Can a Structured Approach to Reflective Practice Enhance Team Skills and Influence Culture?

SIOBAIN BONFIELD & LAURA HAYES

Abstract:
Mental health support teams often deal with trauma-related processes that can manifest in: fractured relationships between consumers and teams; strong emotions and polarising opinions within teams and across service providers. All of which impacts on treatment and outcomes for consumers, with associated impacts on practitioner wellbeing and job satisfaction. Relational mapping, which comes from Cognitive Analytic Therapy (CAT), has been shown to enhance a team's ability to recognise and negotiate trauma-related processes, which include patterns of interaction that are happening at work. This small-scale research project applied relational mapping to two teams' reflective practice, including developing team formulations to enhance a relational response to treatment and improve team culture. It took place at an adult and youth sub-acute service for people living with significant psychological distress and challenges coping day to day. Twenty-six team members from a wide range of professional backgrounds took part, which included attendance at fortnightly reflective practice groups and completion of a range of measures at various time points. Qualitative data was also obtained through focus groups at the conclusion of the study. The results show significant improvement in participants self-reflection and shared reflection after attending reflective practice (between Session 1 and 2, ($t=-2.43$, $df=17$, $p< 0.05$ and between Session 1 and 3 ($t=-2.85$, $df=8$,$p< 0.05$) which was associated with the use of relational mapping ($r = 0.589$, $n=67$, $p=.000$, two tailed). Participants also reported improved relationships with consumers after attending relational mapping sessions. Qualitative results indicated that relational mapping increased participants' capacity to

Dr Siobain Bonfield is the Principal Psychology Educator and CAT Practitioner Victoria, Australia: SBonfield@phcn.vic.gov.au; Dr. Laura Hayes is the Research and Evaluation Manager at Mind Australia: laura.hayes@mindaustralia.org.au

respond consciously and differently to practice challenges but noted difficulties in attending sessions regularly due to rosters. In conclusion, relational mapping is considered a technique that can help facilitate reflective practice, team formulations and enhance team culture, with further evaluation indicated.

Keywords:
Relational mapping; team culture; reflective practice; Cognitive Analytic Therapy, mental health settings

Introduction

Relational mapping is a structured approach to reflective practice and is a technique from Cognitive Analytic Therapy (CAT) that has been used to support teams to recognise and negotiate patterns of interaction that are happening in any given context. It involves mapping dynamics through words and arrows on paper, to identify and better understand challenging or difficult experiences for the team. Relational mapping, and its derivatives such as 'Map and Talk,' has developed from the work of Steve Potter (2020) and has been applied to reflective practice and to the development of team formulations (Priddy et al, 2021). Such applications deepen understanding of what can be experienced in mental health and therapeutic work, including underlying trauma processes re-experienced relationally, and which is an essential component of the work (Kerr, 1999).

Cognitive Analytic Therapy (CAT) is the theory that underpins the relational mapping approach. CAT is not a theory of specific diagnoses but a model of the self and how we are as people (Corbridge et al, 2018). It explains how problematic relational patterns from the past continue to be repeated or re-enacted in present day relationships. The model proposes that experiences early on in life are internalised in the form of relationship templates (or reciprocal roles and reciprocal role procedures), with self, others and the world experienced through these templates. Thus, 'good enough' early life experiences will mean a person internalises a healthy repertoire of templates from which to draw upon when they relate to themselves and others. Equally, exposure to childhood adversity and trauma will mean a more limited repertoire of templates are internalised, reflective of harsh and damaging ways of relating to self and others.

Much has been written, over decades, about how mental health systems are particularly vulnerable to the impact of the work, with teams often mirroring the trauma-related processes of consumers seeking treatment (Menzies, 1960; Main, 1989; Walsh, 1996). The trauma-related processes can manifest as fractured relationships between consumers and teams, strong emotions and polarising opinions within teams and across service provides all of which impacts on treatment provided and outcomes for consumers (Dunn and Parry, 1997; Dreison et al, 2018; Ryle and Kerr 2020), as well as individual wellbeing and job satisfaction, team functioning and team culture (Bloom and Farragher, 2013; Ramsden et al, 2020). Indeed, it is not uncommon for teams to report conflict, exhaustion and burnout when working with people with mental health needs (Dreison et al, 2018).

To work effectively with people living with psychological distress and challenges coping day to day, that are in need of residential services, there needs to be a focus on the relational components of the work including the treating team's ability to think about and re-formulate relational dynamics that are part of a consumer's presentation, to recognise when individual practitioners, multiple team members or the wider system are part of an unhelpful dynamic and to explore different ways of responding, or relating, so as not to be perpetuate an unhelpful pattern that is happening (Kerr, 1999). Such awareness helps increase understanding of a consumer's psychological challenges, reduces reactivity that can result in decisions that (unintentionally) exacerbate distress and can make things worse, offers a corrective relational experience which can be a significant influence on a consumer's willingness to engage in their own recovery, help reduce stress and re-traumatisation and improve team cohesion (West, 2012; Nolan and Butler, 2017; Ryle and Kerr, 2020).

