a vulnerable position.

Whilst James, like the others, reflects on the limitations of the medical model, and that its certainty is not quite what it seems. He carefully questions its validity and evidence base, but manages the uncertainty of the evidence by taking a ‘both and’

approach; he uses what is useful and is cautious about using absolutes. He draws on this flexibility in using different treatment perspectives and options, to be able to respond to others with an acceptance of different positions with regard to treatment.

*‘Yes yeh the idea was that I could use the legal bit and the medical bit and the psychiatric bit and the more systemic bits which is all about relationships and stuff they can all exist and we can dip in and out of them and hopefully I can allow other people to do that by being able to do that comfortably myself without getting all upset ...’chuckles.* JM L 313

Elizabeth sees psychiatry as being able to work with uncertainty, which other disciplines struggle with. She sees this as part of its role, that perhaps other disciplines are uncomfortable with, and derives a certainty of position from knowing this uncertainty is there and she can work with it.

*‘...I think that working with psychotic patients (...) offering psychological therapy for psychotic patients is quite scary and it’s a very specialised area, and I don’t think many non medically trained people feel (...) have an easy inroad actually into that (...) most psychologists did you know were not very keen on it actually’* E L 124

The stickiness of uncertainty, about what works, shifts as Amir describes a flexibility of approach using the interplay between the different treatment models, including pharmacological, and takes a holistic approach to his psychiatry. Like Elizabeth, he presents as confident in being comfortable with the ambiguities. He wants to be able to use all of his skills, including SFT thinking. He actively engages with how drugs influence the patient’s other systems (physical, psychological, social). Amir is clear that SFT thinking enables him to hold a range of positions, which may include uncertainty in his role as a psychiatrist, and this overall is what psychiatry should be able to do.

*'... my view is that the trained psychiatrist which is a medical representation within the mental health system er ...err a good enough psychiatrist needs to have erm systemic thinking to the fore when seeing somebody ...erm so whenever I see somebody, eerrr my initial questions are about medicines side effects and stuff like that but that is not because I think it is important because I think that is something which if I address I would have the time to err discuss issues which are interconnected, systemic like the social err...'*

A L19

It becomes part of their management of uncertainty within mental health as they take the view that they need more than a medical model to help them think about human behaviour. It highlights the complexity of their task that one approach, the medical approach, is insufficient to work with the uncertainty that mental health presents.

Those with a clear sense of a psychotherapeutic position-psychoanalytic or systemic- want this to inform their thinking. CBT, though frustrating, is a practical intervention that they use. They express frustration with the limitations of CBT, as much in treatment impact as how other treatments seem in consequence to be less available. All of them note that CBT tends to be presented with certainty, as a 'cure all' yet they experience it as not being able to deliver.

Elizabeth draws on different psychotherapeutic models to create her own functional practice based model of psychiatry. She uses SFT techniques which embody a way of thinking which she finds liberating in her role as psychiatrist; adding to her skills and also manages uncertainty.

*'... one develops one's own style (...) sort of pick and mix, that one is sort of exposed to and (...) some of the questioning styles, you know used in systemic family therapy are things that I have found incredibly useful and helpful'*

E L40

William conveys both CBT's appeal and its limitations, commenting that the coherence does not reflect the complexity of human life processes and experiences, yet speed is relevant in the context of treatment.



*'...well I think **CBT is unattractive** in its...it is also over simplified (... ) concerned with rather immediate resolution of symptoms and a superficial understanding sort of why it happens just now (... ) I think human behaviour is just so complex so... anything... anything that seems simple I think is sort um unlikely to be correct.'* W

L114

What was important for him was the relevance of having a more comprehensive psychotherapeutic structure to think with, to make sense of patients' experiences, but not necessarily to use. A biological approach was insufficient.

*'psychoanalytic concepts I think one uses much more in thinking about the problem rather than in the intervention.'* W L 99

William nonetheless is aware that this is not enough and positions SFT to provide relief from the mechanistic model of psychiatry he is being asked to deliver:

*'Then sometimes I sort of remember systems, because I think (... ) have a tendency to (be a) bit stuck in the other stuff, so then I sometimes remember but I mustn't ...I remember as it were not to be thinking that I must find a cause and the answer- to find the problem and find the cure- I can think out of that sort of box and I can think about ...the whole rest of it'* W L106

The influence of the medical model is of concern to James. The prevalence of uncertainty within his team, and the constraining nature of its impact on practice, is evidenced for James by the default position of the medical model adopted by him and the team. James conveys the importance of reawakening and maintaining SFT in his practice through training. He believes that if SFT were more embedded they would have a more confident relationship with uncertainty. This echoes William who remembers SFT when stuck, that it offered somewhere to think from, when unable to 'know' as the medical model requires of him. They both see SFT offering a base from which to constructively reflect on uncertainty.

*'Yes. Well I mean I think it is a, it's a sort of struggle and you get this ebb and flow where you go on courses or you read something you kind of revisit it and you kinda feel more ... systemic or more able to think about it, or kind of... or other times when it sort of fades when you get pulled back into the more medical thing erm'*

JM L147

*'What do you imagine it would be like if you had more systemic... (...)? More available' (Researcher)*

*'Yeh I think it would make us more creative and more flexible and I think it would... probably help us as a team to be...erm a bit more confident about... not knowing, uncertainty, and some of the boundary issues and how to manage erm the difficult bits'*

JM L149

Richard ruefully sees SFT as an important treatment with longer-term benefits, but also conveys how a belief in this is undermined by the lack of resources, adding to his difficulties of providing treatment in which he believes.

*'... I think that the evidence is that the the effects the (SFT) treatment effect is almost as powerful as medication (...) so that would suggest that perhaps that would have an effect on people coming back into hospital yeh'*

R L199

The problem of evidence, is carefully expressed by Elizabeth, her dry style underplays the frustration that the evidence based approach brings to working with less clear presenting problems.

*'we all do evidence based therapies of course, and that is another tricky area in itself, as well it's not that one should not believe evidence when it is there but obviously there are all sorts of issues around it.'*

E L244

Amir goes further, identifying non-psychiatric influences at work. This is part of the uncertainty that they manage.

*‘I mean what does a psychiatrist do... I think the influences are complex I mean it is influenced by erm I would say what society expects as well but the government and the NHS expects as well for the future and errr it keeps on evolving the expectations keep on (...) and we try to adapt to that...’* A L335-339

This subtheme explores the belief held by these psychiatrists that they grapple with uncertainty; some hold this more comfortably than others. Whatever their personal level of acceptance of this role, they are acutely aware that wider psychiatry, mental health services and wider society have an expectation of more certainty. Their experience is to manage the uncertain ground, in a context which wants to say psychiatry is certain.

### *3.2 Managing uncertainty (diagnosis and treatment) with families: The experience of working with uncertainty*

This subtheme explores the anxiety about whether uncertainty might open up a ‘*do what you like*’ approach. There is a tension in how to balance the capacity to stay with not knowing, and having to make decisions. It is a subtheme that is articulated very personally, with some pain. They discuss how difficult it is for the services to tolerate what they are trained to offer. In different ways they all express the stressful experience of being a psychiatrist responding to whilst tolerating uncertainty. The way they discuss this draws on what they have found useful, which includes systemic thinking about context and meanings. This ranged from Jane’s concern about what she does not know, to James systemically embracing safe uncertainty.

Elizabeth’s view about psychiatry is that a person is more than the set of symptoms, and that psychiatrists need to grapple with the unknown. Elizabeth speaks quickly using vivid emotional language, recalling her training experiences and the influence in her training of Richard Lucas, a consultant psychiatrist whose use of

psychotherapies in his psychiatric practice was highly valued by her, particularly his idea that:

*'there is no not making sense (...) one was dealing with a process that was actually very powerful um that sort of had some kind of meaning although one wasn't it always necessarily clear.'*

E L173

Elaborating in a very systemic way about her current practice Elizabeth states an illness is not devoid of context, this grounds the uncertainty.

*'...with us we find that somebody is in a completely in a in a unreachable sort of state (...) for weeks and you will know that something is up (...) because people don't become psychotic for no reason at all (...) usually the person cannot talk in a coherent way about it (...) they'll be the psychosis usually is linked things to things about them or things about their experience but (...) eventually one will find out that they had no gas and electricity for six months'*

E L 175

James and Amir use their systemic training to see uncertainty as part of the process of knowing, whilst aware that this systemic perspective is a structure, which tolerates uncertainty in an environment that prefers to use certainties. James reflects on how the systemic perspective and thinking has enabled him to work with patients, tolerate the uncertainties and unknowns with which his work presents him, to the extent where he appreciates how not knowing informs him and adds to his learning. He enjoys the idea of flexibility in choosing what is useful. Perhaps because James has more SFT knowledge he reflects directly on the dilemma of uncertainty and whether it is threatening, using SFT language and references as he had elsewhere in the conversation.

*'I like to know what I am doing or at least knowing I don't know what I am doing and that I have got to choose something'*

*(chuckles) 'Well I even less like doing something that I think I know but I don't (...) so I think we have to embrace the uncertainty and not the lack of knowledge about not what it is but erm that does not mean that you can do what you like'*

*'It means you have to have weighed up the different bits so erm I think, well, I think the systemic lends itself to that kind of thought it tolerates that kind of questioning and uncertainty...'* JM L322-7

James provides ideas of how SFT thinking can address this anxiety in psychiatry. His experience is that it works to think and discuss directly about certainty. In this he talks about SFT being a framework to bring confidence and trust for others to risk uncertainty and to enable constructive reflection.

*'(...) you can project some confidence and other people can be prepared to accept the uncertainty and the kind of risks that might go with that...for their sort of personal practice and to sort of follow you on a little bit of a journey erm...which requires some trust and things like that, so I find that the systemic thinking is very useful in getting that type of frame work allowing you some kind of foundation and being able to reflect on kind of where you are at and where you fit in... the meanings of things'* JM L152

James uses his SFT perspective to carefully identify how being authoritative, enables a safe uncertainty without dismissing or overpowering others. He conveys his awareness of his own power when in the hospital environment, how it can be used to work with uncertainty and the belief that he can use it to enable others.

*'I think it is very important and this (SFT) is different I think to talk about power and authority is slightly different so you can be in that kind of safe uncertain but still have some kind of authority and expertise to offer,'*

*‘without being overpowering and disempowering other people (...) confidence to adopt that kind of position when you are in this kind of environment and everyone is saying that something needs be done now erm with other people who in the hospital who are quite powerful erm I think it is very useful for that... (...)’ JM L164-166*

The participants in this subtheme convey the difficulty and stress of holding uncertainty within services that are less geared to making use of all their skills to do this. The participants who had had more psychotherapy training of any variety accepted and used the uncertainty within psychiatry more easily.

#### **4.4 Master Theme 4: Position of SFT in Mental health services**

This master theme explores the idea that mental health interventions are available in response to, as Elizabeth said, is ‘in fashion’ at any time. It explores the participants’ experience of the position SFT within mental health services. The following subthemes emerged:

4.1 What influences when SFT is used - identifies their experience of how mental health is understood by the NHS.

4.2 How good a fit is SFT for the NHS - ‘I’m not aware of anything being bashed systemic family therapy’ takes its lead from Elizabeth and looks at drivers of change. The participants talked about culture in a broad sense, that of the NHS as well as appreciating the diverse demographic of this NHS trust’s population which reflects the city they are working in, with its wide cultural variation with range of wealth and class. The participants were all clear that SFT brought a useful way to think about people and how they present to mental health services and to the medical model of psychiatry. They talked about it, and engaged with the wider context of the patient and hence different ideas of how to make sense of how people present at mental health services. A number of the participants articulated that there are different ways to interpret and interact with psychiatric symptoms. In the wide socio-economic

cultural diversity of the city they thought the services for patients are not necessarily addressing their needs.

They discuss how the NHS at present constructs mental illness, informs the services available and how they are delivered. What a service provides is connected to what it already provides. So services that have SFT will have service users who know, expect and request it, as well as staff who are aware and able to provide SFT informed services. Conversely without a presence the service cannot train people or familiarise patients with its way of working and then there is no demand for it.

#### *4.1 What influences when SFT is used*

This subtheme describes their experience of what is in fashion in mental health. They describe a system that identifies mental ill health as a fixed entity, located in the individual. A patient fits a treatment pathway and the task of a psychiatrist is to diagnose to get a patient on a pathway. The reduction in clinical space and time also defines who is involved in treatment and the treatment that is possible. They experience this as problematic, frustrating, and undermining.

Elizabeth is agitated about her belief regarding who holds the economic reins of power. That excessive time is spent justifying psychiatric need to those with power and that this unbalances the professional respect within the system about who knows best about mental health for the borough's population. It pains her that she has to convince GP's about how best to deliver services. This conveys to her a sense that her knowledge is not valued. This belief of being professionally undervalued is emphasised for her when commissioning GP's are not interested in receiving what she sees as appropriate feedback about their patients. Her current stance about decision making is expressed with angry resignation.

*'...we have been told that the GPs don't like long letters from us so we don't send them discharge summaries anymore, this was something that was decided, so we send them these notifications*

*instead and when I am writing them I have to write a few extra bits and I think how can they not want to know why someone was even in hospital...the GPs... the GPs are like sort of amongst the obviously they are powerful individuals now... and a great deal of senior management time goes into thinking about what does the GP want... you know and whatever it is is this mystical thing that the GP wants they should have is the view (laughs).'* E L343

William is also clear in his belief that what organises the provision and delivery of services is both economic and dependent on research. William talks with quiet anger about not being able to use his psychiatric knowledge properly to decide to treatment, but has to fit his treatment to the service delivery process. Without a diagnosis then you cannot have the pre-identified treatment. This is the effect of NICE guidelines on treatment planning. His anger extends to what this means for patients that they have to be fitted into a treatment pathway rather than a path being made for the patient. He contextualises the disregard for his skills in terms of economic drivers contributing to service processes:

*'We would see all of the new assessments sooooo we are quite eermmm driven by ...rationing the service ermmm'* W L197

William provides a passionate and graphic description of his experience of the prescriptive nature of the mental health service. He describes how the patient is pre-assigned a diagnostic group to enable assessment, and then assessed as to whether they have severe enough symptoms to be assigned a diagnostic cluster to warrant treatment. He feels very constrained as patients do not always easily and straightforwardly fit a diagnostic cluster, which is the mechanism he must use in order to access a treatment pathway. His language conveys that he experiences services as being dismissive and disrespectful of patients. He concludes that choice is not an option in mental health unlike physical health. He is aware that his challenge or task is to enable access to treatment, which he professionally thinks is most appropriate, but experiences the service as not wanting or respecting his expertise.



*'(...). they got to be in a service line called severe and complex and non psychotic snappy title - lovely words too, um so to get them there they have got to be have been assessed (...)' W L221*

*'So you cannot progress from a to b without a diagnosis?'*  
(Researcher)

*'NO'*

*'And you've check with the patient whether that makes sense'*  
(Researcher)

*'Yes'*

*'And then send them in the direction of the couple and family service'*  
(Researcher)

*'YEEES assuming they met I think another criteria which would need to be in there which is just one of severity (...) otherwise they are not going to get a look in unfortunately -so I need to be able to cluster them in the I need to be able to put them in the right group (...) I mean I don't want to clog up the system as it were with people who are not kind of unwell enough or with people there aren't isn't a big enough service to cater for um. But it is always tempting of course and you say you now -do you need a diagnosis the answer is yes--- of course one hopes one's relatively sophisticated about being willing to kind of pick a diagnosis pick a cluster in order to get a patient the treatment you think that they need. It is **need** it's not what I might call what they might **want** for themselves either, our poor patients get absolutely no choice, if you have physical problem you will get offered a choice.'*

W L224-226

William goes on to comment on the experience that his skill as a doctor is challenged by this process; questioning whether he does really know what is the right treatment.

Richard is fairly measured in his tone about how he perceives the fit between service provider ideas of mental health and provision and that of the patient and families, yet expresses a layer of frustration with again quiet anger at the attitude of service providers to patients. They are not talking the same language. He seems to be questioning rather like William whether service provision is attending to patients or something else.

*'...maybe it made me think differently about some patients having met their relatives I suppose but more I think it made me think more about services in general the sort of approach to people who want help which is often a bit dismissive actually I still think it actually'*

R L209

He conveys a belief in the irrelevance of NICE guidelines and commitment to providing services based on evidence, when resources according to guidelines are not provided, such as SFT. His resigned manner suggests that the fashion for a service has other unnamed influences.

*'no not really no no you would think it would, I mean it is recommended by NICE isn't it so... but it is not followed through with resources'*

R L 195-7

In James' description of how he comes to be working as the psychiatrist lead of the liaison team within the general hospital, he humorously underplays the fragility and vulnerability of his role. He describes that from the outset he was seen as potentially bringing something else with his particular approach to psychiatry, but has to do it with little investment, so exposing the Mental Health Trust expectations.

*'no, it's it's a peculiar set up, so there's been 3 A and E nurses here forever ... who were kind of abandoned to be together virtually'*

*'mm'* (Researcher)

*‘and not to supervised or managed particularly. And I was dropped in in fact I was described as “being parachuted in behind enemy lines”’* JM L224 -227

In describing how the mental health system is delivered the participants voice their frustration about whether services are organised for patients or according to other economic, social and political agendas.

#### *4.2 How good a fit is SFT for the NHS*

This subtheme considers the participants’ lived relationship to the vicissitudes of the world of mental health, their sense of personal agency and of socio-political drivers for different therapies. The work of inspirational and influential figures for 2 members of the study resulted in units being named after them in the Trust, yet fashion has moved on and their model of work only lingers in individuals rather than in Trust wide approaches.

Elizabeth, Amir, William, Richard and James experience psychiatry as part of a wider socio-political world and describe what they see as driving the shifts in fashion. Elizabeth’s use of aggressive slightly caustic language conveys both her frustration and anger with the current provision, but also her understanding of why provision changes. She positions herself as a participant. Elizabeth previously wrote letters (L120) to the Trust as a means of exercising her own power and frustration about provision. In her view SFT does not appear to have a ‘fit’ with the NHS at present:

*‘... it’s a sort of something that goes in fashions in different parts of London... as far as I am aware **here** I mean I don’t think systemic family therapy is offered at all at X hospital in the Y psychotherapy dept. I mean there is apparently somebody that offers some kind of family therapy but (...) I’m not aware of anything being bashed systemic family therapy, here, so that’s the sort of base line so which is pretty sort of low down.’* E L7

For her there are two major influences on service provision. The role of evidence based therapies (L244), which present issues of validity, and the role of GPs who she dryly described as powerful.

The experience of James is more in keeping with Elizabeth in that he sees himself as having agency in what is 'fashionable'. He sees that he must not only work with the current forces but work with it to help it evolve. For him the SFT ideas of working with difference and uncertainty should be used.

*'I think the acute Trusts are all about ...action and doing stuff quickly, getting things sorted and in order to do that you have to decide something and get on with it umm ...our job here is to help the acute Trust by being different in some way... erm 'cos if we were just more of the same, then I don't think we are helping, erm... (...) we have to be able to tolerate uncertainty and erm ambiguity, (...)to do that in some kind of functional way rather than just throwing our hands in the air and going "I don't know"'* JM L151

The role of individuals comes through concerning the current fashion and fit within the NHS for brief interventions, which as Elizabeth says is Mentalisation Based Therapy (MBT). She recognises that it draws on other therapies. William is aware that MBT is being driven by an influential lead, the Chief Examiner of the Royal College of Psychiatry, who is also is a Trust psychiatrist. As a brief intervention MBT fits with the way NHS sees service provision and is therefore acceptable to commissioners. Throughout his interview Richard describes how psychiatry has changed and that he no longer practices in his preferred model of a SFT home treatment, that external forces have changed those services, as they did not fit with the requirements of another point in time.

*'...as a SpR ...er and there was home treatment teams were expanded at that time ...'* R L131

*'... about 8 years ago now I don't think that they operate like that now in fact I know they don't, the pressures on them are completely different ...'* R L57

These influences emerge from the experiences of William, Richard and Amir. Both William and Richard note the experience of how evidence is applied, as unhelpful though in slightly different ways.