More broadly, relational styles of service implementation have been found to impact the service delivery and the ability of a team to function healthily (West, 2012). For example, Nolan and Butler (2017) presented the key learning from the delivery of a psychologically informed service for homelessness founded upon CAT, stating that the implementation of the service led to improved team resilience and improved the skills of staff members, which in turn reduced staff absences and improved continuity of care for clients. Other CAT-based interventions have also been associated with improved team cohesion (Thompson et al, 2008; Carradice, 2013; Kellett et al, 2014;). Relationally aware service provision may also positively impact client engagement with services (Onyett, 1999; Tait et al, 2002). 'Where services are inappropriate to client need, or insensitively delivered, then non-engagement with services as a reaction

to these experiences can be seen as a rational and active choice' (Tait et al, 2002, p.4).

More specifically, relational mapping has been successfully used with teams in the National Health System (NHS) working with people experiencing mental illness (Kemp et al, 2017; Potter, 2020; Ryle and Kerr, 2020; Mulhall, 2021). Relational mapping is a structured approach to reflective practice with teams supported to use the mapping to listen and pay attention to others and themselves, in the present moment; to notice relational patterns as they occur in the work and to use this awareness to enhance understanding of consumers and specific clinical challenges, team culture, and to support treatment response (Potter, 2017). Relational mapping is a useful and helpful tool that can be applied to reflective practice which, as a result, would strengthen team culture which mitigates against stress levels at work (Richter et al, 2011).

The current study took place with two teams working in an adult and youth sub-acute service for people living with significant psychological distress and challenges coping day to day. These teams often support consumers with trauma related distress with services delivered in collaboration within and between a non-government organisation (NGO) and clinical service and offering residential support for 2-4 weeks. Consumers of these services, like many other acute and subacute mental health services, often have a history of childhood adversity and trauma, and as such, patterns of relating can reflect these harmful experiences and underpin psychological distress and challenges. These experiences can often be attributed to people with a diagnosis of personality disorder, and specifically borderline personality disorder, yet it is not uncommon for similar problems to be experienced within teams, with other mental health problems, diagnoses or presentations (Ryle and Kerr, 2020). Further, consideration also needs to be given to the dynamics of the team and system itself, who can have their own historical trauma that can impact on their capacity to work with, and respond to, high levels of stress, adversity and trauma (Treisman, 2021).

Given that consumers of acute and subacute services are usually experiencing higher levels of psychological distress, it is more likely that templates associated with past harm will be re-enacted or repeated through the elicitation of either reciprocating or identifying counter-transference role enactments and which can be understood, in one way, by the unconscious drive to 'compulsively repeat' the traumatic past (Freud, 1914). Mental health service settings are as vulnerable to the impact of unconscious traumatising role re-enactments as the people who receive and deliver the service, with similar feelings and behaviours often emerging (Walsh, 1996; Kerr 1999; Bloom and Farragher, 2013). If these unconscious processes are not understood, then they can lead to both harm to the practitioners and team (through secondary or vicarious trauma), as well as the treatment response to the consumer (such as iatrogenic harm). Equally, being able to understand and formulate re-enactments can have multiple benefits for the team and consumers (Walsh, 1996; Kellett et al, 2014).

Given the context of this study, relational mapping was considered to be the most relevant and useful form of mapping that could be taught to teams to support them to identify patterns of interaction that are happening at work – with consumers, between team members and across service providers, influencing relational styles of interaction and enhancing team culture. Indeed, longer term use of relational mapping has been found to increase relational awareness that is, capacity to think and formulate dynamics that are happening between consumers and practitioners and between consumers, practitioners and the team, which leads to an enhanced approach to routine care and treatment, as well as make a difference to team culture (Potter, 2010). The objective of this small-scale research project was to evaluate the use of relational mapping to enhance team skills through its application to reflective practice, developing team formulations and team culture, as well as usefulness of mapping in practice more broadly. The mixed methods research aimed to examine specific hypotheses around targeted impacts via quantitative measures, as well as explore the broader experiences of practitioners through focus groups.

Methods

Design

This was a mixed methods prospective single group design, with data collected before and after implementation of the intervention.

Setting

The study was set in a metropolitan Adult Prevention and Recovery Centre (APARC) (for clients 16 to 65 years old) and Youth Prevention and Recovery Centre (YPARC) (for clients 16 to 25 years old). APARC and YPARC provide sub-acute care for people living with significant psychological distress and challenges coping day to day. Care is accessed as a step-up residential support where remaining in the community is challenging or

step down care so clients can move out of in-patient settings to access more recovery focused support with 24/7 care.

PARCs are a partnership model delivered jointly by clinical staff employed by a regional health organisation and community mental health practitioners employed by a specialist community mental health organisation partner (they are called SUSD in other parts of Australia). The partnership approach enables an optimal mix of clinical and recovery focused care aimed at a reduction in psychological distress and improvement in functional and personal recovery. However, it also means that different perspectives need support to be heard and integrated into practice.

Sample

The sample consisted of clinical and community mental health practitioners staffing the APARC and YPARC who attended at least one reflective practice supervision session in Relational Mapping.

The intervention

Fortnightly reflective practice groups based on relational mapping were delivered in an APARC and YPARC for all staff. Sessions were held from May 2022 to July 2023. Attendance was optional. Supervision sessions were delivered by SB, who has a clinical doctorate in psychology and has 10 years of specialist training in Cognitive Analytic Therapy and relational mapping.

The reflective practice used relational mapping and included the development of team formulations (when indicated for complex clients) and aimed to support a trauma-informed, collaborative, team culture. Attendees brought issues for discussion, including clinical material or experiences related to adult and youth sub-acute setting that would benefit from being understood further. Relational mapping was used to help track the details and dynamics of both the content and process of the discussion.

Ethical clearance

The study entitled 'Using Relational Mapping to Enhance Team Skills through Reflective Practice, Team Formulation and Team Culture at the PARCS' was given ethics approval through Peninsula Health Office for Research approval number 81429.

Consent

Joining the research was optional and consent was obtained before participants' first session.

Measures and data collection

Demographic data collected included: age; gender; ethnicity; education level; job title; employer; years of working experience; and work setting (APARC or YPARC) was collected.

1. Relational Awareness Measure (RAM): Part A is a 17-item self-report rating scale used to explore participants' experience of reflective practice; Part B is a 5-item self-report rating scale used to explore participants' experience of how much the mapping helped the discussion. The RAM can be used for individual self-reflection and shared reflection within teams. It is a contextual measure of an individual's capacity to link awareness of inner experience to interactions with others. Grounded in emotional and relational intelligence, the RAM assessed awareness of patterns of interaction and the qualities that help its development and orchestration within the chosen context (Potter and Bonfield, 2020). The RAM was given to participants after each reflective practice session.

2. Consultation Outcomes Scale (COS) is a 7-item self-report questionnaire used to explore participants' perceptions of the 'outcomes' of formulation and reflective practice. For example, 'the consultations have helped improve my relationship with clients'. Each item was rated using a visual analogue scale coded 0-13 in 0.5 increments, scaled 0 not at all to 13 very much. For each item, a qualitative response was possible to explain reasons for the rating (Fredman et al, 2018). The COS was collected after each reflective session.

3. The Team-Referent Emotional Intelligence Scale (TREIS) is a 16-item self-report measure which looks at team emotional intelligence that is, the collective ability to be aware, understand, regulate and use team emotions, and its link to team cohesion (Wei et al, 2016). The response format of this scale is a 5-point Likert-type scale from 1= (strongly disagree) to 5 (totally agree). TRIEIS was collected before joining supervision sessions and repeated six months later.

Data was collected at multiple time points including: prior to the study starting; post the 6-month reflective practice groups at the end of the study; and post every reflective practice group.

Qualitative data

Two focus groups, one at the APARC (four female and one male participant) and one at the YPARC (five female participants), were completed after 12 months of supervision sessions. Participants who were rostered on at the time of the focus group attended the session conducted on site by LH. Further qualitative data was collected through open-ended responses included with the quantitative measures.

Analysis

Qualitative analysis:

The focus groups were recorded and transcribed to text. The researchers read and re-read the transcriptions to become familiar with the content to allow the codes and themes to emerge from the data. Initial codes were identified by the researchers, through conversation and considering the hypotheses of the project and developing insights into its purpose. The codes were then grouped into broader themes, which were then reviewed and checked for coherence, relevance and representativeness of the data across both PARCS and clearly defined with a name that represented the essence of the content within each theme. Each theme was then summarised and supported with direct quotes from the transcript.

Quantitative analysis:

Data, identified by ID number only, was entered on to a spreadsheet for analysis. No missing values within scales were imputed because where data was missing, over one third of responses were missing (Elliot and Hawthorne, 2005). Skew was assessed and no data was non-normal.

Categorical data for demographics was reported as numbers. Percentages were rounded up to integers, means and standard deviations were reported to one decimal place and statistical tests to two decimal places. Repeated measures t-tests comparing pre- and post-supervision data were conducted to assess the impact of supervision. Two-tailed statistical probabilities were used because there were little or no previous studies in the area to support directional (one-tailed) hypotheses.

Effect sizes were calculated with Cohen's d. Cohen's classification of effect size was as follows: scores of d=0.20 indicate a small effect, d=0.50 a moderate effect and d=0.80 a large effect (Cohen, 1988).