Richard calmly, perhaps with some resignation, notes the role of NICE guidelines and that even with supporting evidence SFT is barely present. NICE is influential but is inconsistent in its influence, or even with evidence it is not a fit with the NHS

*‘... you would think it would I mean it is recommended by NICE  
isn’t it so...but it is not followed through with resources’*

R L195-7

This frustration about what evidence is accepted and then how it is used with commissioners, is expressed by William when talking about the rise of CBT. For him the fit is less about evidence in terms of outcome and more about what the NHS desires to be the outcome.

*‘Well ultimately the influence behind that (...) is the evidence base  
they (CBT) have managed to get themselves and the fact they  
promised to do things in 6 sessions’*

*‘They never do, but it is what they have managed to convince um its  
commissioners basically that they do’* W L137-140

This current fashion for brief therapy, William recognises not only depends on how commissioners are influenced but also crucially by existing services in terms of training options and service user expectation.

*‘a bit chicken and egg’*

*‘So no one does it (SFT) because few places have got a decent  
service...’* W L131-3

*‘the reality of that on the ground is trainees pretty much taking  
having to take what is available in the services that they work in, so  
it is the existing types of service that then psychiatrists (...) get a  
training in, (...) it works against anything innovative in terms of*

*what your psychiatrists will be trained in because they will only get this experience of the supervised case in whatever is available within the service... by definition'* W L151

Whilst Amir believes the drivers of a fit with the NHS are from a wider health context, identifying public health as an influencer of resource allocation, which includes how psychiatrists are trained:

*'... a struggle that is going on at one level in terms of resources in terms of resource allocation, its 10 /90 so 10 percent on population based interventions (...) ...there is thinking around that, public health in the UK has is quite influential ...'* A L281-3

*'...question who decides, it is a function of resource allocation, erm psychiatrists as a resource what do you need them for and what do they how do you want them to be trained, I think this is what the training committee thinks of...I think other parts of the different system feed into the training committee, that a psychiatrist over the next 10 years is going to be doing xyz'* A L361-3

Perhaps in response to having made a choice to leave Jane is more disconnected from this experience. She notes the social and demographic contexts of her work environment and in her experience influences patient care but not provision. This subtheme considers the participants lived relationship to the vicissitudes of the world of mental health, and their experience of whether services are geared towards patients or other demands. Their sense of personal agency and of socio-political drivers for different therapies varies, reflecting perhaps a level of weariness with adapting to different service changes and demands. The work of inspirational and influential figures resulted in units being named after them, yet fashion has moved on and models of work only linger in individuals rather than in Trust wide approaches.

In this master theme as a whole the participants describe their experience of the SFT 'fit' in the NHS. They have experienced 'fits' for patients and changes in mental health services and therapeutic ideas in psychiatry. They note that regardless of an apparent emphasis on evidence the changes are driven by other factors, which are not always respectful of patients.

# Chapter 5: Discussion

## 5.1 Overview

This chapter discusses how the findings relate to the research questions, existing literature and theory. Qualitative analysis can produce unexpected themes, which is the case in this study. As such some new literature will be introduced in this discussion of the findings. This discussion explores in what way the themes contribute to this knowledge base.

## 5.2 Summary

The findings of this study show how psychiatrists' experience, understand and make sense of SFT. It has explored how they think and use it in relation to their work. It has provided some illumination of the underlying beliefs and uses of SFT, as well as what has influenced these beliefs for them. It demonstrated that the interview process is itself interventive, in that it provided a reflective environment for participants to reflect on their experiences.

The Master themes:

*Master Theme 1:* The past in the present and the future, the impact and relevance of SFT training

1.1 Hope that SFT is more than a set of techniques '*one would have had hopes of it*'.

1.2. Ideas and Hope of SFT in making sense of symptoms '*A sort of welcomed sense of context*'.

1.3. The presence or absence of the family, in mind or reality for psychiatry '*you don't quite see it*' Making sense to psychiatry.



*Master Theme 2: Proximity and distance, exploring the range and limits of accessing both SFT concepts and service provision*

2.1. How accessible (to professionals) is SFT literally and figuratively.

*‘please ring me if you want any kind of any ideas about what I think might help’*

2.2. Perception of accessibility for families literally and figuratively *‘this is where we are at now and next week things will be slightly different’*

*‘...it was interesting in that kind of setting because people were coming from kind of miles and miles around to do this’*

*Master Theme 3: Anxiety and uncertainty*

3.1 Holding risk when the knowledge is less certain than it would have you believe. *‘Think too many difficult thoughts... (...) it’s very challenging because we are walking on quicksand in terms of evidence’*

3.2 Managing uncertainty (diagnosis and treatment) with families.

*Master Theme 4: Position of SFT in Mental health services*

4.1 Position of SFT in mental health.

4.2 How good a fit is SFT for the NHS.

The research question:

**In what ways do psychiatrists working in adult mental health services make sense of Systemic Family Therapy?**

This was explored further through the use of three additional questions

- How do psychiatrists make sense of SFT?
- How do psychiatrists make sense of SFT in relation to psychiatric practice?

- How do psychiatrists incorporate SFT into their own working lives?

The context in which these results should be viewed is of continuing change in service delivery within the NHS of all mental health services; the study was conducted between December 2011 and December 2013. This service, in common with other mental health services, has had to save money. It has tried to do this through such measures as reducing the number of clinical sites, ‘freezing posts’ with some deletion of posts, re-grading staff to lower pay scales and employing new staff on lower grades. All of which has had an impact on morale, expectations of staff, the amount of work and level of responsibility expected, and level of expertise available or required in the services. Additionally, it has been a time when there has been a move towards greater use of electronic data systems with which there have been on-going difficulties, and increased use of outcome measures to evaluate service provision; these have had to be incorporated into the working day. The results reflect an appreciation of this process of change and the requirement to accommodate it within a sense of professional self. The focus on SFT provided an opportunity for these psychiatrists to think about their understanding of mental health as experienced practitioners. The findings generate an understanding of how SFT is experienced and incorporated into the thinking and work of psychiatrists in adult mental health services. Recalling their training as well as work experiences enabled them to explore uncertainties of understanding and anxiety while making sense of mental ill health. The focus on SFT connected these strivings and evoked recollections of the past which seemed important in this on-going process.

Although SFT is the name for psychotherapy concerned with peoples’ experiences and difficulties from a relational and mutually influencing perspective, its use in adult mental health services is limited. The initial literature review explored the nature of SFT, mental health and psychiatry in the 21<sup>st</sup> century, outlined the training mechanisms for psychiatrists including that of SFT, and confirmed that the role of psychiatry remains in flux. In this study the psychiatrists engaged with SFT as mechanism to think about the past, as well as the present in terms of their psychiatric

practice. The four master themes of, The past in the present and the future, the impact and relevance of SFT, Proximity /Distance- exploring the range and limits of accessing both SFT concepts and service provision, Uncertainty /Anxiety and the Position of SFT in mental health services describe the different relationships they all have with SFT and how it makes sense to them.

In the findings there were connections between the master themes; here I want to look at these master themes, and subthemes in relation to the research questions. The earlier literature will be supplemented by additional literature which is pertinent to the identified master themes.

### **5.3 How do Psychiatrists think about SFT?**

The earlier literature review gave an overview of the role and position of Western psychiatry. The current emphasis on biological and pharmacology psychiatry, though dominant is challenged from a range of theoretical positions. The psychiatrists in this study when thinking about SFT became nostalgic about the hopes they had had for psychiatry at the beginning of their careers. The master theme of the past in the present and the future, the impact and relevance of SFT training captured much of this process of making sense of their experiences in relation to the present work environment. This shift into recalling and reflecting on past experience brought to life their current and real endeavours to make sense of current practice with its biomedical and diagnostic emphasis. The remembrance of SFT for Amir, for instance, connected to what is needed to make a good psychiatrist (subtheme 1.1), whilst William recalled SFT in terms of a contrasting way to make sense of mental illnesses and of the hope that it brought to him in the treatment of schizophrenia (subtheme 1.1).

SFT brought the individual patient into a relational and contextual focus, which in training and in subsequent clinical experience they see as important, but in their current working experience has been marginalised. Perhaps because they were a

self-selected sample interested in SFT or psychotherapy within psychiatry, or through experience in clinical work, they have maintained a belief in the contextual and relational aspects of mental disorders rather than adhering to the dominant position that, illness originates within the individual on a biological basis. Bertrando (2009), psychiatrist and systemic and family psychotherapist reflected on his own transition and movement between these roles. He comments that part of the appeal of SFT was that it is ‘agnostic’ about the genesis of mental illness (Bertrando, 2009, p.161) when he was training in the 1980’s with the increasing biological and diagnostic emphases. Like the participants he saw that ‘Expressed Emotion’ (EE) gave psychiatry a set of simple guidelines to work with families and to assess the results’ (ibid. p.162) and like William, he saw that it was a limited psycho-educational way of working with families, within the field of psychiatry. In his career after initial research with EE he was drawn to explore other psychiatric values and ideas. Bertrando (2009) goes on to state he believes that:

“it is important for a systemic therapist to survive within the psychiatric system, that we should be able to stay in psychiatry without necessarily being subject to its prevailing values.” (ibid. p.163).

Bertrando (2009) argues that psychiatrists have a range of ways to think about mental health and illness, whatever the prevailing values; ranging from psychoanalytic to neurological/biological.

The sociological and psychological literature concerning nostalgia observes that nostalgia can be seen as reactionary or sentimental, a retreat from the present into a sentimental past and with it losing a sense of the future (Tannock, 1995; Olick and Robbins, 1998, Pickering and Keighley, 2006; Sedikides et al., 2008). These writers also discuss what more nostalgia represents. Tannock (1995) considers nostalgia to be a mechanism to hold the many voices and experiences of history rather than a single version of history, and posits this in terms of ‘a lapse’ from a continuous shared narrative incorporating pre and post lapse experiences as part of the difficulties with continuity. In section 1.1 the participants located SFT at a past point in their lives when training, and with it various ways of being a psychiatrist.

Elizabeth identified that training was at a time when she experienced different modalities including SFT, which contribute to her practice now. All the participants were concerned that their role as a psychiatrist is more constrained in their current practice. In Theme 4 they expressed anger when recognising the influence of evidence base practice on their service delivery. The service driven model of psychiatry is, as Abed and Teodorczuk (2015) say, at risk of limiting an essential aspect of knowledge and learning within psychiatry. Psychiatry has different layers of information, interpretation and meaning with which to manage the complexity of the task. This is what distinguishes it from physical medicine. Bracken (2014) comments that psychiatry needs to attend to all of it. For these participants the recollection of SFT is part of bringing meaning and continuity back into their psychiatry, which as they voiced in the study, is increasingly not being drawn on sufficiently (subtheme 4.1 and 4.2).

Nostalgia, then, through this ‘lapse’ or interruption to a shared common world connects to the paradigm shifts and difficulties within psychiatry (as described in the introductory literature review). Thus, nostalgia offers a retreat to the past, as well as engagement with the past through recognising its different voices (Tannock, 1995).

The idea that nostalgia responds to the experience of discontinuity, is one that Pickering and Keighley (2006) take further in terms of the speed of modernity with the relentless ‘new’ not making space to notice the loss of what went before, inducing temporary disorientation. By participating in the study, the participants thought about and remembered what had been lost. This was particularly present for them all due to the changes in multi-disciplinary teams resulting in the loss of multi-dimensional clinical, multi-perspective and contextual thinking (subtheme 1.2). The affectionate language used and the felt attraction of SFT, evoked a now absent sense of camaraderie with other professionals and the benefit of shared thinking. Through the shifting restructuring of mental health services, with ever more mobile ways of working, there is less time in a community base Abed and Teodorczuk (2015). The participants were only too well aware that they had less time with colleagues to discuss, reflect and think about diagnosis and treatment. They highlight how this move towards working in isolation and enforced mobility limits both learning and

the experience of good collaborative practice and is, crucially, a deterrent to those thinking of specialising in psychiatry (ibid.).

The introductory literature review discussed biological / neurological causation through to contextual, social, psychological and economic factors, within individually orientated psychiatry which is part of the change which they are experiencing (Kingdon & Young, 2007; Craddock et al., 2008; Bullmore et al., 2009; Bracken et al., 2012; Das, 2013; Moncrieff, 2013; Moncrieff, 2014). More recently, Bracken (2014, p.243) has stated that 'Psychiatry is currently going through a crisis of confidence' rather than of direction. Nostalgia locates this loss of faith in progress, but also engages with how to actively use it as a way of participating in the present and in the future (Pickering & Keightley, 2006). Nostalgic thoughts are a way of managing the clinical difficulty identified by Kingdon and Young (2007).

The present and the future are spoken about by Richard, James and Jane in subtheme 1.2 when discussing their current use of SFT. This subtheme conveys how, in the recall of SFT, there was the idea that it had offered them a way of making sense of symptoms. Participants recalled a time and way of working which could be taken into the present. In their 'retreat' into a past they can sequence events, with movement into the present through 'retrieval' to create a base for renewal and satisfaction in the future (Pickering and Keighley, 2006). Tannock (1995, p.455) describes nostalgia as approaching the "past as a stable source of meaning and value".

Wildschut et al. (2006) explain that people are nostalgic about momentous life events, and making sense of experiences can be seen as a psychological resource to meet existential needs (Wildschut et al., 2006; Sedikides et al., 2008; Routledge et al., 2013). They identify nostalgia as a positive emotional experience, with a capacity to review events including negative aspects, yet retaining a positive outcome. Interestingly, they also suggest that young and old engage in nostalgic thinking quite frequently, and that nostalgia connects the social world to the self, through close relationships and important events. In this study the participants were nostalgic about their training and work experiences of SFT as part of a process to

make sense of both what SFT offered, but also psychiatry. It was an important part of their life. The ‘negative’ or difficult aspects existed, and recalled in section 1.3 in the unsettling and confusing nature of SFT and the relevance of involving families in treatment. Elizabeth and William expressed discomfort such as it being a ‘*slightly artificial setup*’, yet were clear that the patient and their symptoms are part of a wider social context. They describe their confused yet meaningful engagement with SFT which is part of their practice. The emotional warmth with which James, Amir and Richard recall their experiences of working directly with families in a SFT context (subtheme 1.3) also recalls the personal relationships and precious personal life experiences, which through nostalgic reflection augments their meaning. The use of nostalgia by the participants can be seen, according to Routledge et al. (2013), as promoting and protecting a positive view of self and strengthening social connectedness which echoes Tannock’s (1995) and Pickering and Keighley’s (2006) ideas of history dis/continuity. This was evidenced in this study in the description of a changing work landscape through all the master themes, which was also complemented by the way the participants recalled their involvement and ideas for the future. Jane who was soon to change countries wanted to take forward her way of making meaning in psychiatry which included ideas from SFT.

Thus, nostalgia enables the participants to create a narrative of meaning, continuity and understanding of SFT within their learning and work context and to take something from the past into the present and potentially the future. All participants employed nostalgia as a mechanism to create meaning from their experience of SFT.

## **5.4 How do they understand their experience of SFT?**

The 6 participants expressed different understandings of SFT. Their expectations of SFT and their experiences were reflected in the manner of their recollections, which included positivity and warmth. This study shows a range in their understanding of SFT, only those who sought further training being comfortable with it as a modality to use in their practice. Both master themes of *Proximity and distance, exploring the range and limits of accessing SFT concepts and provision (theme 2)* and *Anxiety and*

*Uncertainty (theme 3)* address elements of how SFT is understood in the context of the delivery of clinical psychiatry. This section will explore what informs understanding from a learning theory perspective, context and supervision, and how SFT is understood in relation to psychiatry.

Like nostalgia, ideas of proximity and distance include an aspect of time, in that the present is more proximal and the past more distant. So the recollection of SFT was within previous experience such as training, and the proximity of what is immediate and accessible. For the participants this was both literal availability and accessibility of services and included their own thinking. In this study the availability or proximity of SFT, both theoretically and in practice, has been varied and is coupled with the uncertainty of what psychiatry offers. Accessing and incorporating new knowledge into clinical work comes through learning, of which supervision is a recognised part. Service provision embodies another aspect. Proximity to this is influenced by academic mental health and economics, as well as the anxieties and uncertainties of being a psychiatrist on the '*shifting sands*' of psychiatric theory.

One way of interpreting this is that participants had different learning experiences of SFT, predominantly in their training which accords with the literature on learning theories concerning learning styles (Kolb & Kolb, 2005; 2009; 2012). For example, Elizabeth understood an aspect of SFT through concrete experience in terms of naming the technique in action, whilst James and Amir were clear that active experimentation in sessions with live supervision had markedly influenced their understanding of SFT (subtheme 2.1). James highlights the lived experience of live supervision where he reached an understanding and awareness of multiple perspectives through self-observation. A difficulty in understanding SFT came from William (with perhaps a reflective observant learning style) in his description of SFT as '*sort of an elaborate game*' which is made no clearer by the confusing range of names for SFT which made him unsure of the service offered in his own Trust (subtheme 2.1).

The learning style approach describes one way of thinking about how these psychiatrists have come to understand SFT. Another is the idea of the interactive nature of learning that has been developed in learning theory and sits more in tune



with systemic thinking is the notion of learning through mutual influence (Kolb & Kolb, 2009). Thinking about how these psychiatrists have experienced SFT, and when and where they have gained their understanding is important, as it provides information regarding both influences and development of systemic understanding and skills.

Kolb and Kolb theorising from the perspective of individual experience, developed the Learning Space concept to consider ‘the holistic, dynamic nature of learning style and its formation through transactions between the person and environment’ (Kolb & Kolb, 2009, p12). In this regard they conceive the individual as being in micro and macro interactive contexts (ibid.). They acknowledge their use of situated learning theory which looks beyond physical spaces and includes those that are embedded in mechanisms of the familiar, tradition and history, creating a communal arena of knowledge and understanding. The individual’s position in this literal and figurative learning space both defines their experience of it, and the way they incorporate it into their reality. So William’s relationship with the Trust SFT services is part of the unfamiliar, in the same way that when he was observing SFT it appeared unrealistic, like a game (subtheme 2.1). Yet Jane, who expressed a lack of clarity about SFT, could appreciate that it made sense to families as they would drive miles to attend a clinic in the Australian outback (subtheme 2.2). Similarly, Amir, with some frustration as one with a clear understanding of SFT practice, expressed the view that how his patients’ understood it was influenced by where it was delivered (subtheme 2.2).

Shifting to the interactive nature of the context of learning, Kilminster et al. (2005; 2011) explored the idea that the process of learning and understanding does not have to be solely positioned from the learner’s perspective, in that the context and changes in contexts are as important. The context of learning includes the interrelationship of context and learner. Looking specifically at how doctors learn, Kilminster et al. (2005; 2011) and Zukas and Kilminster (2012) explore another two aspects of learning, transition points, and supervision.

Zukas and Kilminster (2012) reflect on context in that the trainee doctor needs to integrate theoretical knowledge with practice in order to become a practitioner. And

part of this process is drawing on their practical experience of abstract knowledge to be utilised in other settings. Central to this process is reflection, allowing for different interpretation and understandings to emerge (ibid.).

In this excerpt, Richard shows this process when he recounts how practical application of theory became clear when he visited a patient's home:

*'... the quality of the conversation is better actually in the person's house because in the hospital there is a power dynamic it's them on our territory and whereas in when you see somebody at home it is you on their turf and and that subtly changes things I think they can ask you to leave they can tell you to get out (...) and here it is different (...) if they try to leave we stop them (...) that alters the quality of the dialogue that you have um'* R L142  
(subtheme 2.2)

Zukas and Kilminster (2012) are interested in transitions and what they call 'Critically Intensive Learning Periods' (CILPs). This model helps to conceptualise how these participants describe important points of understanding of SFT. Zukas and Kilminster's (2012) idea of transitions draws attention to the experience of known ways of being and working, and the shifts to new unknown ways which are familiar to the rest of the clinical team/work context. These transitions are a sequence of managing uncertainty, their own awareness of how close or proximal the next new experience is to what has gone before and how to integrate this learning (ibid.). James describes his experience of discussing with the psychologists in the GUM unit how they were able to use SFT with individuals, (subtheme 2.1) he explores the new unknown (for him), as well as the familiar for that team which enables him to rethink his preconceptions of SFT. When joining an established SFT clinic, how is this transition managed; the newcomer enters with new unknowns to join those with their known ways of understanding and working. A question to be asked is whether the SFT clinic is aware that this is potentially a Critical Intensive Learning Period.