Level of significance:

Level of significance was set at $p < 0.05$, with no Bonferroni adjustment (Rothman, 1990; Perneger, 1998).

Statistical analyses were performed using SPSS Version 26 (IBM Corp, 2019).

Results

Demographics

Twenty-six staff members consented to participate in the research between May 2022 and May 2023. Participants were recruited across the entire study period due to staff turnover. Nineteen participants identified as female and one as male (n=6 missing data). Seven identified as Australian, five identified as Caucasian or Anglo, three as some other nationality and three as 'mixed' (n=8 missing). Three staff indicated they had a diploma level of education, eight having a degree, four having a post-graduate diploma and five having a masters (n=6 missing data). Twelve staff were employed by the community mental health organisation and eight by the clinical partner (n=6 missing data). Ten participants worked at the APARC, eight at the YPARC and two at both (n=6 missing data). The range of mental health work experience was 6 months to 46 years, with an average of 10.3 years (SD=11.3) (n=6 missing data).

Experience of reflective sessions

The average number of sessions attended where a RAM was completed was 2.58 (SD=1.55) per participant. This ranged from completion of only one RAM (7 participants) to 6 RAM's completed (2 participants) (See Figure 1)

Descriptive analysis of the RAM Part A scores (participants' experience of reflective practice) showed an overall increase in total score as the number of sessions attended increased (see Table 2). Inferential testing was only feasible for comparing matched scores between Sessions 1, 2 and 3. There was a significant improvement in RAM scores between Session 1 and 2 ($t=-2.43$, $df=17$, $p< 0.05$, see Table 2) and Session 1 and 3 ($-t=2.85$, $df=8$, $p< 0.05$, see Table 2)

Table 1: RAM Part A outcomes and significance testing

	Descriptivestatistics			Paired Samplest-test – comparison with baseline ^				
	N	Mean	SD	Mean difference	SD	t	df	*P**
After 1 session	23	106.9	16.5					
After 2sessions	19	116.1	14.1	-11.6	22.9	-2.09	16	0.05
After 3 sessions	11	117.5	14.2	-15.6	4.8	-9.67	8	0.00
After 4 sessions	6	113.7	11.0					
After 5 sessions	5	123.6	10.3					
After 6 sessions	2	122.0	19.8					

*Significance 2-tailed

^ only calculated where sufficient matched records

~Mean difference for matched data only

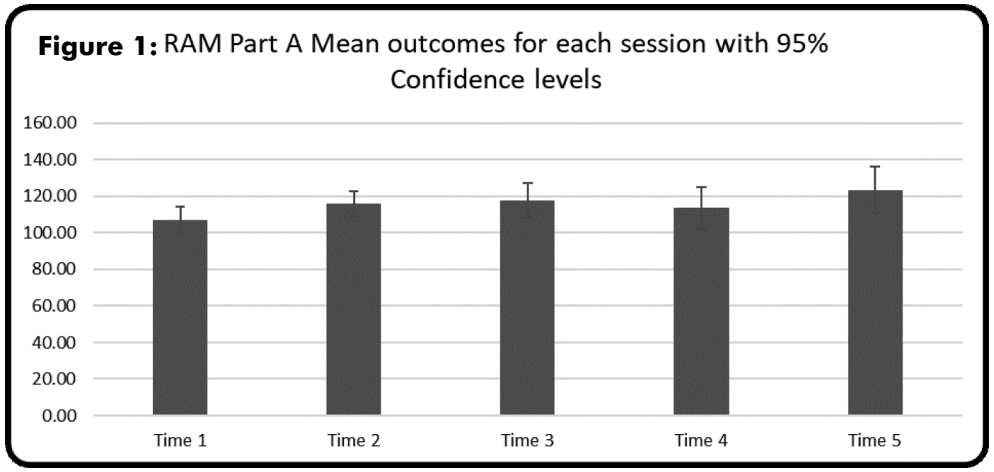
Table 2: RAM Part B outcomes and significance testing

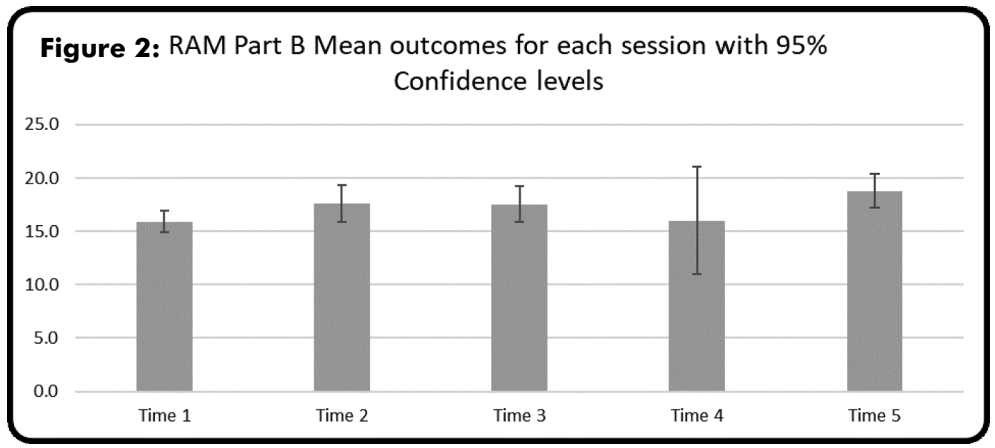
				Paired Samplest-test – comparison with baseline ^				
	N	Mean	SD	Mean difference	SD	t	df	*P**
After 1 session	26	15.9	2.51					
After 2sessions	18	17.6	3.52	-1.8	4.26	-1.83	17	0.08
After 3 sessions	11	17.6	2.46	-2.8	2.86	-3.27	10	0.01
After 4 sessions	6	4	16.0	3.16	-	-	-	-
After 5 sessions	5	5	18.8	1.30				
After 6 sessions	2	17.5	3.54					

*Significance 2-tailed

^ only calculated where sufficient matched records

There was a moderate significant correlation between RAM A and RAM B subscales scores of r = 0.589 (n=67, p=.000, two taled) across all times phases





Descriptive analysis of the RAM Part B scores (how much mapping supported reflective practice) showed an increase in total score (unmatched data) as the number of sessions attended increased (see Table 2). Inferential testing was only feasible for comparing matched scores between Sessions 1 and 2 and 1 and 3. There was a significant improvement in RAM B scores between Session 1 and 2 ($t=-2.09$, $df=16$, $p= 0.05$, and Session 1 and 3 ($-t=9.67.27$, $df=8$,$p< 0.05$, see Table 2)

There was a moderate significant correlation between RAM A and RAM B subscales scores of $r = 0.589$ ($n=67$, $p=.000$, two tailed) across all time phases.

Impact of formulation and Consultation Outcome Scale (COS)
Fifteen COS questionnaires were completed, with 14 having quantitative scores, 11 completing most items and eight adding open-ended comments. Average improvement across all items for all participants was rated was 8.9 (SD=2.9, n=11, Scale 0 not at all to 13 Very much on a VAS). Table 3 sets out ratings for the 7 individual items and qualitative responses to each question.

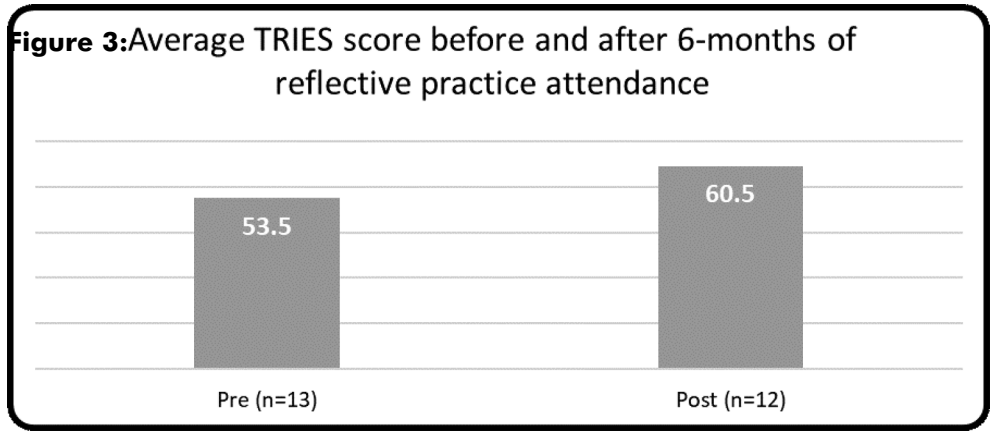
Table 3: Results for Consultation Outcomes Scale (COS)

CSupervision impact on…	N	Mean	SD	Comments on how the supervision impacted this domain
Understanding of practice challenges	14	9.5	2.6	Understanding emotions, seeing links between different thoughts and ideas, being less judgemental
Skills and practice	14	9.3	3.1	Increased communication skills, learning a new model
Learning applied in other situations	14	10.0	2.5	Could apply it to self-understanding or exploring any situation
Wellbeing and reduced work stress	11	8.8	2.8	Debrief and sharing experiences, understanding diverse thinking across the team, time to reflect together
Improved relationship with clients	11	8.0	4.1	Space to support reflection rather than reaction, understanding why some clients react in certain ways
Outcomes for clients	11	8.3	3.8	Greater understanding of clients and the challenges they are facing, identifying triggers
Meeting hopes and goals	9	8.8	3.8	Opportunity to debrief and explore practice challenges in a structured way
Average improvement	11	8.9	2.9	-

Team cohesion
Inferential texting on the TRIES (perception of team culture and emotional intelligence) did not show a significant difference between pre and post scores (see Table 4) whilst inferential testing increased across time (unmatched data – see Figure 3).