The notion of CILPs as contributory to understanding and learning, places emphasis on transitions to a different context of work such as live supervision clinics using SFT. The context of transition into training clinics with live supervision, whether observing or actively participating, and how trainees and the team participate in the new unfamiliar processes within this context which is familiar to some in the team, will impact on trainees accessing new information. Zukas and Kilminster (2012) recognise in their exploration of doctors learning, that doctors frequently shift between levels of responsibility that involves uncertainty, anxiety, and risk. The development of understanding and professional expertise involves supervision of clinical practice, and the implementation of learning. The literature on expertise, according Kilminster and Zukas (2005) considers the difficulty in defining it and accessing it, as it may appear intuitive rather than skilled. They state:

“experts recognise patterns and meanings in information that are not noticed by novices; experts have extensive content knowledge, organized in ‘deep’ ways; context specificity is vital in and experts appear to be able to retrieve knowledge with little effort” (ibid. p.6).

For these psychiatrists their experiences of supervision were greatly varied and influenced their learning.

The uncertainties of the therapeutic arena were conveyed effectively by William in his dry description of psychiatrists’ need to be eclectic in their skills, as much as by Jane who is clear that pharmacological treatment is not as solid as once portrayed (subtheme 3.1). They recognise the need to incorporate both medical approaches and different psychological ones. Their experiences of teaching and supervision of different psychological therapies identified a different style of teaching within SFT, which affected their understanding of it. Their understanding of SFT related to their experience of live supervision and available expertise. William and Elizabeth describe observing supervised live SFT clinical work, but they did not convey an experience of being exposed to extensive knowledge or/and skills (subtheme 2.1) and they were left with uncertainty. The reverse could be said of James, Richard and Amir, whilst Jane knew she was experiencing something meaningful she did not

experience being taught well enough to understand properly (subthemes 2.2 and 3.1).

Kilminster and Zukas (2005) note that in the medical literature there is little that considers theoretical models of supervision, but that models from other disciplines had two common themes. Firstly, it is possible to categorise supervisory behaviours, secondly, the nature of supervision needs to adjust to the recipient's level of experience. They raised the unexplored difficulty, of how supervisors should identify an appropriate level of supervision (*ibid.*). In their review of the literature they note that trainees report too little supervision and insufficient feedback, with a critical rather than a constructive focus, though recognising that the expectations of trainee and supervisor may not be the same (*ibid.*) Hence Kilminster and Zukas (2005) argue that the distinction between educational and clinical supervision evaporates by the use of a workplace curriculum as clinical activity becomes an integral part of learning, and so improves the value of the learning.

This fits with the experience of the participants. In terms of SFT in the work place, supervision is often 'live' as well as retrospective and affords the opportunity to learn with guidance both theoretical and practical. In the study participants who had joined therapy sessions, Richard, James and Amir, all had a more confident understanding of SFT because the learning had made sense (subtheme 2.1).

A question is what would have made it possible for William and Elizabeth to have understood SFT better. Firstly, one writer reminds us the trainee has to want to learn and this may be influenced by different unknown factors (Race, 2005). Given the concern expressed in research by trainees of getting it right and experiencing supervision as more critical than constructive, the importance of CILPs in accessing new information, the use and management of SFT live supervision clinics in a training appears important for the incorporation of theoretical knowledge into a clinical repertoire (Kilminster, 2007).

SFT literature specifically discusses the supervisor's contribution to the processes of learning within supervision and training, through consideration of the ideas of Kolb (1984) and Schön (1987), exploration of the 'domains of action' (Lang et al., 1990)

and ‘levels of contexts’ (Cronen, 1994) alongside ideas of common language and expression, the use of ‘irreverence’ (Cecchin et al., 1992) to maintain curiosity. These contribute to the richness of what Anderson (2000) argues is learning as a social and co-creative process, and that learning and understanding occurs when we reflect on action and create meaning from it. James uses his understanding of SFT to think about uncertainty, not as lack of knowledge but knowing what you do not know (subtheme 3.2).

Neden and Burnham (2007) discuss bringing relational reflexivity into Kolb’s model of learning and incorporate ideas of movement rather than fixed positions. For SFT supervisors the experiences of these psychiatrist in not quite being able to grasp what was happening in SFT clinics (subtheme 2.1) could be reconsidered using Burnham’s (2010) idea to use both Kolb’s theories of learning and Schön’s (1987) of reflexivity to create a ‘curiosity compass’ to help trainers/ supervisors and trainees make sense of their learning, stating:

“Experience by itself does not necessarily lead practitioners to learning. It requires the ability to reflect on that experience in ways which lead to active experimentation with difference in the performance of their practice.” (Burnham, 2010, p. 58).

Burnham and Harris (2002) explore ideas of culture as applied to supervision, from a SFT perspective, suggesting it should address three domains. Firstly, that of the broad culture of supervisory practice including the training and educational context. Secondly, the culture of the supervisory relationship and finally, culture within the therapeutic relationship.

All these factors need attention, by these psychiatrists who are working with uncertainty both within psychiatry and their knowledge of SFT (subtheme 3.1). How can these psychiatrists engage with “relational risk taking” as discussed by Mason (2005) unless it is done in supervision? Mason (ibid.) recognises that systemic and family practice and thinking has increasingly, since the 1980’s, been engaged with collaborative processes.

He sees this as congruent with the systemic concept of ‘mutual influence’ which incorporates the idea of a collaborative process which welcomes being influenced by another, (ibid.p.298). What interests and concerns Mason in this process of paying appropriate attention to other marginalised discourses, is that ‘the inappropriate and unhelpful marginalisation of the expertise of the therapist and the supervisor might sometimes be in danger of occurring;... in danger of becoming too safe in underusing the ownership of our expertise through the giving out of ideas- as an addition to (rather than instead of) the employment of our expertise through the use of curiosity [Cecchin,1987] (ibid.p.298-299)’. He goes on to say that this process of relational risk taking for supervisors ‘involves taking risks interpersonally, as part of the process of finding positions of safe uncertainty and authoritative doubt (Mason, 1993, 2002)’ (Mason, 2005, p.299). In subtheme 2.1 the experience of how knowledge was not conveyed is made clear, by the lack of clearly held expertise within a live supervision clinic, when William speaks of experiencing SFT as ‘an amusing game’.

More recently Burnham (2012) has asked that supervisors be aware of the shifting manner of presentation that needs to occur when moving between identities of therapist and supervisor, referring to both use of language and tone, as well as physical presence. He identifies that these all impact on the trainee for the trainee needs to be clear which professional role of the clinician they are responding to and working with.

These writers situate themselves as brokers between the understandings within domains. However, this literature is often used in the context of teaching SFT to SFT trainees rather than to introduce other professionals to systemic ideas. Another dimension to this working between worlds is visible in the discussion by Edwards and Patterson (2006), who consider the experience of SFT trainees working in GP clinics. They highlight the need to help them become familiar with the culture of the clinic and of the environment in order to be able to join it and work with and within it. This

idea of domains for supervisors actively engages with the learning issues surrounding CILPs (Kilminster and Zukas, 2012).

New comers to systemic practice are grappling with the challenge of thinking in relational rather than individual terms, in an environment with areas of potential conflict, such as ‘right’ and ‘truth’. The systemic therapist in a ‘Bertrando’ psychiatrist, who holds an ‘agnostic position’ would be called to step out of that certainty of knowing and decision making, and engage with processes of mutual influence and interactional change. James has the idea of a ‘*stranger from a foreign land not being too different*’, otherwise the town avoids the stranger (subtheme 2.1). In this study, those with a better understanding had a stranger (SFT) not too different who allowed them to be curious about SFT. The shift to a relational epistemological stance which SFT requires, in which the not too different stranger potentially encourages curiosity, is recognised by Hill (2014) in his discussion of bringing systemic practice into clinical psychology practice, saying:

“[...] support (is necessary) not only in gaining knowledge of family therapy models, but also in making a challenging ‘epistemological shift’ (Cullin, 2014) from internalised models of psychopathology to systemic ways of thinking about problems and change.” (Hill, 2014, p.277).

This idea of not quite getting SFT and of not being guided to understand and grasp it, whilst finding it appealing, is described in subtheme 2.1 in the experience of Jane, William and Elizabeth, along with how to manage uncertainty and the constructive role SFT can play in this (subtheme 3.2). This is where SFT ideas about supervision need to be considered in relation to those learning SFT skills, from other professional groups particularly psychiatrists, as it would expand the use and understanding of SFT across disciplines and adult mental health services.

## **5.5 How do they take SFT forward into their working lives?**

This discussion considers SFT in terms of the wider context in which these psychiatrists’ work. How these psychiatrists take their experience of SFT into mental health and psychiatry, was explored in Master theme 4 *Position of SFT in*

*Mental Health services.* They all expressed the view that they used SFT ideas, with Amir, Richard and James clear that their clinical work incorporated SFT. Yet they experienced a sense of impotence or frustration about SFT in the work place.

The earlier literature review of adult psychiatry and SFT in the UK found that it was limited to a consideration of SFT with regard to specific diagnostic categories and service development, rather than the experience psychiatrists have whilst training in SFT (Scott et al., 1981; Leff et al., 1985; Leff et al., 1989; Kuipers et al., 1992; Burbach et al., 1998; Leff, et al., 2000; Jones, and Asen, 2000; Burbach et al., 2002; Asen, 2002; Asen, 2004; Asen and Schuff, 2006; Stanbridge, Burbach, 2007; Stanbridge et al., 2009; Asen and Scholz, 2010; Asen et al., 2012; Brown et al., 2015; Jackson, 2015). The participants' experiences of exposure to SFT (master theme 1) reflects how SFT existed and now exists in more specific areas of diagnosis and treatment much as the literature suggests, and that services have shifted in how SFT is included.

The introductory literature identified the biological approach of current psychiatry and the difficulties of diagnosis, which is one of the psychiatry's roles. The participants also are aware of the largely negative impact of providing treatment via diagnostic category on their way of working (subtheme 4.1). If SFT follows a diagnostic category, then it contributes to what Richard and William noted in subtheme 4.2; the availability, or lack of availability, of a range of psychotherapeutic modalities, limiting the range of skills and services (the acquisition of skills), which in turn influences future availability. William (subtheme 4.1) is particularly clear about how constraining this approach is on how he is expected to deliver psychiatry.

Other countries, in their consideration of SFT training in psychiatry, have recognised its usefulness but also the factors that mitigate against it in psychiatry (Schmid & Bonjean, 1995; Shah et al., 2000; Berman & Heru, 2005; Schweitzer et al., 2007a). This literature tells us there is an interest in how SFT skills are acquired and there is a value placed on psychiatrists acquiring them in some institutions but not others. It adds that the acquisition of skills is most useful within a team



approach, rather than by an individual practitioner. Certainly this fits with Jane's, Richard's, Amir's and James' experience (master theme1).

The participants variously struggle with what SFT is. The names changes over the years, from family therapy to systemic family therapy, to family and systemic therapy and systemic family psychotherapy, as well as the different schools within it, and those that place themselves to one side like Narrative Therapy, has confused some of these participants. There is a difficulty of identity for both newcomer and outsider alike and is confusing at best.

In the introduction the term Systemic Family Therapy (SFT) was identified as an inclusive term for family and systemic based psychotherapeutic interventions. Eisler (2005), in an editorial in the Journal of Family Therapy, draws attention to the reality that the NICE guidelines, when looking at the evidence base for family therapy, often includes such treatment under the term 'family interventions'. This ignores that the studies it draws upon to reach this conclusion are specific about whether they are systemic family psychotherapy or a broader family or psycho-educational intervention. Stratton's (2011) review of the SFT evidence base considers how this appears to be related to whether the evaluators of research are knowledgeable about SFT. This highlights the difficulty in identifying SFT as a specific way of thinking (only the two participants who had had further SFT training were comfortable with the range of names that fall under the SFT umbrella). Whilst William referenced not being clear what kind of SFT is available within his Trust (subtheme 2.1), Elizabeth bluntly said, *'I'm not aware of anything being bashed systemic family therapy, here'* (subtheme 4.2) but then said that the Trust does employ systemic family therapists in adult services.

What Elizabeth captures is the idea that in order for an intervention to have a presence in the NHS it needs an advocate, in the same way that MBT has within the Royal College of Psychiatry through the Chief Examiner (subtheme 4.2). The Home Treatment Model, appreciated by Richard, was originally delivered as the Crisis Team which had been developed and

established in 1970 by Dennis Scott (Scott & Starr, 1981). Although SFT practice spread in the 1980s and 1990s, when it was establishing itself it could be seen as perhaps a casualty of timing, as concurrently, academic psychiatry moved towards the biological. Services were dramatically altered, through the closure of large psychiatric institutions in response to shifts in social and political perceptions and the expectations held of psychiatry. Along with this is that SFT engaged relatively little with the UK emphasis on evidence based practice (NICE). NICE was noted by the participants as significantly influencing current service provision (subtheme 4.2).

Elizabeth expresses her frustration about the way services are resourced and how decisions are made as to what fits into the NHS. The idea that service provision ‘go[es] in fashions’ can be addressed by considering who currently advocates for which services. The current ‘*fashion*’ can be seen as a result of increasing emphasis on specific treatment pathways of evidence based practice, following both NICE guidelines and academic research that influence the commissioning process (subtheme 4.1). Their discomfort results having to follow the ‘*fashion*’ of the shift towards evidence based practice, which encompasses ever more economic ways to deliver services. These guidelines sit against the participants’ own clinical experiences over time, the growing academic work addressing the shift in difficulties with validity of drug trials, as well as the challenge to the use of randomised control trials (RCTs) as the ‘gold standard’ of evidence for treatments<sup>8</sup> (Bentall, 2009; Thomas et al., 2012; Moncrieff, 2013; Moncrieff and Timimi, 2013; Moncrieff, 2014).

Service and practitioner attitudes to including families are discussed throughout the themes. James discusses the experience of trying to engage SFT services (subtheme 3.1) in terms of patient transition and treatment. Both Amir and Richard express concern about the fit or lack of fit between service provider ideas of mental health and provision, and that of the patients and families, seeing them as talking a different language (subtheme 4.1). The SFT informed Home Treatment which

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<sup>8</sup> RCTs have enabled treatments that more easily fit this form of evidence to gain greater influence

engaged with families, has been taken forward by Richard into his current work (subtheme 4.1), but is not any longer an option. Richard's view that services are dismissive of families is reflected in the development of new services since 2010, those such as Increasing Access to Psychological Therapies, (IAPT) which claim to address the 'Think Family' (Morris et al., 2008) agenda, but may not result in therapeutic work with families (Shepherd, 2011). Another contributing factor to accessing services is practitioner attitude, spoken of in the master theme of Proximity and Distance. William (subtheme 2.1) acknowledges that lack resources may be used as an 'excuse' not to offer SFT, and Jane reflects on how difficult it is to engage with the family. Again in subtheme 2.2 Elizabeth and William expect patients to be as uncomfortable as they are with SFT, as a reason to limitedly engage with it. This influence of clinician's attitudes and assumptions on who attends SFT sessions was identified in CAMHs by Walters et al. (2001) and may well be applicable in adult services.

SFT is identified as useful by patients and families, through having the shared experience, and contributing to changing patterns of relating alongside enabling constructive repositioning of the patient of themselves in the world (Allen et al., 2013). But research concerned with patient and carer experience reflects that although government policy and approach has shifted, their experience has remained that of not being listened to and needs not being met, taking the view that little has changed regarding who is listened within the treatment process (Askey et al., 2009; Reed et al., 2012).

This study addressed psychiatrists' experience of SFT. As practising psychiatrists the participants provide diagnoses, which as William cogently said, is currently required in services to access treatment (subtheme 4.1). In the introductory literature Craddock and Mynors-Wallis (2014) placed diagnosis as a professional responsibility not a choice. Without a diagnosis, a defined course of treatment according to the NICE guidelines cannot be prescribed. The participants were uncomfortable with the 'fixedness' of this approach in terms of delivery and for patients (subtheme 4.1 and 4.2), because it does not engage with the dilemmas they experienced concerning the shifting role of psychiatry in a culturally diverse and

economically unstable environment. Rather, as previously discussed, it only engages within on-going discussions about the nature of psychiatry. Their concern was described in the literature review by Maj (2012, p.137) as a profession which can be seen as “unduly pathologising ordinary life” as a mechanism to expand influence.

They expressed not only their dislike and discomfort with the effect this has on their role as diagnosticians but that it unhelpfully restricts clinical decision-making around treatment options and does not fit with the whole body of knowledge concerning mental health (subtheme 4.1). As a SFT therapist I was sensitive to statements that focused on the individual in the interviews. My curiosity about their discussion of the individual and interpersonal, was informed by the critiques of psychiatry by Rose (1998; 2007) and Tomm (1991) regarding the increasing emphasis on ‘self’ in medicine and psychiatry and the alternative ways of considering mental health in terms of interpersonal behaviours.

Colombo et al. (2003) discuss the perspective of multidisciplinary teams where medical influence stems from the value that society places on medicine. Both Elizabeth and James saw that engagement with their influence was needed (subtheme 1.2 and 4.2). The role of the multidisciplinary team was seen as important by all the participants reflecting the movement towards the idea of multi-professional teams mental health and to the addressing ideas in the *New Ways of Working* document (Department of Health, 2005). However, the participants experienced that as teams were reorganised, their ability to share a common language and understanding was eroded, which impacted on the team’s ability to function (subtheme 1.2). This reflects the importance of collaboration in achieving successful change within teams and organisations, as stated by Robinson and Cottrell (2005). These psychiatrists experienced these changes as being imposed upon them (subtheme 1.2).

The importance of the multidisciplinary team was identified in the development of the Open Dialogue intervention, as it enables or disables the integration or separation of mental health services with patients and families (Brown et al., 2015a). McNab (2014) refers to SFT as ‘dancing between discourses’ as a way of managing the tension between diagnosis

and meaning. She sees this dance as a SFT skill which makes best use of the interventions available. The development of SFT orientated interventions within UK mainstream adult services, namely, the Somerset Model (Burbach et al., 1998; Burbach et al., 2002; Stanbridge et al., 2009) and Dialogical Practice in the UK (Jackson, 2015) has been based on years of collaborative research between psychiatry, mental health professionals and service users. These developments embody the necessity of sharing resources and responsibilities. In addition, they have found ways to bridge differences and respect the utility of different understandings of mental health.

The idea of multi-professional teams has existed for some time and has taken different forms. The research on the effectiveness of these teams reflects the importance of establishing leadership and professional boundaries and roles, to avoid fear of ‘creeping genericism’ (Brown et al., 2000). These participants affected by the reorganisation of the NHS at the time of this study and their responses reflect that change is a process which needs to be respectful of existing practice even if recognised to be flawed. In the context of rapid reorganisations change needs time to become embedded, so that adjustment to new roles and identities can take place which joint training enables (Brown et al., 2000; Robinson & Cottrell, 2005; Larkin & Callaghan, 2005; Fiddler et al., 2010; South West Yorkshire Partnership Trust, 2011).

## Chapter 6 Clinical Implications, future research and limitations

### 6.1 Clinical implications arising from this study

In looking at these findings it is possible to extrapolate some tentative clinical implications.

The difficulty in grasping SFT and how it is used in mental health practice raises questions about the role it plays in addressing and bridging that difficulty in teaching and supervision of psychiatrists. Part of this, the study suggests, is that SFT may need to forge a clearer identity and name. It has become confusing to others partly through repeated name changes but also because at times different models have sought a unique identity rather than to be clearly identified as part of SFT. A clearer definition would enable SFT to be understood as psychotherapy with a distinct approach.

The confusion in grasping SFT experienced by some participants sat alongside the experience of something appealing and useful. Although they were left with uncertainty about whether it was a ‘mirage’ or really existed. They articulated difficulty in shifting from individual emphasis to a relational focus partly due to this not being an explicit idea conveyed to them, and because the working context is dominated by an individualized perception of human distress. This highlights that in any SFT training the shift in thinking towards a relational frame must be clearly attended to, or it may continue to be experienced as unsettling for reasons not well understood. From this study it can be inferred that trainers need to actively bridge relational and individual perspectives and emphasize relational and contextualizing thinking as distinct from focusing on the individual.

What comes through in this study is the gap that occurred in the process of learning for these psychiatrists and how important it is for systemic trainers to engage with

different supervisory positions within the training context and with the different positions that the trainees need to attend to. The theory and discussion of SFT supervision needs to be used in order to provide different positions in supervision and improve learning experiences and outcomes (Burnham and Harris, 2002; Mason 2005; Neden and Burnham, 2007; Wilson, 2007; Burnham, 2010; Burnham, 2012). The findings explored different learning experiences, contexts and how the process of learning SFT could be attended to: that training needs to be part of a clinical experience that is reflexive in nature, with learning as an interactional process in the clinical environment. The shift into a new context for the trainee, but a known one to other professionals as in the notion of CILPs (Kilminster et al., 2011), may be a helpful model and could be addressed by the supervisor to avoid trainees being alienated from learning.

The master theme, *the past in the present and the future, the impact and relevance of SFT training* was valuable as it reflected on and examined this nostalgia as a mechanism to retain what has been perceived as useful, and to take it into both present and future. The risk of looking back can be seen as a wistfulness for some golden age, rather than remaining connected to valuable experiences with a place in the present. In this way, knowledge of other ways of thinking has been useful to the participants in managing how to function in an ever more prescriptive service delivery system. It also enabled them to be critical of such a system. The emphasis on medication and individualized care has not excluded SFT from their psychiatry repertoire, and it still makes sense - even if only for some. Even for those with this incomplete and slightly ungraspable 'making sense' the study suggests that SFT still has value in the day-to-day psychiatric practice of trying to comprehend patients' experiences and to improve their quality of life. The breadth of knowledge Amir saw as a requirement for being a good psychiatrist was evident from all of the participants who emphasized learning a range of approaches from biological to psychological. This clinical perspective is a necessary balance to the academic emphasis on the biological (subthemes 1.2 and 2.1).

The mechanism of interviewing enabled these psychiatrists to be reflective. The style of the interviewing was influenced by the researcher being a systemic family psychotherapist which in common with IPA endeavours to have 'open' questions to explore ideas; to enable unexpected and different possibilities to emerge, which may open up other possibilities. This role of systemic thinking to be an enabler of the many contexts and possibilities is examined in systemic supervision literature. It demonstrates a value in having systemically informed research interviewers.

Issues with the delivery of mental health care were clearly identified by all participants. Two related implications arise from this. Firstly, they spoke about the shifting nature of mental health knowledge, alongside their experience of mental health problems as being biologically, socially and psychologically constituted, whilst working in a context driven not only by a desire for certainty and economically effective solutions, but also one which has an increasing emphasis on 'self' and individual pathology as discussed by Rose (1998; 2007) and Lupton (2012). So although family therapy and interventions are recommended by NICE guidelines to be included in the treatment for disorders identified within adult psychiatry, provision remains limited. These psychiatrists acknowledged that they struggle to use SFT, partly though service provision but also their own attitude and knowledge of it. Viljoen et al. (2005) describe the lack of professional awareness that SFT is a credible treatment option thus influencing its provision. The experience of considering the needs of a patient with provisions that only reflect dominant voices in psychiatry has left these psychiatrists standing on 'quicksand' in terms of treatment options and experiencing a disregard for their knowledge. Secondly, this speaks to their experience that the current implementation of these guidelines, with its emphasis on the individual effectively rationing services, providing no choice of treatment in contrast to physical medicine which offers choice of care.

In the interviews these psychiatrists conveyed some fatigue with delivering services in this way, this contrasted with how they had conceived their role when training and in their previous experience service delivery. The process of the interview brought this into a place for reflection, and towards the end of the interviews they



expressed a need for change, though with the sense that their own agency was limited. I interpreted this as a response to the wearisome process of reorganisation to which they had been exposed for some years. Elizabeth (subtheme 4.1) expressed both her anger but also her experience of frustrated agency or power when discussing the greater role commissioning bodies have to that of psychiatrists in developing service provision. Other services described by Reed et al. (2012), Burbach et al. (2002) and Allen et al. (2013), in the UK and Haun et al. (2013) in Germany, document service changes which incorporate SFT. This research suggests that what influences psychiatrist in using SFT is the importance of an organisational culture shift to enable implementation of SFT; taking it from research into practice (Eassom et al., 2014; Haun et al., 2013). Furthermore Haun et al. (2013), in their review of efficacy and sustainability of SFT support and endorse the whole team approach to training and implementation of SFT. What role did psychiatry have in influencing these organisational and cultural shifts? There is a need for those with agency, such as psychiatrists, to engage with their power in the domain of treatment.

However poorly SFT may be represented in psychiatry training, some appreciation of it remains and accessing SFT provision should be possible. The interview and research process of the study has potential relevance to help general adult psychiatrists to think about their work and explore how they might want to work differently. The impact of SFT thinking and dialogue with adult mental health services and psychiatry has generated other responses to service provision, such as Open Dialogue and Somerset family service (Burbach et al. 2002; Jackson 2015.)

These findings point towards how to adjust and adapt training and services so that even the existing mechanisms of experiencing training in SFT will make better sense.

## **6.2 Strengths and limitations of the study**

The interviews were conducted with a self-selected sample. They could be seen as a group then who were interested in SFT or interested in general psychiatry and mental health service provision. The study was conducted in London, and a study

conducted elsewhere with different demographics and working environments may well produce different responses. Although this does not invalidate the finding, it does limit the conclusions that can be drawn. The validity of the findings in an IPA study is addressed through the use of small heterogeneous samples where the richness of the data is examined in close detail. This close and in depth examination, with a clear audit trail to findings, is more important than the sample size.

Change in service delivery is accompanied by a sense of flux, limited control and low mood and energy, but it can enable reflexivity. The study was able to tap into these psychiatrists' desire to reflect and make sense of their experiences.

### **6.3 Recommendations for future research**

This study specifically focused on adult psychiatry, where there has been a tendency to limit or ignore SFT irrespective of best practice guidelines. It addressed psychiatrists' experiences of SFT and in their reflections they considered how they thought families made sense of SFT, which was influenced by their own understanding of the modality. A complimentary study would explore the experiences of other professionals, of patients and families to gain insight into their understanding of SFT, the impact it has had on their lives, and what enabled them to access and engage with it. It would also be useful to conduct a study in a different geographical area to explore differences in experience.

## Chapter 7 Reflexivity and conclusion

### 7.1 Perceived constraints

The initial constraint was to fulfil the NHS ethical process and to find sufficient participants from one Trust; as gaining approval to approach a second would have been too time consuming. In a time of great change and pressure in the NHS there is a reticence from professionals to take on further tasks into already crowded schedules. I am, therefore, grateful to the psychiatrists who despite time constraints and limited interview space were flexible enough to not only accommodate me, but to co-create the rapport needed to both explore and share their experiences.

### 7.2 Reflections

The interviewees were generous with their time and conveyed interest in the subject. They were thoughtful about mental health services and how they are delivered to convey respect, as much as care and concern for those who accessed their services. Their capacity to think and work beyond the narrow confines of current psychiatry was impressive.

Researcher reflexivity is an important aspect of the qualitative research process. Earlier I discussed what I bring in terms of values, background perspective and assumptions. As part of sustaining awareness throughout the research, I found it valuable to discuss (and record) my thinking and experience of both doing and writing the research with colleagues and friends as well as my supervisor. In this way, reflexivity enables my contribution as researcher to be visible within the research process, a process which having not conducted qualitative research before, I found to be draining yet fascinating.

Gail Simon (2014) recounts a researcher's experiences when conducting research: 'he reflected that while he was trying to fade himself out to foreground the research

questions and be a ‘good’ (meaning unobtrusive) researcher, he wasn’t allowing for how others saw him.’ (Simon, 2014, p.19) I was conscious of how caring and thoughtful these clinicians were, and how they attempted to make sense and engage with their working environment in different ways. From the beginning, I was well aware that I was a participant and not a neutral observer. Bracketing this part of myself was important, as much as being aware that it mattered to the participants that I was an interested participant observer.

From a self-reflexive perspective I was aware early on in the interview process that the participants were aware that I work as a consultant systemic family psychotherapist within the Trust, and saw me as knowledgeable about systemic services in the Trust, and that the participants viewed me to some extent as a colleague. I confirmed to them that I have my own experience of the changes to services that were being experienced by the clinicians which was received I believe as being conscious of the stresses in the Trust. One effect of this that I experienced was they were initially cautious of what was to be talked about in the interview. I had to revisit the purpose of the study. I reiterated that this study was concerned with their experiences of SFT and not with evaluating their knowledge of it, nor was the study evaluating services or their capability. In all the interviews, particularly the first, I became aware that the process had the quality of a ‘consultation’ for the psychiatrists about their work. My awareness of this affected how I conducted the interview in that I sought to not enquire or respond as a ‘consultant to them’ but to keep the interview as open as possible. I experienced them as using the research interview as an opportunity to think about their practice as consultant psychiatrists, rather than consultation as such, in a work environment where there has been little opportunity to reflect in this way. However, I do think my skills as a systemic practitioner were enabling of this reflective dialogue, therefore the process of interviewing was interventive.

I was conscious in the initial interviews of balancing semi-structured interview questions with a free flowing conversation and maintaining a researcher’s open curiosity. This approach ‘fits’ well with systemic constructs and the approach of

irreverence and curiosity (Cecchin et al., 1992). The ‘mutual influence’ within a semi-structured interview provided an opportunity for the participants to reflect on what they were saying and, this was apparent with the first participant, William, who towards the end of the interview reflected on his thoughts about how his team had, did and could function. Therefore, bringing another recursive layer to the role of the researcher to engage with what Smith et al. (2009, p.189) discuss in terms of ‘layers of reflection’ occurring for the participant during the process of being interviewed. This is appropriate to this study as the researcher is a clinician within the same Mental Health Trust.

Once I had interviewed the first four respondents, and started to review each transcript, the richness of the data became apparent, it also sparked a curiosity about why so few psychiatrists had responded. Perhaps they were cautious about the researcher being both a consultant systemic family psychotherapist and a member of the Trust as well as the purpose of the research,. These service changes made any respondent’s time or mine more or less available and affects the workload and stress of the participants. This is explored both within the summary of themes, and the in the discussion. I reflected later that I only slowly progressed my study partly because I too experienced service changes within the Trust

### **7.3 Personal learning**

During the research I learnt about qualitative research processes, and the value of the insights it brings. The insider-out approach is respectful of real life and experience. I have a greater appreciation of how these psychiatrists are dedicated to providing care for their patients and trying to provide care, which is more than the tightly defined psychiatry they are increasingly asked to provide.

As this study evolved the complementarity between SFT and IPA became clearer. The SFT emphasis on curiosity and ‘not knowing’ but informed within a self-reflective and reflecting position, sat well with the recursive process of IPA. It is also a disabler/abler in the sense that I am only too aware that the recursive nature of understanding can continue unless a decision is made to stop, as is the case with IPA.

In the process of interviewing I needed to be careful to be an interviewer and not a consultant family therapist, such as in the interview with William and his concluding thoughts that maybe his team had settled enough to begin to develop and be self-critical.

## **7.4 Conclusion**

The earlier literature addressed training and research regarding the interplay and relationship between SFT and psychiatry in the UK, particularly focusing on diagnostic categories and evaluation of whole team approaches. The meaning and utility of SFT experienced by psychiatrists has not been explored. This study sought to investigate and explore this gap, exploring how SFT is understood and used. The aim of addressing this is to make better sense of the relatively small role Systemic Family Therapy has in the treatment of adults with psychiatric problems, despite research and evidence of its efficacy over the last half century. The study has addressed this by examining how psychiatrists have made sense of it, both personally and in their psychiatric practice, and how they have taken it into their working lives. The procedures of both qualitative research and IPA are that they employ a small number of participants, to enable thorough interrogation of the richness of the data. I became immersed in the data, and in so doing was struck by the reflexivity the respondents brought to the subject, and how they reflected on what they were saying during the interviews.

In this study it has been possible to gain insight into the ways SFT is made sense of and understood by other professionals which influences whether it is used as a modality in the treatment of adult psychiatric patients. A useful finding is that professionals, who have limited training to SFT, find the different names that are used in the systemic field confusing. This adds to the important finding of the difficulties in comprehension experienced by psychiatrists when taught SFT. The way SFT is taught and the engagement of SFT with the medical training process varied. For some participants, their experiences reflected that SFT was limitedly accessible, both literally and figuratively. Whilst others found it accessible enough, but then had to seek out more teaching beyond the introductory exposure. The

participants' recollections and reflections on their experiences give an insight into the difficulty of finding meaning in these experiences without meaningful guidance. They contrasted this with the experience of being taught in a more planned way, for example in CBT.

Nonetheless the participants experienced that SFT, even when hesitantly grasped, offered something useful and appealing to the practice of psychiatry. It was associated with retaining a belief that a patient is more than an individual with symptoms and is a social being. This experience of SFT was retained by them and brought into their current, practice dominated as it is by biological psychiatry and diagnosis driven treatment pathways; as their experience in clinical practice is that the dominant approaches are insufficient for making sense of patients' distress.

The existing literature examines the applicability of SFT to diagnoses, service delivery outside the UK and how specific SFT training is incorporated into psychiatry training. This study provides insight into the lived experiences of the issues and difficulties for psychiatrists in using that training and working effectively, even if for some it is only through retaining the belief that it holds something useful (even if elusive). The theme of The past in the present and the future, the impact and relevance of SFT training captured a yearning for an ideal or more satisfactory practice that contrasts with their working life experiences. A better grasp of SFT would enable psychiatrists to be more confident about when and how to use it as a modality. They could then use their power and position as diagnosticians to advocate for SFT provision to deliver the appropriate treatment, in accordance with the NICE guidelines. The training experiences varied and reflected the further finding concerned with best practice and resource allocation, whether this followed NICE guidelines or whether it was selective in following NICE guidelines.

Although the participants struggled with the epistemological shift, they retained an experience that SFT could be useful, but had somehow not quite fulfilled its potential. Having a more intelligible training experience is connected to the 'chicken and egg' idea of training and resources. If SFT is available to psychiatrists it is possible to learn about it, but without trained staff it cannot become a resource for

staff and patients in mental health services. Training rotations that have access to SFT in adult services will be able to engage trainees in this way of working, but only if the trainees experience the bridging between the two domains of thinking as happened for three of the participants.

What the participants' experiences did support from the literature was that context was highly relevant to how they conceptualized presenting problems. They were aware that SFT had influenced them and continued to influence them in this regard. Thus as clinical psychiatrists they valued having even a limited alternative set of tools to make sense of psychiatric symptoms, as in their experience symptoms did not always easily fit into diagnostic categories.

Psychiatry has a clear role and significant power in continuing to shape NHS mental health services. This study has explored psychiatry's struggle to be more than a bio/medical model and the ways in which SFT has been experienced as contributing to that struggle. This research suggests ways in which SFT could be more accessible to psychiatry, to training and to service provision and so contribute to this endeavour. It also suggests that the process of participating in research conducted within a systemic frame of reference was conducive to a reflective process for the participants about their work and expectations of work as psychiatrists. I hope that studies like this will add to the work available for policy makers to review when considering how the NHS functions.



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# Appendices

## Appendix A: Advertisement for participation in the study

*Advertisement/Email to team managers to cascade to all team psychiatrists.*

### AN INVITATION

**To participate in a qualitative research study.**

**The study is being conducted by Amanda Austen, Consultant systemic and family psychotherapist, as research material for a clinical doctorate with Birkbeck College, University of London.**

**‘Does systemic psychotherapy make sense to psychiatrists working in adult mental health services?’**

I wish to interview psychiatrists, from a range of grades that have completed core training and have MRCPsych.

### **Purpose of the study**

This research seeks to study in what way psychiatrists in particular understand, make sense of and use systemic psychotherapy, in adult mental health services. I want to explore the relationship between psychiatry and systemic and family psychotherapy within a mental health context .

### **What is involved?**

The research involves your participation in a semi-structured interview, lasting between 1 hour and 1 ½ hours.

### **What are the benefits of the study?**

Having completed the study, I aim to share the findings with Adult Mental Health services and CAMHs, with the aim to improve service delivery across the age range.

**All participation is confidential.**

**I will contact each team shortly to speak with anyone interested in being interviewed.**

**If you would be prepared to be interviewed please respond to this email**

[work email given](#)

## Appendix B: Participant Information sheet

### Information sheet

Department of Psychosocial Studies.  
BIRKBECK  
University of London  
Malet Street,  
London WC1E 7HX  
020 7631 6000

#### **Title of Study: 'Does systemic psychotherapy make sense to psychiatrists working in adult mental health services?'**

*Name of researcher: Amanda Austen*

The study is being done as part of my clinical doctorate degree in the Department of Psychosocial Studies, Birkbeck, University of London. The study has received ethical approval.

This study wants to learn more about psychiatrists' lived experience of systemic and family psychotherapy in the field of adult mental health.

- If you agree to participate you will confirm on the consent form that in the interview you should not make reference to identifiable patient information. Should you make reference I will ask you to anonymise it.
- Once you have agreed to participate we will establish a convenient time and place for me to interview you for about an hour to an hour and a half.
- You are free to stop the interview and withdraw at any time.
- A code will be attached to your data so it remains totally anonymous.
- The analysis of our interview will be written up in a report of the study for my degree.
- You will not be identifiable in the write up or any publication which might ensue.

The study is supervised by Dr Lisa Baraitser who may be contacted at the above address and telephone number.

---

## **Appendix C: Interview schedule**

### **Does systemic psychotherapy make sense to psychiatrists working in adult mental health services?**

#### **Interview schedule**

#### **1) What do you think of when I say systemic and family psychotherapy?**

- Can you tell me a bit about your understanding of systemic and family psychotherapy?
- Have you come into contact with it, and what do you make of it?
- When did you first know anything about it?
- Why did this happen?
- Where did this happen?
- What did you expect?
- Who introduced you to it? How? Why?

#### **2) I'm wondering about how you see the role of systemic and family psychotherapy in adult psychiatry?**

- Can you tell me what place in your working life systemic and family psychotherapy has at the moment?
- Can you tell me about what you think systemic psychotherapist do?
- And a little about how you work as a psychiatrist?
- How do you think the two practices might influence each other?
- I'm wondering about the ways systemic thinking might be of use in your work as a psychiatrist?
- How would you describe the impact of systemic ideas on your practise as a s psychiatrist

#### **3) How has it influenced how you think about your identity as a psychiatrist?**

- What previous knowledge have you drawn upon?
- Can you tell me more about that?
- What do you think about this?

#### **4) Trainee psychiatrists can complete their training without having ever been in a systemic clinic, although they all must have done CBT and psychoanalytic cases what do you think about this?**

- What is your own experience in training and of training others?
- Can you tell me more?

**Does systemic psychotherapy make sense to psychiatrists working in adult mental health services?**

**Interview schedule continued**

**5) I'm wondering where you think systemic theory and practice sits within a multi-disciplinary team. How is it seen, how is it used, what role and function might it play in relation to other modalities?**

- Do you use the same words and language?
- What words would you use?
- What influences decisions?
- How can you tell?
- Can you tell me a little more about the role of systemic and family psychotherapy on multi disciplinary working?
- Can you tell me about how you feel or think about this?

**6) I'm wondering how you think about a patient's wider family and network, in your work as a psychiatrist?**

- What influence does it have?
- What is it like when you involve families and carers?
- Can you tell me more about family and network in your work?
- Do you have any more examples?
- Could you say more?

## **Appendix D: Approval from Birkbeck College University of London Ethics Committee**

Begin forwarded message:

**From:** "SSHP Ethics" <sshpethics@bbk.ac.uk>

**Subject:** **Ethics proposal 2011-64 Austen, Amanda**

**Date:** 22 December 2011 14:43:33 GMT

**To:** <austen.amanda@googlemail.com>

**Cc:** "SSHP Ethics" <sshpethics@bbk.ac.uk>

Date of submission: 14<sup>th</sup> November 2011

Investigator: Amanda Austen

Reference n.: 2011-64

Title of Project: 'How does systemic psychotherapy make sense to psychiatrists working in adult psychiatry?'