Table 4: TRIES outcomes and significance testing

Pre			Post			Statistics					
N	Mean	Std. Deviation	N	Mean	Std. Deviation	Mean difference	SD of difference	t	d	p	Effect size
13	53.5	14.1	12	60.5	14.6	-5.0	15.4	-0.2	7	0.39	0.32



Qualitative themes
Staff observed nuanced changes in their own practice, team skills and made suggestions for further implementation opportunities.

1. Impact on practice

a. Noticing patterns

Relational mapping was used during the reflective practice groups to

explore a particular clinical issue or case in more depth. This included identifying patterns of interaction experienced by different members of the team, which were not expressed overtly but enacted in relation to another. Picking up on patterns was an implicit aim of the project, in that it deepens a formulation of a consumer's presentation beyond diagnoses:'

> 'It was good to have a space to look at patterns that clients were going through and that we were maybe enacting as a team. I think we don't get a lot of room here to talk about that, it's busy. That was helpful.'

> '. . . thinking about feelings more complex clients might elicit in the team like frustration or annoyance or causing some people to want to provide more but other workers to feel more frustrated.'

Picking up on patterns of interaction and how they contribute to the therapeutic work was referenced:

> 'I think that part of CAT, the relational mapping, is identifying the patterns we're not aware of that we play out, I think if we can't identify the patterns that we're caught in they can get in the way of {the consumer's} recovery.'

The wording in the following quote illustrates the impact on practice, through 'picking up on patterns' as well as the internalisation of CAT thinking, given the use of language related to the CAT model and relational mapping more specifically:

> 'the signals that were coming through in the patterns…there was thinking about patterns of behaviour and what positions we get put in, people in the team and individuals in the team and reflecting on that, like I might be pulled into that position where you want to offer more and more, where that is coming from? and finding some kind of middle path.'

b. Understanding the patterns and what they mean

From picking up on patterns of interaction, some participants spoke about how this deepened their formulation of consumers including what was driving, or underpinning, their presenting behaviours and concerns, as well as ways of responding. More specifically, the following quote illustrates an understanding of self-harm, as 'a pattern' of relating or seeking help, and how this influences how others' respond:

> 'Talking about self-harm. . . you might have one clinician who responds in a way of being more nurturing, or what can I do to help? Or talk to the Doctor about sectioning them. You might have another clinician who is a bit more punitive or much more limit setting. . . So now it might be more let's have a think about why is the client expressing certain things? It might be that they're afraid of discharge because they feel like they're leaving all their supporters and they're really fearful of being all alone again. Their hopes would be maybe to have perfect support, to be perfectly supported all the time? '

c. Responding differently and thinking about 'exits'

Participants spoke about how the reflective practice groups supported the noticing, naming and negotiation of relational patterns of interaction often experienced as difficult and challenging. This included responding in ways that did not perpetuate unhelpful relationship dynamics or 'enactments,' which are called 'exits' in CAT.

> 'We think about how we do things and why, rather than just automatically doing things. . . let's think about that, let's think about what positions are we being drawn into {feeling like} we need to rescue them, or we need to do more, or becoming punitive or rejecting. . . and to be more aware.

> 'It might be more to think about okay, let's talk to the client about it, *you know, discharge is hard, I wonder if you might be a bit worried?* You can have different conversations rather than being reactive and being reactive in different ways depending on who the client speaks to.'

d.Self-reflection

The reflective practice groups provided an opportunity for the team to stop, think and come together to reflect on their practice, which is shown in the following quotes:

> 'It reminded me of critically reflecting on myself, I think it contributes to the team as well, obviously we have our own biases and beliefs and experiences and you might make a decision depending on that, but it's reminded me of when I'm doing something…why am I doing it? It's really helped with that reflection process for me.'

> 'If it's helping me improve my practice then I'm contributing….it contributes to the team and the service we're providing as well. I think if you're more mindful and wanting to improve your practice then it does improve the quality of the service.'

2. Team Skills

A fourth theme that emerged in the focus groups included specific discussion around the role of relational mapping on team skills and including culture:

> 'There was some space to reflect around the different team dynamics and space for different viewpoints to be talked about, not like there's one right or one wrong, it's just like what's happening here and where are we positioned?'

> 'If you can't work as a team, it's just not going to work on the floor in general and that's going to impact on the clients…..I think it was a respectful environment and people were able to voice their stuff, there was maybe a few moments here and there where it was a bit harder to speak out, early on, that's what I found there were a few moments where it was harder, people had different opinions and it can be hard to speak up, but later on not so much.'

> '. . . it was nice to have the space where we could sit down as a team and just discuss something, even to have the acknowledgment of knowing someone else found a situation really hard, was actually great.'