Dear Amanda,

The School of Social Sciences History and Philosophy Ethics Committee has scrutinised this proposal and has given it ethical approval providing that the following changes are made:

There is a query for the second part of question 4 ("can you tell me more about what were you thinking?") It is not clear what it asks and what is the purpose of the question.

There is a typo in another question starting with "How why".

As a precaution please note, that the interviewee is specifically asked, unless essential to do otherwise, not to discuss any particular patient and if so to make sure no identifiable details are discussed.

It is also advisable that the student interviews psychiatrists who also work privately, so that if they do mention patients, they cannot automatically be assumed to be NHS patients. Please keep this message as official record of the approval for future reference. We will be happy to provide a formal letter of approval upon request.

Good luck with the research.

With best wishes

Mrs Paula Fortune  
Team Leader  
Department of Psychosocial Studies  
School of Social Sciences, History and Philosophy  
Room G06, 30 Russell Square  
London WC1B 5DT  
Ph: 020 76316367

<http://www.bbk.ac.uk/sps/>

If you have a request for information as defined by the Freedom of Information Act or Data Protection Act, please redirect your email to the School of Social Science, History and Philosophy's Freedom of Information Officer, Sarah Banks. (email [s.banks@bbk.ac.uk](mailto:s.banks@bbk.ac.uk)) to ensure your request receives our prompt attention. Any statutory timeframe for a response will not commence until the request is received by the above named or alternative contact and, where appropriate, the requisite fee has been received. You can also check the College's Publication Scheme for information that is already available [http://www.bbk.ac.uk/about\\_us/foi](http://www.bbk.ac.uk/about_us/foi)

**Birkbeck College is London's only specialist provider of evening higher education.**

 Please consider the environment before printing this e-mail.

## Appendix E: Approval from North Central London research consortium NHS



North Central London Research Consortium  
3rd Floor, Bedford House  
125 - 133 Camden High Street  
London, NW1 7JR

14/12/2011

Ms Amanda Austen



Dear Ms Austen,

**Study Title:** Does systemic psychotherapy make sense to psychiatrists working in adult mental health services. A qualitative study interviewing psychiatrists to explore their understanding and use of systemic psychotherapy

**R&D reference:** 11MHS54

**REC reference:** N/A

I am pleased to confirm that the above study has now received R&D approval, and you may now start your research in the trust(s) identified below.

*For R&D office only: please electronically tick, bold, italic & underline the applicable trust(s). Any selected trust(s) without being electronically tick, bold, italic & underline will not be validated.*

NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>
NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>
NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>
NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>	NHS	<input type="checkbox"/>



Please ensure that all members of the research team are aware of their responsibilities as researchers which are stated in page 2. For more details on these responsibilities, please check the R&D handbook or NoCLoR website: <http://www.noclор.nhs.uk>

We would like to wish you every success with your project

Yours sincerely,

Angela Williams  
R&D Manager



## Appendix F: Participant consent form

### Consent form

Title of Study: Does systemic psychotherapy make sense to adult psychiatry?

Name of researcher: Amanda Austen

- I have been informed about the nature of this study and willingly consent to take part in it.
- I understand that the content of the interview will be kept confidential.
- That the transcripts will be reviewed by the interviewer and her academic supervisor.
- I understand that any reference I, as an interviewee, make to patient care, I will anonymise.
- I understand that I may withdraw from the study at any time.
- I am over 16 years of age.

Name \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Department of Psychosocial Studies  
BIRKBECK  
University of London  
Malet Street,  
London WC1E 7HX

020 3073 8045

### Appendix G: Example from transcript 3

Notes L language, C contextual, D description	Line	Initial comment	Transcript 3 Amir	Potential themes+Description of theme	themes	subtheme	Master theme
C refuses to use alternatives- in the psychologist- service and team mismatch L hiding emotion	158	difficulties of team	A he even started a group there was there was this when we got a psychologist there was this great gift that had been given and team said oh we want you we want you and he said well we will do a parent group that type stuff and poor man started and I supported and I said don't get upset .. both laugh after 2 weeks after the 3rd week he was there and nobody turned 4th week nobody turned up ... so .. that is something that the team needs I think that maybe .. so .. I said it was a unique team so erm there was something which was lacking in the team it was given to them but it was very difficult for them to tolerate it so after that er er or maybe they were maybe protecting their abandonment to their perceived psychology the 2 yrs that	NHS resource impact difficult to value psychological therapy as not very available new	ST thinking different perspective – access	access /distance in physical and in mind  promologation 'bashing' sft	NHS fit
	159		jointly say you abandoned us joint laugh				
C the dominance of Med model D of avoidance	160	values professional diversity	A so who knows so but I think that is something that is lacking would probably be lacking within the adult psychiatric system that the psychologist informs errrr the team in terms of systemic thinking. I mean I have to say that some psychologists that I have worked with.. talk about systemic thinking but are not err are more the corporate medical than the medical practitioners themselves ,, they want the	medical model v psychological		access /distance in physical and in mind  view sft home in context proximal	NHs fit

			person to be medicated but I mean I have in fact some of the social workers I have worked with I have joked with them that I am more of a social worker than you... I guess that unmet need this side of Barnet Enfield and Haringey			to families Stuckness limitations med mod	
C competing voices issues of power	161	competition in team	A so who knows so but I think that is something that is lacking would probably be lacking within the adult psychiatric system that the psychologist informs errrr the team in terms of systemic thinking. I mean I have to say that some psychologists that I have worked with.. talk about systemic thinking but are not err are more the corporate medical than the medical practitioners themselves ,, they want the person to be medicated but I mean I have in fact some of the social workers I have worked with I have joked with them that I am more of a social worker than you... I guess that unmet need this side of Barnet Enfield and Haringey	unmet need of patients	Complexity and constraint	Stuckness limitations med mod  risk management	Anxiety / uncertainty
	162		AA do you think that will change?				
C service and nhs L emotion for patients	163	patients need to demand for unmet need	A it needs to change I think it will change when the demand when people get more ... erm by people I mean patients	patient expectation of treatment-not met needs change			
	164		AA patients				
L frustration C cultural issues service not matching/ meeting	165	demographics and provision change needed	A get more empowered I mean there is if you look at it err systemic divide if you look at the geography of X(Trust)	patient voice needs to be louder- demographic context and expectation differences	Power	promologation 'bashing' sft	Nhs fit
	166		AA yes				
	167		A there is this line				
	168		AA yeh				
C avoids population D details	169	population is diverse and	A and if you look at even if you look	relevance and experience of	ST	multiple	Prox/distance

		clinicians not diverse in their experience	even look at the clinical directors most of them look in the east side their their practice they are clinicians their practice based experience is ..does not reflect this population,	culture variation demographic context and expectation differences and relationship to practice and service offered is different	Thinking-influences practice ST thinking different perspective -	contexts of meaning access /distance in physical and in mind	
	170		AA yeh yeh				
L nature of thinking how and whys	171	values systemic thinking for the organisation	A there are splits in the systemic I guess I am talking about the splits aren't when I talk about more systemic thinking can help a team evolve I think it can bridge the splits because you think of things more fluidly rather than in concrete compartments	systemic thinking enables thinking fluid less concrete ST flexible enables thinking	Inclusion of family	complexity in including the family  view sft home in context proximal to families  fit of sft in nhs	The Past in the Present and the Future, the impact and relevance of SFT training

## Appendix H: Examples of all themes from transcripts

Notes L language, C contextual, D description	Line	Initial comment	Transcript 1 William	Potential themes+Description of theme	themes	subtheme	Master theme
C 'different approach potentially', complex v straightforward, Theory about group of people and questions C Different from med model D Making differentiation- 'from the usual sort of medical model which has a sort of linear causality concept to one that is a bit more complex' linear and context-syst is diff to med model C contrast model L-linear needs less words then systemic. L 'welcomes more more all the other influences'	13	different	W um.. but.. taking quite quite a different approach potentially from the usual sort of medical model which has a sort of linear causality concept to one that is a bit more complex than that and <b>tries to take into account, ...all kinds of other welcomes more more all the other influences that might be there on presenting patient as well as other people that might be around them..</b>	Different from medical model Systemic Conceptions of Illness it is not necessarily the illness that really causes it it is their reactions to the symptoms or their reaction to this possible presence of the illness ' T1 (92)	Complexity and constraint	experience of sft  complexity in including the family	The Past in the Present and the Future, the impact and relevance of SFT training
L Welcomed / inviting? C Own world, internal world not external recognition did not go beyond it L 'sort of told' cautious vague language Med model wants norms of disease process, he follows expectation of med model though limited C in med school FT in specific contexts L-accuracy dilemma? 'sort of' is this a way of qualifying knowledge base? Vague L Vague uncertainty-experience of it as a 'fad' L/C label what fits in his experience. L told 'sort of' L they would considered-cautious not in a position to judge, positioning himself as non expert	24	thinks of a group setting	W um I think in medical scho student ... medical school we were sort of told about it as it(SFT) were we sort of learnt about it and then one of my attachments in psychiatry in medical school- so before I qualified and did psychiatry training-but in medical school that was in an inpatient unit um an <b>adolescent inpatient unit um .....and.. the unit they were sort of into it there, they would considered themselves to be using a systemic approach amongst others I would say but they Had community meetings they Had you know staff meetings before and after community meetings they were doing quite sort of therapeutic community</b> type of approach as well would say	exposure- medical school and psychiatry training  where the patient really was just the presenting feature of some other problems within the group usually a family. ' T1(48)	Conceptions of illness/Treatment	view sft home in context proximal to families  thinking space and normality  complexity in including the family  multiple contexts of meaning	The Past in the Present and the Future, the impact and relevance of SFT training
	36	timing	W Yes that was quite a long time ago that was in my training, I think I was a specialist registrar when I did that ...so I would it was	very informative, patients don't exist in a vacuum	Experience of ST	Experience of ST access	The Past in the Present and the Future, the

			sort of late 90's			/distance in physical and in mind thinking space and normality	impact and relevance of SFT training
C concern about effect on relationships of illness is not separate from relationships 'it is their reactions to the symptoms....possible presence of this illness' CL	91	symptoms and relationships	<b>W</b> Ah no I do not think it is separate from relationships. I was just meaning that it is not necessarily the illness that really causes it it is their reactions to the symptoms or their reaction to this possible presence of the illness if you see what I mean	Complexity  mechanism of service provision- makes it harder to get a service	NHS Context	complexity in including the family  thinking space and normality	The Past in the Present and the Future, the impact and relevance of SFT training
D enjoys his 'eclecticism' Important for him as a psychiatrist	96	eclectic psychiatrist	<b>W</b> Well like every psychiatrist I WOULD SAY I was a bit eclectic	Experience/psychiatry/eclectic skill set of good psychiatrist is to be eclectic  NHS Context - Reorganization	NHS Context	complexity in including the family  thinking space and normality	The Past in the Present and the Future, the impact and relevance of SFT training

CD range of influences Different functions of the influences 'thinking about the problem rather than in the intervention'	98	wide influences	<b>W</b> Definitely biology I prescribe all over the place, but Cognitive influences , behaviour stuff I am doing the whole time you know making suggestions about what people could actually do with time um psychoanalytic concepts I think one uses much more in thinking about the problem rather than in the intervention	Experience/treatment - top of mind (biology/prescription), then cognitive/behaviour "stuff" Psychodynamic conception of illness (group psychotherapy/individual) Medical model conception of illness	NHS Context	complexity in including the family  thinking space and normality  view sft home in context proximal to families	The Past in the Present and the Future, the impact and relevance of SFT training
Clarifies-Wants to understand the idea in the question-	178	process of teams	I was sitting there going oh god you know stuff and nonsense how ridiculous but soon what we did transmorphified into lunch, so every week after our Friday morning team meeting someone would bring in lunch it was just the most fantastic thing , it just such a nice team ummmmm so it was a bit a aa bit of a a aa you know along with everything else about the changes I wasn't someone who was moved from a team that I hated I wasn't please to get out of the old team as it were... I was sort of .. not you know I was not particularly wanting to change team so this whole thing of trying not to get off the subject too much- this whole thing about how teams you know build themselves into a unit to deal with that whole process would be really relevant I would imagine.	NHS Context - Reorganisation  experience		fit of sft in nhs experience	The Past in the Present and the Future, the impact and relevance of SFT training



Notes L language, C contextual, D description	Line	Initial comment	Transcript 1 William	Potential themes+Description of theme	themes	subtheme	Master theme
C 'different approach potentially', complex v straightforward, Theory about group of people and questions C Different from med model D Making differentiation- 'from the usual sort of medical model which has a sort of linear causality concept to one that is a bit more complex' linear and context-syst is diff to med model C contrast model L-linear needs less words then systemic. L 'welcomes more more all the other influences'	14	contrast with medical model	W um.. but.. taking quite quite a different approach potentially from the usual sort of <b>medical model which has a sort of linear causality concept to one that is a bit more complex than that</b> and tries to take into account, ...all kinds of other welcomes more more all the other influences that might be there on presenting patient as well as other people that might be around them..	More complex  Complexity/multiple approaches/ST	Complexity and constraint	access /distance in physical and in mind  thinking space and normality	Prox/distance
'seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times ' Impact on family/patient Understanding for patient important 'might have seemed quite a strange process to the kind of subject'	33	artificial setup	W I suppose , it seems, it can, yer no at times its <b>seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times</b> in a way I did not think it was always easy for the patient or the family to sort of quite know what was going on it might have seemed quite a strange process to the kind of subject	<b>Experience/Training/Procedure - seems slightly artificial Off putting-Elaborate game/religious ceremony T1(33)</b>  Context of illness - precipitating factors team based; ST use of mirrors/video	Conceptions of illness/Treatment  Experience of ST	view sft home in context proximal to families thinking space and normality complexity in including the family multiple contexts of meaning Experience of ST access /distance in physical and in mind thinking	Prox/distance
D Importance of having another approach	45	sense of getting	W Not of systems we have <b>access to what is called couple and family service sort of</b>	Use of existing ST service T1(45)	Exposure to ST	Experience of ST	Prox/distance

		it precisel y right, not wanting to mislead	service within the psychology dept at X Hospital and I kind of presumed that they work in that way though I actually don't know the specifics of what particular models they might define that they are using	Being Watched, Mirrors		access /distance in physical and in mind thinking space and normality position of sft in nhs	
	48	wider than the individu al	W oh Well .. usually if sort of I was seeing a patient and felt that.... it was a sort of a really obvious example of where the patient really was just the presenting feature of some other problems within the group usually a family. yeh and quite often just within a couple I suppose as well because they call themselves a couple and family	Language/tone conveys idea/premise Meaning/Definition of ST/Family Therapy vs. Systemic (Same thing, lack of understanding, the terminology) T1(48)	Exposure to ST	Experience of ST  access /distance in physical and in mind  thinking space and normality position of sft in nhs	Proximity and distance, exploring the range and limits of accessing SFT concepts and provision
'the title makes quite a lot of difference' ie refer to understanding of service from title	52	names matter	W I think it probably would yes. yer I think that the title makes quite a lot of difference ,,,	Language - Meaning/Definition of ST/Family Therapy vs. Systemic - seems slightly artificial Offputting- Elaborate game/religious ceremony	Exposure to ST	Experience of ST  access /distance in physical and in mind thinking space and normality	Prox/distance

Then qualifies further to 'hear just about them doing....that they want referred'	54	impacts on using a service how it is called	<b>W</b> Probably not not as much as what you hear just about them doing and hear that they want um what they want referred and so on ... yer		Exposure to ST	Experience of ST access /distance in physical and in mind  thinking space and normality	Prox/distance
L Slips into 3rd person-distancing, less personal less painful? 'grossly over simplified .... and possibly was just plain old wrong' D Importance of having another approach D C he makes a distinction between systemic and family therapy Describes process C 'this is a really amusing game for me' interesting but not serious Not sure what is happening-is this working what is it doing for whom? CD then says therapist would know	67		<b>W</b> yeh One was beginning to realised that that was grossly over simplified .... and possibly was just plain old wrong actually in in certain circumstance and that it would be nice to have another approach in other circumstance, I did quite like... I am just trying to remember I think we saw a video or something when I was trained about it, this may not be specifically systemic this may be more of a family therapy thing, of circular questioning and that whole approach . um so asking questions like -how it would be for so and so in the third partly,- did x um- which I thought was very interesting , but as I say it did soon seem a bit of a ....this is a really amusing game for me , is it actually going to get patients going , is going to get the family changed or is it gonna ... so I mean I think the answer to that is like all therapies it needs to be done by a skilled therapist a good therapist who is in tune with what is going on	use of video live supervision - different perspective-systemic techniques/skills therapist  inclusion of family medical model rarely actively invite family	Inclusion of family	complexity in including the family  view sft home in context proximal to families  fit of sft in nhs	Prox/distance
What is available defines what experience is possible L clear that lack of it makes it difficult to provide training to increase provision	133		<b>W</b> S so no one does it because few places have got a decent service where if you are doing something long term it would be systemic there kind of thing or even a short	Training- lack of availability 'chicken and egg' systemic needs a	ST thinking different perspective -	multiple contexts of meaning	Proximity/distance

			term thing it is a bit of vicious circle	group, more than 2 people, and can't be rushed		access /distance in physical and in mind	
D works against anything innovative Self limiting system Surprised by lack of access	152	self perpetuating range of training	<b>W</b> Yeh... I think that is true. but in terms of meeting the requirements the long and short case, <b>the reality of that on the ground is trainees pretty much taking having to take what is available in the services that they work in</b> , so it is the existing types of service that then psychiatrist that get a training in , so you really need <b>it works against anything innovative in terms of what your psychiatrists will trained in because they will only get this experience of the supervised case in what ever is available within the service .. by definition</b>	Experience/Training Influences - Top/down influence from head of Royal College of Psychiatry (Antony Bateman)		access /distance in physical and in mind	Proximity/distance
CL way of rationalising doing less thinking doing it differently would alter his awareness in the process would make him more aware of other professional approach D Working with another would offer opportunity to learn, different experience Generate other ideas and questions L C Different 'slants' what is of interest Concern that medical process or need to clarify is boring as reason not to do it	208	time is a difficult y and how to do things differently together and gain though recognises the difference different prof perspectives might bring	<b>W</b> Well I think the <b>big difference it would make to me would be to it makes me more aware of how I am doing the assessment and makes me more aware that the other person the professional that I am doing it with would be likely to be learning from each other from it as well..... it is very different experience</b> , think from you know going going they way one tends to do an assessment versus sort of managing the fact that there is 2 or you trying to do an assessment, plus you are from different <b>kind of professional backgrounds as well, so you have slightly different slants or you've got sort different things you think might be the most important thing to go through</b> or ummmm you are worried that they are going to be bored while you kinda go through more of the medical history or something you want to clarify,,um ,yes so it makes a difference	ST Thinking-influences practice	logistics	multiple contexts of meaning  access /distance in physical and in mind	Prox/distance