Within this theme, there was also discussion around skills such as being consistent as a team and supporting each other which, given the nature of the work, is fundamental for team cohesion:

> 'We talked more as a team, as opposed to the Mind workers or not the Mind workers – different workers responding differently, we tried to make it more *everyone responds in a similarly way*.'

> '. . . it was a chance for staff to reflect because I think a lot of the time, we don't get to do that because it's all about the client. So you end up having all this built-up frustration, so it's good to have your {reflective practice} session without seeming self-centered to talk about how you feel.'

3. Implementation Opportunities

This theme referred to practical issues around opportunities and challenges in delivering relational mapping supervision sessions and possibilities for deeper embedding of the approach:

a. Scheduling and continuity

Rotating rosters and varying work shifts posed challenges for workers to consistently attend the reflective practice groups, which ran on the same day and time each time, as illustrated below:

> 'The majority of the team work on shift rosters, not always the same people are on, that made it a bit tricky because you don't necessarily have the same people attending.'

Given that the attendance at reflective practice changed frequently, this had an impact on the project, making it difficult for learnings to be shared effectively across the team and for momentum to develop. One participant spoke about this specifically:

> 'People learnt something in one group, it might be another three sessions before they got back in {to another group} and the people who came in the week after, they didn't have the benefit of the last week's {group}, they got maybe a bit of a handover but they weren't in there, so they were playing catch up, again and again.'

It is probably that challenges in scheduling and continuity were exacerbated by the lack of training and preparation:

b. Training and Preparation

A one-day training that included an overview of CAT and core skills in how to map patterns of interaction to support a relational formulation and working was planned. However, given that this project was implemented during the tail-end of the COVID-19 pandemic, there were service constraints caused by a reduced workforce, which meant that it did not go ahead and the impact of this is clearly evidenced in the following two quotes:

> 'I was expecting that introduction which we didn't get, it went straight onto the mapping, I think people were confused by that and they had trouble keeping up.'

> 'The underlying theory, when people don't know it, discouraged them.'

c. Deeper embedding

Some participants suggested integrating relational mapping into the referral assessment process to support the team to be thinking relationally 'from the start:

> 'I think it's easy with young people to reinforce the role of their parents and re-enact that. I think we got pulled to do that and if we're not able to map it out we just end up being part of

> that…and often a really key precipitating factor to them coming in, something within their family, their patterns of responding can evoke us to respond like a parent would.'

d. Formulating early for referrals that cause anxiety
It was further suggested that there could be a space for the team think about referrals that can cause anxiety:

'information. . . that makes you go 'oh Jesus' and you start with an anxiety that makes you look at a person {consumer} differently because of the words that have been used instead of 'why did they do that?'

> 'I love that we can develop a formulation prior to someone coming in, that we can start. . . as a group. . . we are all consistent about how we're going to approach certain actions.'

Discussion

This small-scale research project aimed to introduce relational mapping into two teams working with consumers experiencing psychological distress and challenges coping day to day, residing for 2-4 weeks within a subacute setting. Its key objective was to evaluate whether relational mapping enhanced team skills though its application to reflective practice whereby the teams used relational mapping to notice, name and negotiate patterns of interaction happening at work. Given that underlying trauma processes are known to be re-enacted within mental health settings impacting both the people who receive and deliver the service (Walsh, 1996; Kerr 1999; Bloom and Farragher, 2013), we wanted to see if the mapping helped with the development of team formulations and to think and work more relationally, all of which would impact team culture.

Although the quantitative analysis was limited by small numbers in the available participant group and in limited matched data due to staff turnover (and poor execution of data collection), its results, alongside the qualitative data, indicate improvements in staff learning and team cohesion, and valuable insights linking consumer experience, staff experience and team dynamics. Indeed, the results show that scores on the Relational Awareness Measure (RAM) steadily increased in relation to the number of reflective practice sessions, suggesting that over time, participants felt more able to pay attention to relational patterns happening at work and to use this awareness to navigate and negotiate strong feelings and ideas which are often connected to underlying (and unconscious) trauma processes. The moderately significant correlation between Part A and Part B of the RAM, showed that there was a relationship between reflective practice experienced as containing, supportive and trauma-informed and the use of relational mapping in helping to identify relational patterns and keep track of the conversation by providing a structure to the reflective space. The average improvement on the raw data on the Consultation Outcome Scale (COS) suggested a favourable position towards the team having time to formulate experiences happening at work – a process associated with reducing unhelpful, and at times harmful patterns of interaction with consumers and between team members (Thompson et al, 2008; Johnstone and Dallos, 2013). Further, the average raw scores on the Team-Referent Emotional Intelligence Scale (TREIS) improved across time, suggesting a favorable position towards improved team cohesion.

In Victoria, Australia, where this project took place, it is common for partnership delivery of subacute services to occur (i.e. a non-government organisation (NGO) and clinical service). But such collaborations do not come without challenges, tensions, or perhaps 'splits', often experienced between 'non-clinical and clinical' services. Collaboration within and between services requires discussion and negotiate of challenges and tensions – a necessary part of teamwork yet not always an easy thing to speak about. It was anecdotally observed that most participants took part with enthusiasm and seemed to both enjoy and benefit from learning and using relational mapping. It was also noted that as the supervision groups progressed, there was increasing discussions around dynamics within the team and the team culture more broadly. This was referenced in the qualitative analysis, in relation to the recognition of the need for the teams to work together to provide a consistent approach, embrace different perspectives and 'integrate'.

This project focused on team skills because working in a mental health setting means exposure to experiences of trauma (or repetitions of past harm re-occurring within the context of current interactions and relationships), which understandably impact on practitioners and the work or treatment provided. Reflective practice is recognised as being essential for teams working in mental health settings (Potter, 2017) with many different models or structures applied. The findings of this study indicate that relational mapping is a valuable tool that adds structure to reflective practice within residential mental health settings. This value speaks specifically to the need of recognising that there are underlying trauma processes in play, that relate to the psychological needs of

consumers as well the dynamics of the team and system – and that the latter two are impacted over time by accumulative stress, adversity and trauma that happens within the workplace and that affects culture (Treisman, 2021). Having a structure, within reflective practice, for teams to speak about 'what is being enacted between us that relates to the work' will help with the digestion of trauma in the transference, reduce the repetition of unhelpful relational patterns and enhance relationships within the team sustaining people working in mental health settings over time Indeed, team culture has a role to play in sustaining people in work, or work environments, that can present a challenge, and in preventing the longer-term impacts of harmful environments (Thompson et al, 2008; West, 2012; Nolan and Butler, 2017). A more open culture for the exploration of experiences at work is an essential component of supporting teams to function well (Bloom and Farragher, 2013) and can reduce staff turnover which has cost implications for training, skill base and consumer care.

Implications

Given the increasing complexity in services and use of consortia and other collaborations to deliver integrated care, the use of reflective practice has an increasing role in building cohesive teams. As demand for mental health care workforce grows, there is an increasing need for effective implementable approaches to maintain staff wellbeing, reduce burnout and reduce staff turnover. Although preliminary, the results of the current study show that structured reflective practice approaches such as relational mapping can deliver improvements on these many levels.

Being able to speak about team dynamics, conflicts and culture, with diversity of perspectives held, is a sign of an emotionally intelligent team (Bloom and Farragher, 2013). This project provided a structure to enhance team skills that support relational understanding and working, as well as a culture of focusing on the team as part of the work. Although preliminary, the findings indicate that relational mapping would benefit from further exploration as a tool that is a mediating factor in enhancing team skills through reflective practice and team formulation. Further projects could examine the impact on staff wellbeing and turnover, reduction in stress, feelings of overwhelm, clinical uncertainty and self-doubt..

Implementation challenges

This project was implemented at the tail-end of the COVID-19 pandemic, which meant that the workforce was both depleted and reduced in numbers. The workforce constraints meant that the one-day training in relational mapping was not able to go ahead. Further, the workbook, developed to support the project, was also not available until half-way through the project. This impacted the implementation of the project, as was identified as a theme in the qualitative findings. It is indeed, thought necessary for training to occur to support the learning in 'how to' map relationally and that the workbook would support the development of this skill and deeper embedding into everyday practice. Given that a sustained period of joint mapping will develop a team's capacity to think and formulate relationally in the ordinary run of everyday work-life when not mapping (Potter, 2020) it is realistic to allow for up to two years for the development and deeper embedding of a new team skill. Whilst the findings in this study indicate participant interest in learning and using relational mapping as a tool to enhance understanding, communication, and intervention, it also underscores the importance of adequate training and support for effective implementation.

Limitations

The quantitative data obtained in this project was small, impacting effect sizes and overall findings. Staff turnover also meant that matched data was low. This may bias results as drop out might also indicate that the intervention was perceived as unhelpful. Given the limitations around the quantitative data collection, the qualitative data was able to add valuable insights into the impact of relational mapping and benefits to participants. For example, before the project the teams' had previously spoken about how certain dynamics have an impact, particularly 'splitting', with the qualitative findings indicating that awareness of relational dynamics had developed, with greater attention to, and recognition of, patterns of interaction being spoken about more generally and able to be used to better understand the psychological needs of consumers. The participants were keen to find additional ways to apply what they had learnt in the project to continue to improve the service, suggesting that it was experienced as having some value. □

Acknowledgements

Thank you to all participants for taking part in the project and for having a go at learning a new skill and being vulnerable when needed. Thank you to Steve Potter for his supervision and guidance throughout the project.

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