LC enthusiastic , interested , ‘alternative whole approach’ D Challenge to thinking-useful	59	challenges medical which is inadequate	<b>W YESS I mean</b> I thought it was very interesting, and I thought ..I think. was and I thought I do not know whether it was introduced to me or whether this was what I made of it, it seemed quite an interesting alternative whole approach actually, and <b>quite sort of a challenge to something that certainly in medical school and increasingly since really</b> , one was finding was inadequate which was the this medical idea that A is the problem which has led to C or B and I am going to give the treatment C which is just going to get rid of the whole thing	Experience/ST Challenging  process needs to make sense to patients	Inclusion of family	complexity in including the family  view sft home in context proximal to families  fit of sft in nhs	<b>Proximity and distance, exploring the range and limits of accessing SFT concepts and provision</b>
<b>Notes L language, C contextual, D description</b>	<b>Line</b>	<b>Initial comment</b>	<b>Transcript 1 William</b>	<b>Potential themes+Description of theme</b>	<b>themes</b>	<b>subtheme</b>	<b>Master theme</b>
He says because he should? C feels tested?Context-his context is change of service-prof identity threatened L-needs to be coaxed to talk C Wanting acceptance from interviewer Likes to contextualise his own statement L Hesitant language, what is right /wrong, going forward Implies position noted by researcher L Medical terminology –FT something usefully more ‘ A sort of welcomed sense of context as opposed to a .. bad medical model which can sort of wish that there were not a sense of context just want it to be a disease process’ What is welcoming /unwelcoming, positioning and obligation, no choice L medical model ‘bad’ as denies context, reinforces contrast to med model-scattered experiences presenting his knowledge L Welcomed- brave to be different-bad v welcome Implied opinion Might get lost C Expectation to follow medical model even if do not want to Invested in it- feels in this position	21	welcomes' context positive	<b>W</b> Yes A sort of <b>welcomed sense of context as opposed to.. . bad medical model which can sort of wish that there were not a sense of context just want it to be a disease process</b> I suppose is the usual mode kind of I am presumed to be working hopefully most of us don't but ha	Medical model - bad medical model no context  Complexity-logistics-time	Complexity and constraint	Stuckness limitations med mod  risk management	Anxiety / uncertainty
L Slips into 3rd person-distancing, less	65	precise ,	<b>W</b> yeh One was beginning to realised that	Experience/Medical	Inclusion of	complexity in	Anxiety/uncertai

personal less painful? 'grossly over simplified .... and possibly was just plain old wrong' D Importance of having another approach D C he makes a distinction between systemic and family therapy Describes process C 'this is a really amusing game for me' interesting but not serious Not sure what is happening-is this working what is it doing for whom? CD then says therapist would know		wrong, not as says on the tin, lots of questions game or a skill	that was grossly over simplified .... and possibly was <b>just plain old wrong</b> actually in in certain circumstance and that <b>it would be nice to have another approach in other circumstance</b> , I did quite like... I am just trying to remember I think we saw a video or something when I was trained about it, this may not be specifically systemic this may be more of a family therapy thing, of circular questioning and that whole approach . um so asking questions like -how it would be for so and so in the third partly,- did x um- which I thought was very interesting , but as I say it did soon seem a bit of a ....this is a really amusing game for me , is it actually going to get patients going , is going to get the family changed or is it gonna ... so I mean I think the answer to that is like all therapies it needs to be done by a skilled therapist a good therapist who is in tune with what is going on	model wrong/oversimplified/doesn't consider inclusion of family negative	family	including the family  view sft home in context proximal to families  fit of sft in nhs	ny
	102	influences on thinking less on interventions-how so?	<b>W</b> I mean not as an intervention not as way of getting the patient to understand....yes I do		NHS Context	complexity in including the family thinking space and normality view sft home in context proximal to families Stuckness limitations med mod	Anxiety/uncertainty

D Uses when stuck Repertoire as part of being eclectic C 'fit' of thinking important, to offer different things to different patients	108	variety to complement variety within patient presentations	<p><b>W</b> I think it is <b>often when the initial tendency to use the medical model kind of is not working or fitting easily</b> umm some of this can happen this might all happen in the initial assessment a journey over a specific length over time but I suppose <b>one would hope to have some kind of repertoire of ways of thinking about it or ways of communicating then with the patient that..</b> sufficient to be able fit with different patients you know and their relatives if they are there at differing times that is the aim</p>	<p>Experience/Medical model not working</p> <p>lack of time being a psychiatrist</p> <p>Meaning/Systemic as part of a toolkit (repertoire) skill set of good psychiatrist is to be eclectic</p> <p>NHS resources</p> <p>Experience/lack of knowledge &amp; skill in the model</p>	NHS resources	<p>thinking space and normality</p> <p>multiple contexts of meaning</p> <p>Stuckness limitations med mod</p>	Anxiety/uncertainty
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	115	systemic deeper-somehow this is more respectful of humanity and of complexity of change	<p><b>W</b> Gosh what has influenced that ? well I think the <b>CBT is unattractive</b> in its it is also over simplified I think or can seem to be can seem to be very ..concerned with rather immediate resolution of symptoms and a superficial understanding sort of why it happens just now and why we have managed to get it to go a way just now, um <b>so systems is one of the ones that is definitely looking to have a deeper understanding of things and therefore maybe to you know for the intervention to be more successful to offer a more lasting sort of change or rebalancing or shifting or whatever it might be be ...um</b> I think human behaviour is just so complex so anything anything that seems simple I think is sort um unlikely to be correct</p>	<p>ST thinking - as more informed ST Thinking-influences practice</p> <p>NHS resourcees- Experience/Rationin g services reduced - mechanism to decide who gets the ration, and who gets the more specialised service (where you get assessed again)</p>	NHS resources	<p>multiple contexts of meaning</p> <p>Stuckness limitations med mod</p>	Anxiety/uncertainty
	179	avoidant	<p>But <b>we do not really address it very head on we sort of hope</b> I think we sit work with each other for a while and work out who can be trusted to pull their weight you know who you like working with who you don't like to work with ..and we sort of sit and do that... sort of settled into that without attending to it you know without actually thinking about it I think ..PAUSE</p>	<p>Hope?NHS Context - Lack of Leadership No team cohesiveness (psychiatry)</p>		<p>Stuckness limitations med mod</p>	anxiety uncertainty
<p>'one never knows' 3rd person Using jargon results in not knowing how they are using it</p> <p>'all commonly used to something slightly different 'Nod not question</p> <p>DC his context is not safe to question</p> <p>Grateful that no one asks</p> <p>Team is not safe he says 'not at the moment it is not the sort of team where someone, sort of gets all a serious'</p>	188	is interested in language is used and misused and creates understandings or not	<p><b>W</b> That is interesting one never knows particularly the more sort specific it is to a particular school of thought ie jargon - the less you know how someone is using the term . <b>It is alright to use a term when you might have vaguely heard that term but when someone says that is manipulative, or that is behavioural or that they acting out -do they mean in the significant way in which I would understand it to be defined or are they doing something else, you know those words are all commonly used to something slightly different</b></p>	<p>Shared Language/Identity (yes/no)</p> <p>Experience/lack of shared understanding of the therapeutic language used</p>	language	<p>Stuckness limitations med mod</p> <p>multiple contexts of meaning</p> <p>view sft home in context proximal to families</p>	anxiety uncertainty



private checking possible answers with description	L	D	193	not knowing is not possible	<b>W</b> I think that would be difficult to do in our team at the moment because it is big and its lots of new people that were not together before and I think that would be hardddd to say that in the team meeting probably. I think if someone really didn't know they might sort of ask their chum afterwards or google it afterwards or something you know	NHS Context- Reorganisation +/- impact on confidence/competence		Stuckness limitations med mod  thinking space and normality	Anxiety/uncertainty
<b>Notes L language, C contextual, D description</b>			<b>Line</b>	<b>Initial comment</b>	<b>Transcript 1 William</b>	<b>Potential themes+Description of theme</b>	<b>themes</b>	<b>subtheme</b>	<b>Master theme</b>
L Different context/job speech to lighten change in experience / disappointment- painful providing limited service	Lightness of D frustration of		78	difficulties in getting more than psychiatry for patients	<b>W</b> That was my experience in a previous incarnation of this job when I was doing inpatients as well as um community patients and focusing pretty much on severe and enduring mentally ill patients . Um so getting just very difficult getting therapist from other bits of the service to come in and do therapy !and and or getting other team members to train up to have some skills from those models um.....only got so far actually yeh .....	NHS resources Experience/difficult to get any therapy for chronic mental illness  Language/tone conveys idea/premise Complexity - language of therapy/meaning	Nhs Resources  Language	fit of sft in nhs  multiple contexts of meaning view sft home in context proximal to families promologation 'bashing' sft Stuckness limitations med mod	Fit in NHS
Personally certain of knowledge-his context Rules do not specify modality L precision			131	chicken and egg recognising how self fulfilling limitations are	<b>W</b> Yes in practice absolutely that is defined what is available by services that are available locally-a bit chicken and egg	Experience/Training - exposure is wholly dependent on what is in service to train for, training is self-replicating and self-limiting ("stuck") sort of welcomed sense of context as opposed to... bad medical model which can sort of wish that there were not a sense of context just want it	ST thinking different perspective – access	access /distance in physical and in mind  promologation 'bashing' sft	Nhs fit

				to be a disease process ' T 1(21)			
C current emphasis is on 'evidence base' promising quick change	137	ideas of evidence based - a frustration at this way of thinking	<b>W</b> Well ultimately the influence behind that you referred to when we were n starting that is the <b>evidence base they have managed to get themselves and the fact they promised to do things in 6 session</b>	NHS Context- Evidence based practice  Use of ST - TEAM Depends on (good/bad Experience/lack of knowledge & skill in the model	Use of existing ST service	access /distance in physical and in mind view sft home in context proximal to families Stuckness limitations med mod fit of sft in nhs promologation 'bashing' sft	NHs fit
C reality is that quick change does not happen Sad, disappointed Impact is on commissioning process Belief that psychiatry college does not prefer one over another Psychoanalytic psychotherapy represents psychotherapy Putting context if someone has a relationship to a Psychotherapy that it has a bigger voice potentially Getting dynamic therapy , to be brief, acceptable to commissioners is the task knows personally –his context important person in system so certain of information	140	it does not work in real life but it fits the politics	<b>W</b> They never do , but it is what <b>they have managed to convince um its commissioners</b> basically that they do that is what is on offer I think that more than any thing else I do not think there is a great great college tendency one way or another. Having said that my dear friend the Chief examiner who works in this trust who won't mind me saying is that he leads the psychotherapy section as well -he is an analyst by background-although his service, Anthony Bateman to to to really get dynamic types of therapy trying to be kind of brief and getting to the point and therefore being sort of acceptable to commissioners.	POWER royal college/ <b>nhs/.govt</b>		promologation 'bashing' sft	Nhs fit

	141		<p>W They never do , but it is what they have managed to convince um its commissioners basically that they do that is what is on offer I think that more than any thing else I do not think there is a great great college tendency one way or another. Having said that my dear friend the Chief examiner who works in this trust who won't mind me saying is that he leads the psychotherapy section as well -he is an analyst by background-although his service, Anthony Bateman to to to really get dynamic types of therapy trying to be kind of brief and getting to the point and therefore being sort of acceptable to commissioners.</p>	POWER royal college/nhs/.govt		promologation 'bashing' sft	
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### Appendix I: Example from whole transcript 1 with themes

Notes L language, C contextual, D description	Line	Initial comment	Transcript 1 William	Potential themes+Description of theme	themes	subtheme	Master theme
Believes is open to using systemic ideas Believes has order of intervention modes C L Quick to qualify his ordering to say is not value based ordering, Cautious ermm does not want to offend-get it wrong	112	lots of influences not necessarily see systems as first but sees positively	<p>HA I see myself open to it but a fly on the wall in my consultations would probably come up with a lot of other words of other schools of thought before they came up with systems , I think they would see medical, cognitive behavioural, social and systemic would be somewhere after those I think in practice. Although I feel much so of positive about it as an approach as I do about for instance than I do about CBT</p>	<p>Medical model first port of call</p> <p>NHS Context- limited access to therapy/skills in adult services</p>	NHS resources	<p>access /distance in physical and in mind</p> <p>thinking space and normality</p> <p>multiple contexts of meaning</p> <p>Stuckness limitations med mod promulgation</p>	Anxiety/uncertainty

			generally speaking ermm I mean I think it is very attractive and nice			'bashing' sft	
	113		<b>AA</b> What has influenced that... What has influenced that?	NHS Context-resources/reorganisation- limited access to therapy/skills in adult service	NHS resources	access /distance in physical and in mind  thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod promulgation 'bashing' sft	
Describing his experience of another modality Patients and symptom/illness is more complex, he is respectful of people's experiences as being more than a set of symptoms CBT is superficial to him C C Interested in 'deeper understanding' system(ic) part of this L his use of word systems when means systemic yet he is particular about getting things right-he is aware that he C Interested in helping change for patient, that humans behaviour is complex, needs more than simple intervention to be correct D	114	CBT oversimplified superficial	<b>HA</b> Gosh what has influenced that ? well I think the <b>CBT is unattractive</b> in its it is also <b>over simplified</b> I think or can seem to be can can seem to be very ..concerned with <b>rather immediate resolution of symptoms and a superficial understanding sort of why it happens just now and why we have managed to get it to go a way just now</b> , um so systems is one of the ones that is definitely looking to have a deeper understanding of things and therefore maybe to you know for the intervention to	Complexity/CBT over-simplified (yet CBT has a 'fix it' approach like medicine Key therapeutic models used (CBT) and psychodynamic ( group / individual	NHS resources	access /distance in physical and in mind  thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod promulgation 'bashing' sft	The Past in the Present and the Future, the impact and relevance of SFT training

			be more successful to offer a more lasting sort of change or rebalancing or shifting or whatever it might be be ...um I think <b>human behaviour is just so complex so anything anything that seems simple I think is sort um unlikely to be correct</b>				
	115	systemic deeper-somehow this is more respectful of humanity and of complexity of change	<b>HA</b> Gosh what has influenced that ? well I think the <b>CBT is unattractive</b> in its it is also over simplified I think or can seem to be can can seem to be very ..concerned with rather immediate resolution of symptoms and a superficial understanding sort of why it happens just now and why we have managed to get it to go a way just now, um <b>so systems is one of the ones that is definitely looking to have a deeper understanding of things and therefore maybe to you know for the intervention to be more successful to offer a more lasting sort of change or rebalancing or shifting or whatever it might be be ...um I think human behaviour is just so complex so anything anything that seems simple I think is sort um unlikely to be correct</b>	ST thinking - as more informed ST Thinking-influences practice  NHS resourcees- Experience/Rationing services reduced - mechanism to decide who gets the ration, and who gets the more specialised service (where you get assessed again)	NHS resources	access /distance in physical and in mind  thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod promulgation 'bashing' sft	Anxiety/uncertainty

C models of intervention need to reflect complexity	116		<b>AA</b> So of understating?	Resources - 'We would see all of the new assessments soooo we are quite eerrmm driven by ...rationing the service ermmm..... That's the big one I would say ' T1 (197-199)	NHS resources	access /distance in physical and in mind  thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod promulgation 'bashing' sft	
C	117		<b>HA</b> So the complicated ones seem unfortunately ones seem seems to be more likely to be true as it were mrm	lack of time	NHS resources	access /distance in physical and in mind  thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod promulgation 'bashing' sft	Anxiety/uncertainty
L	118		<b>AA</b> So how would you say systemic ideas have influenced you?	Influence on Power dynamic ( patient / prof)	Power	promulgation 'bashing' sft	

Wants to be precise – ‘purely systems theories’	119		Pause	POWER royal college/nhs/.govt	Power	promulgation 'bashing' sft	
L checking with psychiatrist as eclectic C does not see systemic as part of his psychiatry Needs precision of application to confirm that he uses systemic ideas	120	precise , wrong, not as says on the tin, lots of questions game or a skill	<b>HA</b> Well life is so yeh I I would I hesitate to kind of over state it really you know..... systems purely systems theories probably not a great deal in all honesty	POWER royal college/nhs/.govt	Power	promulgation 'bashing' sft	Nhs fit
	121		<b>AA</b> So you would not see it influencing I suppose as You you in your in your professional identity as a psychiatrist its its not part of that modality?	Experience/ST influences - Chief examiner (a psychoanalyst) - top/down go by the rules, systems influence POWER royal college	Power	promulgation 'bashing' sft	Nhs fit
	122		<b>HA</b> No I do not think it is really in a day to day way	patient confidentiality-misuse /inversion	Power		
	123		<b>AA</b> That it is interesting that you say that	POWER training /experience who to include - perception of need	Power	promulgation 'bashing' sft	
L	124		<b>HA</b> Interested I	process needs to make sense to patients/family	Power		
	125		<b>AA</b> It is interesting hearing you in the dialogue it has left you with a contextual value.....it place that... you started the conversation with placing context	Different from medical model; Systemic Conceptions of Illness	ST different perspective -	multiple contexts of meaning  access /distance in physical and in mind  promulgation 'bashing' sft	
L ‘many ticks’ doing properly	126	thinks of context but deos nto see that a a major influence	<b>HA</b> I like it I Kind of do like it. I am on its side as it were but honestly as it were in practice like I said if a systems person came in a did a	ST thinking rather than practice	ST different perspective -	multiple contexts of meaning  access /distance	Prox/distance

		from systemic	tick as it were for every time I a I did a something that was absolutely definitely systemic and absolutely no other influences in it I do not think I would get many ticks as it were. Yeh			in physical and in mind  promulgation 'bashing' sft	
C	127		PAUSE	use of video live supervision - different perspective- systemic techniques/skills therapist	ST different perspective -	multiple contexts of meaning  access /distance in physical and in mind  promulgation 'bashing' sft	
DC	128		<b>AA</b> I mean -one thing that struck me when working with trainee psychiatrists um was that there are and trainees psychiatrists training in psychotherapy that <b>there is a requirement to do a CBT cases and a requirement to do a psychoanalytic case but there is not systemic requirement in a sense just what was your own experience? did you have such...?</b>	Experience/Training  ST thinking rather than practice ' I like it I Kind of do like it. I am on its side as it were but honestly as it were in practice like I said if a systems person came in a did a tick as it were for every time I a I did a something that was absolutely definitely systemic and absolutely no other influences in it I do not think I would get many ticks as it were.' T 1 (126)	ST Technique vs thinking		
Own experience or different therapy models was limited	129	precise understanding corrects me	<b>HA</b> My own case was psychodynamic and I did very short cases certainly one in CBT um.. yeh I think they were probably all CBT ish and actually <b>some were was just BT, I fact I know the rules quite well</b> , I do the scheme the trainee scheme locally the requirements do not specify the	Experience/Training (rule based, averse to taking risks)  Client/patient part of social context/network	ST thinking different perspective -	multiple contexts of meaning  access /distance in physical and in mind  promulgation 'bashing' sft	Proximity/distance



			modality actually				
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## Appendix J: Example of transcript 1 - Master theme: The Past in the Present and the Future, the impact and relevance of SFT training

L D specific context Liaison child psychiatry- specific context Actually SEE-qualifying is experience-accurate LD use of 'sort of' to be cautious about what he has seen and done D 'Had seen it..... had worked in teams where they sort of had systemic.....I have so sort of been behind...'	29	seeing and doing - becomes technical	<b>W</b> That was at the Royal Free, which was ummm quite a hospital based service, . actually so there was a lot liaison child psychiatry more than standard what used to be called child guidance kind of services, so I did not actually SEE very much family therapy in that... erm.. and then I had seen it in <b>other points in training, I had worked in teams where they sort of had systemic or family therapy going on, um..so I have so sort of been behind windows and things</b>	<b>Exposure- Experience - first observation of systemic therapy T1 (29)</b>	Conceptions of illness/treatment	view sft home in context proximal to families  thinking space and normality  complexity in including the family  multiple contexts of meaning	The Past in the Present and the Future, the impact and relevance of SFT training
L D specific context Liaison child psychiatry- specific context Actually SEE-qualifying is experience-accurate LD use of 'sort of' to be cautious about what he has seen and done D 'Had seen it..... had worked in teams where they sort of had systemic.....I have so sort of been behind...'	30	windows	<b>W</b> That was at the Royal Free, which was ummm quite a hospital based service, . actually so there was a lot liaison child psychiatry more than standard what used to be called child guidance kind of services, so I did not actually SEE very much family therapy in that... erm.. and then I had seen it in other points in training, I had worked <b>in teams</b> where they sort of had systemic or family therapy going on, um..so I have so sort of been behind windows and things	<b>Experience - team based ST use of mirrors/video</b>  Systemic Conceptions of Illness ST thinking	Conceptions of illness/Treatment	view sft home in context proximal to families  thinking space and normality  complexity in including the family  multiple contexts of meaning	The Past in the Present and the Future, the impact and relevance of SFT training

L D specific context Liaison child psychiatry- specific context Actually SEE-qualifying is experience-accurate LD use of 'sort of' to be cautious about what he has seen and done D 'Had seen it..... had worked in teams where they sort of had systemic.....I have so sort of been behind...'	31		<b>W</b> That was at the Royal Free, which was ummm quite a hospital based service, . actually so there was a lot <b>liaison child psychiatry more than standard what used to be called child guidance kind of services</b> , so I did not actually SEE very much family therapy in that... erm.. and then I had seen it in other points in training, I had worked in teams where they sort of had systemic or family therapy going on, um..so I have so sort of been behind windows and things	<b>Experience/Training/Procedure - done differently to mainstream psychiatry</b>  Illness-use of diagnosis Experience/Training - hope that family collaborate with him/understand	Conceptions of illness/Treatment	view sft home in context proximal to families  thinking space and normality  complexity in including the family  multiple contexts of meaning	The Past in the Present and the Future, the impact and relevance of SFT training
	36	timing	<b>W</b> Yes that was quite a long time ago that was in my training, I think I was a specialist registrar when I did that ...so I would it was sort of late 90's	very informative, patients don't exist in a vacuum	Experience of ST	Experience of ST access /distance in physical and in mind thinking space and normality	The Past in the Present and the Future, the impact and relevance of SFT training
Being a consultant means less flexibility in ways of working?	43	precise person	<b>W</b> That was in my training the child job so all my consultant stuff has been in adult, and I have not seen any.. really.. I wouldn't say	Experience/Consultant/ <b>No adult family therapy/systemic work</b>  Groupwork	Exposure to ST	Experience of ST access /distance in physical and in mind thinking space and normality	The Past in the Present and the Future, the impact and relevance of SFT training

LC enthusiastic , interested , 'alternative whole approach' D Challenge to thinking-useful	58	systemic is interesting and alternative	<p><b>W YESS I mean</b> I thought it was <b>very interesting</b>, and I thought ..I think. was and I thought I do not know whether it was introduced to me or whether this was what I made of it, <b>it seemed quite an interesting alternative whole approach actually, and quite sort of a challenge to something that certainly in medical school and increasingly since really</b> , one was finding was inadequate which was the this medical idea that A is the problem which has led to C or B and I am going to give the treatment C which is just going to get rid of the whole thing</p>	<p>Meaning/Medical Model <b>inadequate</b> - Systemic an Alternative approach</p> <p>Inclusion of family</p> <p>Illness - Separating Families</p> <p>(RiftExperience/Mental illness distances people 'gradual isolation from family member everyone grows up um and you know reach an equilibrium which typically fairly distant path' 1 (86)</p>	Inclusion of family	<p>complexity in including the family</p> <p>view sft home in context proximal to families</p> <p>fit of sft in nhs</p>	The Past in the Present and the Future, the impact and relevance of SFT training
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**Appendix K: Example of transcript 1 - Master theme: Proximity and distance, exploring the range and limits of accessing SFT concepts and provision**

C 'different approach potentially', complex v straightforward, Theory about group of people and questions C Different from med model D Making differentiation- 'from the usual sort of medical model which has a sort of linear causality concept to one that is a bit more complex' linear and context-syst is diff to med model C contrast model L-linear needs less words then systemic. L 'welcomes more more all the other influences'	14	contrast with medical model	W um.. but.. taking quite quite a different approach potentially from the usual sort of <b>medical model which has a sort of linear causality concept to one that is a bit more complex than that</b> and tries to take into account, ...all kinds of other welcomes more more all the other influences that might be there on presenting patient as well as other people that might be around them..	More complex  Complexity/multi ple approaches/ST	Complexity and constraint	access /distance in physical and in mind  thinking space and normality	Prox/distance
	32		AA What do you make of that? (...)				
'seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times ' Impact on family/patient Understanding for patient important 'might have seemed quite a strange process to the kind of subject'	33	artificial setup	W I suppose , it seems, it can, yer no at times its <b>seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times</b> in a way I did not think it was always easy for the patient or the family to sort of quite know what was going on it might have seemed quite a strange process to the kind of subject	<b>Experience/Training/Procedure - seems slightly artificial Off putting-Elaborate game/religious ceremony T1(33)</b>  Context of illness - precipitating factors	Conceptions of illness/Treatment	view sft home in context proximal to families  thinking space and normality  complexity in including the family multiple contexts of meaning	Prox/distance

	34	elaborate game	<b>W</b> I suppose , it seems, it can, yer no at times its seemed slightly artificial set up a bit of a...a fairly sort of an elaborate game at times in a way <b>I did not think it was always easy for the patient or the family to sort of quite know what was going on it might have seemed quite a strange process</b> to the kind of subject	team based; ST use of mirrors/video	Experience of ST	Experience of ST  access /distance in physical and in mind  thinking space and normality	Prox/distance
	40		<b>W</b> Since then not much 'cos I have been a consultant you see	Experience/Consultant/Not Much - WHY?  medical school and psychiatry training	Exposure to ST	Experience of ST access /distance in physical and in mind thinking space and normality	Prox/distance
	42		<b>AA</b> You had any exposure in any in any 'cos you have worked in both child and adult so?	Training- lack of availability 'chicken and egg'	Exposure to ST		
D Importance of having another approach	45	sense of getting it precisely right, not wanting to mislead	<b>W</b> Not of systems we have <b>access to what is called couple and family service sort of service within the psychology dept at Chase Farm and I kind of presumed that they work in that way</b> though I actually don't know the specifics of what particular models they might define that they are using	Use of existing ST service T1(45)  Being Watched, Mirrors	Exposure to ST	Experience of ST access /distance in physical and in mind thinking space and normality position of sft in nhs	Prox/distance

	46		<b>AA</b> When would you use that service?	training not valued	Exposure to ST		
C D 'access to what is called couple and family service..' 'kind of presumed that they work in that way though I actually don't know the specifics of what particular models...' Needs to be clear has limited information does not want to mislead or be misled-accurate 'really obvious example' accurate/certain fits service offered FT His view of FT 'presenting feature of some other problems within the group usually family'	47	systemic and presenting problem	<b>W</b> oh Well .. usually if sort of I was seeing a patient and felt that.... it was a sort of a really obvious example of where the patient really was just <b>the presenting feature of some other problems within the group usually a family. yeh and quite often just within a couple I suppose as well</b> because they call themselves a couple and family	St concept of illness	Exposure to ST	Experience of ST access /distance in physical and in mind thinking space and normality position of sft in nhs	Prox/distance

## Appendix L: Example of transcript 1 - Master theme: Anxiety and Uncertainty

D Uses when stuck Repertoire as part of being eclectic C 'fit' of thinking important, to offer different things to different patients	108	variety to complement variety within patient presentations	<b>W</b> I think it is often when the initial tendency to use the medical model kind of is not working or fitting easily umm some of this can happen this might all happen in the initial assessment a journey over a specific length over time but I suppose one would hope to have some kind of repertoire of ways of thinking about it or ways of communicating then with the patient that.. sufficient to be able fit with different patients you know and their relatives if they are there at differing times that is the aim	Experience/Medical model not working  lack of time	NHS resources	thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod	Anxiety/uncertainty
D Uses when stuck Repertoire as part of being eclectic C 'fit' of thinking important, to offer different things to different patients	109		<b>W</b> I think it is often when the initial tendency to use the medical model kind of is not working or fitting easily umm some of this can happen this might all happen in the initial assessment a journey over a specific length over time but I suppose one would hope to have some kind of repertoire of ways of thinking about it or ways of communicating then with the patient that.. sufficient to be able fit with different patients you know and their relatives if they are there at differing times that is the	being a psychiatrist Meaning/Systemic as part of a toolkit (repertoire) skill set of good psychiatrist is to be eclectic  NHS resources Experience/lack of knowledge & skill	NHS resources	thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod	



			aim	in the model			
	111		<p><b>AA</b> So do you see it influencing your practice as a psychiatrist? I mean it is a fairly open question given that the psychiatric training encompasses..</p>	<p>Context - resources- thinking NHS Context- limited access to therapy/skills in adult services</p>	NHS resources		
<p>Believes is open to using systemic ideas Believes has order of intervention modes C L Quick to qualify his ordering to say is not value based ordering, Cautious ermm does not want to offend-get it wrong</p>	112	lots of influences not necessarily see systems as first but sees positively	<p><b>W</b> I see myself open to it but a fly on the wall in my consultations would probably come up with a lot of other words of other schools of thought before they came up with systems , I think they would see medical, cognitive behavioural, social and systemic would be somewhere after those I think in practice. Although I feel much so of positive about it as an approach as I do about for instance than I do about CBT generally speaking ermm I mean I think it is very attractive and nice</p>	<p>Medical model first port of call  NHS Context- limited access to therapy/skills in adult services</p>	NHS resources	<p>thinking space and normality  multiple contexts of meaning  Stuckness limitations med mod</p>	Anxiety/uncertainty

	113		AA What has influenced that... What has influenced that?	NHS Context-resources/reorganisation- limited access to therapy/skills in adult service	NHS resources		
	115	systemic deeper-somehow this is more respectful of humanity and of complexity of change	W Gosh what has influenced that ? well I think the <b>CBT is unattractive</b> in its it is also over simplified I think or can seem to be can seem to be very ..concerned with rather immediate resolution of symptoms and a superficial understanding sort of why it happens just now and why we have managed to get it to go a way just now, um <b>so systems is one of the ones that is definitely looking to have a deeper understanding of things and therefore maybe to you know for the intervention to be more successful to offer a more lasting sort of change or rebalancing or shifting or whatever it might be be ...um</b> I think human behaviour is just so complex so anything anything that seems simple I think is sort um unlikely to be correct	ST thinking - as more informed ST Thinking-influences practice  NHS resourcees- Experience/Rationing services reduced - mechanism to decide who gets the ration, and who gets the more specialised service (where you get assessed again)	NHS resources	multiple contexts of meaning  Stuckness limitations med mod	Anxiety/uncertainty

### Appendix M: Example of transcript 1 - subtheme: NHS fit

Personally certain of knowledge-his context Rules do not specify modality L precision	131	chicken and egg recognising how self fulfilling limitations are	<b>W</b> Yes in practice absolutely that is defined what is available by services that are available locally-a bit chicken and egg	Experience/Training - exposure is wholly dependent on what is in service to train for, training is self-replicating and self-limiting ("stuck")  sort of welcomed sense of context as opposed to... bad medical model which can sort of wish that there were not a sense of context just want it to be a disease process 'T 1(21)	ST thinking different perspective – access	access /distance in physical and in mind  promologation 'bashing' sft	Nhs fit
	132		<b>AA</b> Exactly a bit chicken and egg	ST Thinking-influences practice	ST thinking different perspective -		
	134		<b>AA</b> You are part of the training board .. what influences um the ... I mean there are certain things that are .. the requirement to do training patients as such what do you think influences the college in its lack of influence ?		ST thinking different perspective -		
	135		<b>W</b> Interesting	Welcomes/Open-minded approach? 'all kinds of other welcomes more more all the other influences that might be there on presenting patient as well as other people	ST thinking different perspective -	multiple contexts of meaning  access /distance in physical and in mind	

				that might be around them..' T1(3)		promologation 'bashing' sft	
Expanding questions interest him	136		<b>AA</b> What is the emphasis coming from ..... CBT 's RISEN and had has become part of what is available so?		Use of existing ST service		
C current emphasis is on 'evidence base' promising quick change	137	ideas of evidence based - a frustration at this way of thinking	<b>W</b> Well ultimately the influence behind that you referred to when we were n starting that is the <b>evidence base they have managed to get themselves and the fact they promised to do things in 6 session</b>	NHS Context- Evidence based practice  Use of ST - TEAM Depends on (good/bad Experience/lack of knowledge & skill in the model	Use of existing ST service	access /distance in physical and in mind  view sft home in context proximal to families  Stuckness limitations med mod  fit of sft in nhs  promologation 'bashing' sft	NHs fit
C reality is that quick change does not happen Sad, disappointed Impact is on commissioning process Belief that psychiatry college does not prefer one over another Psychoanalytic psychotherapy represents psychotherapy Putting context if someone has a relationship to a Psychotherapy that it has a bigger voice potentially	140	it does not work in real life but it fits the politics	<b>W</b> They never do , but it is what <b>they have managed to convince um its commissioners</b> basically that they do that is what is on offer I think that more than any thing else I do not think there is a great great college tendency one way or another. Having said that my dear friend the Chief examiner who works in this trust who won't mind me saying is that he leads the psychotherapy section as well -he is an	POWER royal college/ <b>nhs/.govt</b>		promologation 'bashing' sft	Nhs fit

Getting dynamic therapy , to be brief, acceptable to commissioners is the task knows personally –his context important person in system so certain of information			analyst by background-although his service, Anthony Bateman to to to really get dynamic types of therapy trying to be kind of brief and getting to the point and therefore being sort of acceptable to commissioners.				
	141		<p>W They never do , but it is what they have managed to convince um its commissioners basically that they do that is what is on offer I think that more than any thing else I do not think there is a great great college tendency one way or another. Having said that my dear friend the Chief examiner who works in this trust who won't mind me saying is that he leads the psychotherapy section as well -he is an analyst by background-although his service, Anthony Bateman to to to really get dynamic types of therapy trying to be kind of brief and getting to the point and therefore being sort of acceptable to commissioners.</p>	POWER royal college/nhs/.govt		promologation 'bashing' sft	
cautious about impact Cautious about disclosure- who would know D L 'grinding axes' aggressive way to describe why one modality favoured over others D trainees train in what is available	142	recognises how influential some people can be, but also cautious to make sure he does nto convey that malice exists	<p>I suppose.mm Bit it is effective of course so he is so he is quite a big cheese in the college, he is the chief examiner there that section of the royal college which gets to says what is in the exams and psychotherapy um so psychotherapy generally is well represented and certainly whilst we are talking about, yes I should try to keep it anonymous shouldn't I , I am not aware of anyone who is grinding axes in order that their really specific ... you know really their particular school of thought type of approach, should dominate in the college I am not really particularly aware of that umm</p>	Experience/ST influences - Chief examiner (a psychoanalyst) - top/down go by the rules, systems influence POWER royal college		promologation 'bashing' sft	Nhs fit

# Appendix N: Example from reflexive diary

Post Interview 5 — 20/12/13

- bit odd starting interviews
- in old fashioned and - no one knows quite who is who.
- End of Day - walk to office - explanation of day
- very fast talk - felt overwhelming at first -
- again how the interview becomes a narrative place for the interviewee
- that I am interested in that need to talk.
- got calmer - she really was fast and somehow harsh got caring.
- powerful person - I then struggle with the equipment!
- Such a sense of trying to do a good job, punctuated with mechanisms of delivery - she was restrained but less so than other interviewees
- So hard to conclude it - somehow a cathartic experience

### Appendix O: Profile of participants

<b>Alias</b>	<b>Core Training Location</b>	<b>Current NHS, large mental health trust)</b>	<b>Time in current post</b>	<b>Level of training SFT</b>	<b>Approx time since qualifying</b>	<b>Approx age</b>
<b>William</b>	London	Community support and recovery team	Recently reorganised into new team	Exposure whilst training in psychiatry	25yrs	45-55
<b>Jane</b>	London and Australia	Inpatient Unit (psychosis)	Recently reorganised with a new team	Exposure whilst training with specific clinic workshops	10yrs	35-45
<b>Amir</b>	London and Pakistan	Community support and recovery team	Recently reorganised into new team	Specific training in supervised clinic	10-15yrs	45-55
<b>James</b>	London	General hospital Psychiatric Liaison	Approx. 4yrs	Specific training in supervised clinic, and theoretical course	5-10yrs	35-45

<b>Elizabeth</b>	London	Inpatient Unit	Recently reorganised with a new team	Exposure whilst training in psychiatry	25yrs	45-55
<b>Richard</b>	London	Inpatient Unit	Recently reorganised with a new team	Exposure whilst training in psychiatry and in home based outreach based on systemic principles	20yrs	40-50



### Appendix P: Potential themes

	<u>Potential Themes 1</u>	<u>Potential Themes 2</u>	Potential themes 3	<u>Potential Themes 4</u>	Potential themes 5	potential themes 6
medical model	Welcomes/Open-minded approach?	Influences - Training	NHS context	Meaning of ST	Training-exposure	ST perspective - engaging with the perspective and experience of patients and families
experience	Different from medical model	Training - Exposure	NHS Context - Lack of Leadership	Use of ST	Training changes over time	Illness-use of diagnosis
training	Meaning/Medical Model inadequate - Alternative approach	Training - Influences (Australia)	Training - Influences	Use of ST (Objectified/Permanent/Video)	Time passing/timing-changeTraining - Exposure	Medical model conception of illness
influences	Medical model - bad medical model	Training - Exposure (Lack of explicit training 'techniques', so they don't actually get the theory) - mismatch between theory and doing	medical model v psychological	Use of ST - varies by location/culture of NHS trusts	Key therapeutic models used (CBT)	Importance of social norms in conceptions of illness
nhs context	Experience/Medical model not working	Influences - Leadership (Lead	patient needs	Use of ST - can be practiced with	Use of Systemic	Systemic Conceptions of

		Psychologist), Lack of Leadership		individual as well as couple/family	Therapy (ST)	Illness
culture	Stuck in the medical model/systems, "stuck", problem à find cure	Influences - Leadership (Lead Psychologist)	ST thinking	Use of ST to make non threatening clinical thinking environment	ST Use of techniques	ST useful
use of ST	Experience/Medical model wrong/oversimplified/doesn't consider CIRCUMSTANCES	Influences - Personal Interest	Impact of ST	Use of ST- organisation change	ST thinking	Benefits of increasing use of ST
positive st	Medical model - risk averse, set of rules, conformity, demand for competence (quite different collegial dynamic to therapeutic inter-relationships), are we managing the risk?	Initial exposure - Family/Eating disorders/Inpatient s	Use of ST	Use of ST- supervision of other professional staff	ST Thinking-influences practice Use of Systemic Therapy (ST	Systemic thinking - practical, and needs to be practical, and still be able to stand back, observe and conceptualise what is going on
time	Medical model - demand for competence, attributes lack of knowledge sharing due to 'new team'	Initial exposure - Abroad (Australia)	culture (need for cultural competence)	Use of ST- thinking	positive personal relationship to ST	positive personal relationship to ST feeling good /positive( about work)
game	Medical model first port of call	Use of ST - early intervention as a service organises peoples' thinking of	culture	Use of ST as Useful	ST thinking - as more informed	ST Use of techniques

		what to expect, pre-set thinking (limiting)				
makes sense	<b>Meaning/Medical model vs. systemic techniques/skills therapist</b>	Use of ST - <b>Good team has team ethos</b> that is apparent, early intervention more cohesive		ST thinking - <b>must be open to change in clients' thinking too</b> ; change in thinking is not abnormal but a common experience	ST Thinking- influences practice	Benefits of increasing use of ST
inclusion of family						Systemic Conceptions of Illness ST useful
impact of ST		Use of ST/ <b>Enjoyable</b>		<b>Different schools of ST</b>	Offputting- Elaborate game/religious ceremony	<b>Different schools of ST</b>
context	medical model? <b>Family is a problem/awkward</b> interferring	Use of ST/ <b>Interesting</b>		ST Thinking - as the outsider/ <b>different but not too different</b>	process needs to make sense to patients	Training - Exposure: it is vital that psychiatrists do receive exposure to as wide a view of what is mental illness and what comprises, what contributes to an individual becoming ill, are they seeing it in

						individual terms, or are they seeing it as a symptom of the relationship/group /social dynamic/context
models	Textbook talk?	Use of ST/ <b>Managing the distress</b>		ST thinking - as more informed	Conceptions of Illness	Inclusion of Family
evidence	<b>Experience</b> - first observation of systemic therapy EXPOSURE child psychiatry	Use of ST - <b>Depends on (good/bad team)</b>		ST thinking - <b>trying to influence others in the system about 'other ways of thinking'</b>	broad medical model v psychological	<b>Network of relationships</b>
	Experience/Training ( <b>rule based, averse to taking risks</b> )	Use of ST - <b>Relatively senior team members use psychotherapy, senior people bring knowledge and capacity to think around something (wisdom)</b>		ST thinking - <b>a model way of thinking rather than simply technique</b>	Illness - Separating Families (Rift)	Inclusion of Family or illness and <b>responsibility</b>
	Experience - team based	Use of ST - <b>Not part of standard care</b>		ST thinking - <b>has broad relevance across the board</b>	Context of illness - precipitating factors	<b>process needs to make sense to patients</b> Inclusion of Family
	Experience/ <b>Training/Procedure</b> - done	Use of <b>ST/Managing the distress</b>		Theory vs. technique		<b>ST perspective - engaging with</b>

	differently to mainstream psychiatry					<b>the perspective and experience of patients and families</b>
	Experience/Training/Procedure - seems slightly artificial Offputting-Elaborate game/religious ceremony	Use of <b>early intervention model and ST</b> - Ad hoc 'we have loosened our criteria'		Constructivist model of ST	Idealised Hope vs reality patient	<b>Family inclusion - they want constant dialogue, they want to be involved, this psychiatrist uses an open door approach, meaning he is open to other members' of the patients' social network being interested in the patient, he's open to the idea that the family will be invited, rather than have to be invited. If you do that within the first 72 hours, you are giving the family the message that they</b>

						are important and part of the solution
	Experience/ <b>Consultant</b> /Not Much - WHY?	Mismatch of model- Early intervention with actual context		<b>Video as objectification</b> , but also useful training tool for ST therapists	NHS Context - Resources	Inclusion of Family ST Thinking - fluidity- from using systemic thinking ST Use of techniques process needs to make sense to patients
	Experience/ <b>Consultant</b> / No adult family therapy/systemic work	Medical model - divergence from (Oz vs UK)		The video as a <b>reflexive training</b> tool/you have to be open to how you practice	Power dynamic [of psychiatry/NHS]	Inclusion of Family very important <b>family not carers</b> not the same
	Experience/ <b>Challenging</b>	Relationship - Wider Relationship than Medical Model		Context of ST therapy important - interpretation vs. truth (no right or wrong)	medical model v psychological	NHS Context - Resources
	Experience/ <b>difficult</b> to get any therapy for chronic mental illness	Time passing/ timing-change		NHS context - reorganisation affecting where ST is practised	Client Context - <b>Family sociodemographic</b> (e.g., black, middle class, age of	<b>ST Use of techniques</b> NHS Context - Resources

					client)	
	Experience/Training	Shared learning (NHS)		Conceptions of illness (acute vs. general hospital)	Client Context-child protection issues	NHS Context - Training Exposure limited by resource
		Shared language/alliance/i identity		Medical model v psychological - conceptualisation of illness and language used to define illness (e.g., not only concrete, but al vulnerability to certain symptoms or experiences)	Client context-process needs to make sense to patients	NHS Context-allocation of service- rationing?
	Experience/Training - hope that family collaborate with him/understand	Key therapeutic models (CBT)		Psychiatric mindset - default position	Client context-impact on relatives	NHS context - reorganisation and pressure of work, has actually changed the practice of systemic therapy
	Experience/lack of knowledge & skill in the model	key treatment models- recovery and carers		Role of psychiatry in ST	Client Context - Family sociodemographic	Key therapeutic models used (CBT) and psychodynamic NHS Context - Resources Training Exposure
	Experience/treatment -	Family perception		medical model v	Inclusion of	Key therapeutic

	top of mind (biology/prescription), then cognitive/behaviour "stuff"	of Treatment/key therapeutic models		psychological - struggle, ebb and flow (you get pulled back into the more medical thing)	Family	models used (CBT) and psychodynamic NHS Context - Resources
	Experience/Mental illness distances people/effect of the illness	Complexity/Openin g up process		Medical model versus Psychological	POWER patient requests no family/confide ntialit	ST Thinking- influences practice
	Experience/psychiatry/e cclectic	Complexity/NHS Context - Resources		Psychologists doing systemic work - Couple outsourced to ST by psychologists	NHS Context - Resources	<b>Formulation meeting</b> - how it happens, how it is organised by the Ward clerk - you can do it if you believe it (it's possible, but still difficult)
	Experience/Not much	Complexity - the shared approach makes the complexity manageable		Training - Influences (lack of ST exposure)	NHS Context- Evidence based practice	Home treatment (influence by Denis Scott - Amanda has paper somewhere)
	Experience/Training - exposure is wholly dependent on what is in service to train for, training is self- replicating and self- limiting ("stuck")	Complexity- What is Illness- context		Training - Exposure		<b>Application of systemic thinking in acute psychiatry</b> (occurred in the 80s and 90s (home visits), it couldn't



						hold it's ground with the growing dominance of pharmacology / home visits is expensive, but in the longterm / we don't look longterm anymore, short-term treatment is the 'best practice', getting patients through the system as quickly as possible, with the minimum of intervention; also a sense that longterm is confused with expensive, and chronic
	Experience/ST influences - Chief examiner (a psychoanalyst)	Complexity-Lost in Family life and wider social context		Training - Exposure (how psychiatrists engage with ST as family work)	NHS Context - Reorganisation	Shift from home treatment to the patient coming into the hospital, on the doctors territory, but JG doesn't do the

						admissions as such, he doesn't do sectioning, he sees patient, once they've had a bed, but he still has an initial 'systems meeting'
	Experience/ST influences - Chief examiner (a psychoanalyst) - top/down go by the rules, systems influence	Relationship-Wider relationship than medical model Medical model-psychotherapeutic interventions		Idealised Hope vs reality [of ST practice]	Illness - Separating Families (Rift)	Shift from home treatment to the patient <b>coming into the hospital, on the doctors territory</b> , but JG doesn't do the admissions as such, he doesn't do sectioning, he sees patient, once they've had a bed, but he still has an initial 'systems meeting', a formulation meeting (invite family members in to have a chat about what's going on, and this is what is being lost

						in the current practice of in-hospital systemic therapy)
	Experience/ST influences - Top down/ who flies the flag for a particular therapy	feeling good /positive( about work)				Context - Family/client context
	Experience/Training Influences - Top/down influence from head of Royal College of Psychiatry (Antony Bateman)	read / knowledge / learningmake sense of task ( psychiatry),		Benefits of increasing use of ST		Assessment at HOME patient believes is understood
	Experience/lack of shared understanding of the therapeutic language used	Diagnosis/needs missed		Power dynamic [of psychiatry/NHS]		
	Experience/Rationing services reduced - mechanism to decide who gets the ration, and who gets the more specialised service (where you get assessed again)	Illness - Generational/entrenched perception by family and services		Power dynamic [of psychiatry/NHS] - ST thinking useful for this, more open-mindedness		patient believes is understood Influence on Power dynamic ( patient / prof)
	Experience/Rationing - systemic needs a group, more than 2 people, and can't be	Context-of illness		NHS context - resources		NHS Context TEAM contribution to family inclusion

	rushed					and process
	experience - resources/time/ number of professionals	context of illness <b>social economic mental health use</b>		Shared Language/Identity (yes/no)		Influence on <b>Power</b> dynamic ( patient / prof)
	Experience/When Use <b>Systemic - severity,</b> meeting criteria, diagnostic clusters, enough staff to cater for it	reality of social <b>context of workplace</b>		Making referrals		NHS (carers assessment )has defined patient's personal relationships as dependent - <b>Language (POWER)</b>
	experience training-- <b>enthusiasm</b>	<b>mechanism</b> of context of illness		Working with children		
	Experience of ST - <b>very informative,</b> patients don't exist in a vacuum	Context <b>Traumatic</b>		Other Influences - Personal interest		
	training /experience who to include, flexibiltiy based on	context and use of <b>different health care resources</b>		NHS Context		
	experience /training use of humour to not question	Context-Family <b>desperate</b>		Inclusion of family - education/learning		
				Inclusion of family - sometimes you only get one person there		
	experience training-- <b>enthusiasm-</b>	Context - <b>Clientelle</b> (family		Inclusion of family - <b>tone</b>		

	<b>ASSERTIVE</b> influential	sociodemographic)				
	experience/training	Context- <b>danger - meaning of environment</b>		Inclusion of family to <b>EXCLUDE patient</b>		
	experience <b>training not valued</b>	Context of illness <b>family provides information</b>		Inclusion of family		
	Meaning/cure	Context - <b>Clientelle (family sociodemographic)</b>		<b>Patient confidentiality-misuse/inversion</b>		
	meaning of treatment	Context - <b>Family externalises and blames authorities for family members illness</b>				
	<b>Meaning/Hopes</b> it can beyond the medical approach (e.g., schizophrenia), and severe and enduring mental illness	Context of illness - <b>precipitating factors</b>				
	<b>Meaning of ST/Group &amp; Family</b>	Context - <b>Sense of family failure and traumatic admission process</b>				
	Meaning/Definition of ST/Family Therapy vs. Systemic (Same thing,	Context of <b>engagement with family traumatic</b>				

	lack of understanding, the terminology) - no cross reference in his thinking					
	Meaning Not a FIT for family	<b>What is illness-Context</b> - Clientelle (family sociodemographic)				
	Meaning/Systemic as part of a <b>toolkit (repertoire)</b>					
		NHS Context - Reorganisation				
	More <b>complex</b>	NHS Context - Resources				
	Complexity	change in service ethos/conceptualisation (POWER)				
	Complexity/ <b>multiple approaches</b>					
	Complexity/CT over-simplified (yet CBT has a 'fix it' approach like medicine)					
	Complexity - <b>language of therapy/meaning</b>					
	complexity- <b>logistically/emotionally</b>					
	complexity- logistics-					

	time					
	complexity- too difficult					
	Hope?					
	No team cohesiveness (psychiatry)					
	context TIME pressure rationing					
	context /professions rationing					
	Context - -thinking					
	context- get through the work resources/time					
	context service provision more flexible					
	context limitations of service provision					
	context					
	context- service interested in recording not treatment					
	context - resources					
	context/logistics					
	Context - sense of context					
	Family-based					
	inclusion of family					

	experience//understanding patient					
	inclusion of family experience medical model					
	inclusion of family positive and negative					
	inclusion of family meaning of treatment					
	inclusion of family and knowledge					
	perception					
	Perception - <b>That ST is resource intensive</b> , at a time when the NHS has those resources → idea gets lost that it can create change					
	<b>POWER</b> training /experience who to include - <b>perception of need</b>					



### Appendix Q: Master Themes

<u>potential themes</u>			abstract sub themes	abstract sub themes	abstract sub themes	abstract sub themes	abstract sub themes	abstract sub themes	more abstract Sup /Master themes		<u>potential themes</u>		-	1st themes	1st themes	1st master themes
ST exposure	experience of sft										ST exposure	moved to Exposure to ST		Exposure to ST	NHS resources	power
ST exposure /Experience - first observation of systemic therapy	experience of sft		access /distance in physical and in mind						position of sft in nhs		ST exposure /Experience - first observation of systemic therapy	moved to Exposure to ST		Medical model	NHS context	

Training other hope expectati on	expe rien ce of sft		acc ess /dis tan ce in phy sica l and in min d	thin kin g spa ce and nor mal ity				prom ologat ion 'bashi ng' sft			Training other hope expectati on	moved to Exposu re to ST	Compe ting models	Power
Exposur e to ST	expe rien ce of sft		acc ess /dis tan ce in phy sica l and in min d					prom ologat ion 'bashi ng' sft			Exposur e to ST	moved to Exposu re to ST	Compl exity and constra int	Compe ting models
Influenc es											Influenc es	moved to Exposu re to	Concep tions of illness/ Treatm	

												ST	ent			
Medical model	multiple contexts of meaning					Stuckness limitations med mod	risk management					Medical model	Medical model	personal interest		
Competing models	experience of sft					Stuckness limitations med mod		fit of sft in nhs				Competing models	Competing models	Power	Conceptions of illness/ Treatment	
Competing models (integrated)	experience of sft								anxiety uncertainty			Competing models (integrated)	moved to Competing models	Inclusion of family	Medical model	conceptions of illness/ treatment
Other specific trainings	experience of sft											Other specific trainings	moved to Competing models	language		

Key therapeutic models	multiple contexts of meaning										Key therapeutic models	moved to Competing models	Context	'being a psychiatrist'
Nhs Evidence based						Stuckness limitations med mod	risk management	fit of sft in nhs			Nhs Evidence based	moved to Competing models	Experience of ST	language
Shared learning (NHS) ST outsourced to Psychologist	multiple contexts of meaning										Shared learning (NHS) ST outsourced to Psychologist	moved to Competing models	NHS context	personal interest
Completing models (lack of true multidisciplinary cohesion)	multiple contexts of meaning					Stuckness limitations med mod	risk management	promotion 'bashing' sft			Completing models (lack of true multidisciplinary cohesion)	moved to Competing models	NHS resources	

)											)					
Time		complexity in including the family	access /distance in physical and in mind	thinking space and normality							Time	moved to Competing models		'being a psychiatrist		
Time Training								fit of sft in nhs			Time Training	moved to Competing models		ST thinking different perspective	Inclusion of family	
times change									Proximity and	NEWN	times change	moved to Competing		ST Technique vs thinkin	Complexity and	complexity of real people

									distance, exploring the range and limits of accessing SFT concepts and provision	A M E			models	g	constraint
Complexity	experience of sft	complexity in including the family			view sft home in context proximal	Stuckness limitations mediated mod						Complexity	moved to Complexity and constraint	Use of St thinking	Context



			in mind										
Concepti ons of Illness	mult iple cont exts of mean ing						risk mana geme nt					Concepti ons of Illness	moved to- Concep tions of illness/ Treatm ent
Concepti ons of illness/T reatment	mult iple cont exts of mean ing	com plex ity in incl udin g the fami ly		thin kin g spa ce and nor mal ity	vie w sft ho me in con text pro xim al to fam ilie s			fit of sft in nhs				Concepti ons of illness/T reatment	

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Context of illness - precipitating factors						Stuckness limitations med mod			The Past in the Present and the Future, the impact and relevance of SFT training	N E W N A M E		Context of illness - precipitating factors	moved to- Conceptions of illness/ Treatment	
Context of illness	multiple contexts of meaning				view w sft home in context proxim							Context of illness	moved to- Conceptions of illness/ Treatment	

ST Technique vs thinking

ST thinking different perspective

**contact with systemic psychotherapy**

					al to fam ilie s								
Awarene ss of illness context					vie w sft ho me in con text pro xim al to fam ilie s							Awarene ss of illness context	moved to- Concep tions of illness/ Treatm ent
Illness						Stuc kness limit ation s med mod						Illness	moved to- Concep tions of illness/ Treatm ent
personal interest								prom ologat ion				personal interest	person al interest

Exposu re to ST
Experi ence of ST

								'bashing' sft						
Power								promotion 'bashing' sft				Power	Power	
Focus on relationships not 'illness'	hope	complexity in including the family			view sft home in context proximal to families	Stuckness limitations med mod		fit of sft in nhs				Focus on relationships not 'illness'	moved to Inclusion of family	
Inclusion of family		complexity in including the			view sft home in con			fit of sft in nhs				Inclusion of family	moved to Inclusion of family	

		family			text proximal to families								
Commitment of families to ST treatment					view sft home in context proximal to families						Commitment of families to ST treatment	moved to Inclusion of family	
Language	multiple contexts of meaning				view sft home in con						Language	moved to language	

					text proximal to families								
Importance of Language/tone	multiple contexts of meaning											Importance of Language/tone	moved to language
Context					view sft home in context proximal to families	Stuckness limitations mod						Context	Context

Level of ST experience			access /distance in physical and in mind								Level of ST experience	moved - Experience of ST
Experience of ST			access /distance in physical and in mind								Experience of ST	moved - Experience of ST

Frustration with NHS system (barriers within the system)								prom ologat ion 'bashi ng' sft			Frustration with NHS system (barriers within the system)	moved to NHS context	
NHS - systemic process (how patients are moved through system)			thin kin g spa ce and nor mal ity			Stuc kness limit ation s med mod		fit of sft in nhs			NHS - systemic process (how patients are moved through system)	moved to NHS context	
NHS Context								fit of sft in nhs			NHS Context	moved to NHS context	
Psychotherapeutic/ ST Influences -	expe rien ce of sft		acc ess /dis tan ce in phy sica l and								Psychotherapeutic/ ST Influences -	moved to NHS resources	

			in min d										
Complex ity/NHS Context		com plex ity in incl udin g the fami ly		thin kin g spa ce and nor mal ity	vie w sft ho me in con text pro xim al to fam ilie s							Complex ity/NHS Context	moved to NHS resourc es
NHS reorgani sation				thin kin g spa ce and nor mal ity				prom ologat ion 'bashi ng' sft				NHS reorgani sation	moved to NHS resourc es



NHS resouces	mult iple cont exts of mean ing		acc ess /dis tan ce in phy sica l and in min d	thin kin g spa ce and nor mal ity		Stuc kness limit ation s med mod		prom ologat ion 'bashi ng' sft			NHS resouces	moved to NHS resourc es
Psychiat ric mindset	mult iple cont exts of mean ing					Stuc kness limit ation s med mod					Psychiat ric mindset	moved to 'being a psychia trist
Psychiat ry as a skill set	expe rien ce of sft										Psychiat ry as a skill set	moved to 'being a psychia trist
Psychiat ry needs to reflect on						Stuc kness limit ation					Psychiat ry needs to reflect on	moved to 'being a

profession					s med mod						profession	psychia trist
Relation ship - Wider Relation ship than Medical Model	mult iple cont exts of mea ning			thin kin g spa ce and nor mal ity				prom ologat ion 'bashi ng' sft			Relation ship - Wider Relation ship than Medical Model	moved to 'being a psychia trist
rigidity of labels versus confiden ce in own disciplin e					Stuc kness limit ation s med mod						rigidity of labels versus confiden ce in own disciplin e	moved to 'being a psychia trist
Role of psychiatr ist					Stuc kness limit ation s med mod						Role of psychiatr ist	moved to 'being a psychia trist

Role of psychiatrist vs. psychologists and other allied health professionals	multiple contexts of meaning										Role of psychiatrist vs. psychologists and other allied health professionals	moved to 'being a psychiatrist'
Expertise of systemic thinking				thinking space and normality							Expertise of systemic thinking	moved to ST thinking different perspective
perspective	multiple contexts of meaning						fit of sft in nhs				perspective	moved to ST thinking different perspective -

Defining ST				thin kin g spa ce and nor mal ity				fit of sft in nhs			Defining ST	moved to ST thinkin g differe nt perspec tive	
How psychiatrists conceptualise ST	multiple contexts of meaning			thin kin g spa ce and nor mal ity		Stuckness limitations med mod		fit of sft in nhs			How psychiatrists conceptualise ST	moved to ST thinkin g differe nt perspec tive	
ST perspective								fit of sft in nhs			ST perspective	moved to ST thinkin g differe nt perspec tive -	

ST perspective - engaging with the perspective and experience of patients and families	multiple contexts of meaning	complexity in including the family			view w/ soft home in context proximal to families						ST perspective - engaging with the perspective and experience of patients and families	moved to ST thinking different perspective -	
ST thinking			access /distance in physical and in mind								ST thinking	moved to ST thinking different perspective -	

ST importan ce of context							fit of sft in nhs				ST importan ce of context	moved to ST thinkin g differe nt perspec tive -	
Different perspecti ve techniqu e	mult iple cont exts of mea ning		acc ess /dis tan ce in phy sica l and in min d					prom ologat ion 'bashi ng' sft			Different perspecti ve techniqu e	moved to ST thinkin g differe nt perspec tive	
Applyin g ST	expe rien ce of sft										Applyin g ST	moved to ST Techni que vs thinkin g	

Technique vs thinking	experience of sft					risk management		fit of sft in nhs			Technique vs thinking	moved to ST Technique vs thinking	
Use of ST techniques	experience of sft		access /distance in physical and in mind								Use of ST techniques	moved to ST Technique vs thinking	
Use of St thinking	experience of sft										Use of St thinking	moved Use of St thinking	
Using ST	experience of sft		access /distance in								Using ST	moved Use of St thinking	

			physical and in mind										
Use of existing ST service	experience of sft					Stuckness limitations med mod		fit of sft in nhs			Use of existing ST service	moved to use of St services	
Using existing ST services	experience of sft	complexity in including the family		thinking space and normality				promotion 'bashing' sft			Using existing ST services	moved to use of St services	
Access to ST			access/ distance in phy		view sft home in con			promotion 'bashing' sft			Access to ST	moved to use of St services	



