Creating Dialogic Contexts for Multidisciplinary Clinical Reviews: The Reflecting Team Process

Roxanne Garven
Systemic Consultation Centre, Perth, Western Australia

When multidisciplinary teams review their work, it is common for clinicians to hypothesise about their clients from the perspective of their role or theoretical model. The outcome of this review process may depend on the team's views. Here the epistemological position taken by team members about reality and objectivity can lead to starkly different pathways. There can either be a dialogue about different hypotheses, with the team jointly constructing new meanings; or, conversely, there can be a monologic exchange based on competition between different hypotheses. This paper explores why teams may struggle with coordinating different theoretical approaches and models. It suggests the dialogic nature of a reflecting team process offers one approach for helping teams to find ways of 'putting their differences to work'. Ideas for implementing this process within multidisciplinary teams are illustrated with comments provided by teams who have begun to experiment with this approach.

Keywords: Multidisciplinary, isomorphic, clinical reviews, dialogue, reflecting team.

Integrating Disciplines and Skills in Multidisciplinary Teams

How does an ethic of hospitality translate into everyday clinical practice and team functioning? For me it suggests an integrative model for child and adolescent mental health services that utilises the unique roles, skills and training of all team members, whether in biological psychiatry, social work, cognitive psychology or family therapy. Integrated teamwork values multiple frameworks and perspectives in the complex and difficult work of therapy with children, adolescents and their families (Larner, 2003, p. 215).

Many organisations in the helping professions such as those supporting individuals and families with mental health, drug and alcohol problems, or intellectual disabilities contain multidisciplinary teams. The rationale for a multidisciplinary approach is to be able to offer an 'in house' comprehensive assessment and treatment...
approach for the complex work inherent in these fields. These teams are often comprised of a mixture of psychiatrists, medical practitioners, psychologists, nurses, social workers, occupational therapists, speech therapists, and dieticians.

Clinical review meetings are regularly arranged so that the various skills and roles held by the different members of multidisciplinary teams can be employed for the benefit of the client and the clinician. In this regard, Rhodes et. al. (2011) illustrate the use of the reflecting team as a means of introducing systemic hypothesising for multidisciplinary teams working in the area of intellectual disabilities. The intent is to create a ‘reflective practice’ approach in which clinicians become more cognizant of links between behavioural interventions by the agency and systemic family relationships.

In my experience, as a past team member and currently as an external consultant to multidisciplinary teams, harmoniously synthesising a variety of skills, roles, and theoretical models is not an easy task. One of the restraints seems to lie in a natural and common response, which is to offer one’s model as a solution to a colleague’s case. This process of embedding our preferred clinical theory into review or consultation contexts has an isomorphic quality, in that an individual’s ideas or thinking tends to be moulded into the same shape.

Within a multidisciplinary setting, the consequences of this process can be either confusion, as a flurry of different maps and frames are offered; or competition, as clinicians lobby for their model to become the preferred one. This is illustrated in Figure 1 below. Though there may be a variety of ideas in the room, this does not guarantee a discourse that is inclusive of these differences. As Trimble (2002, p. 275) describes it: ‘In groups, one voice may dominate and silence all others, or all participants may subordinate their individual voices to generate a single monopolistic perspective. Despite the appearance of more than one point of view in polarised disputes, such discourse is monologic because the participants are single minded in
their commitment to their positions, attending to their opponents’ utterances solely for the purpose of refuting them.

Conversations with colleagues and observations of team reviews over time have led me to think that these occurrences may be quite common. In the last three years, I have used a Reflecting Team Process (RTP) as a way of offering a different context for clinical case consultations within multidisciplinary teams in child and adolescent mental health, adult mental health, disability services, and drug and alcohol treatment centres. This began with a wish to find ways to minimise the monologic effects of isomorphic responses, in order to include the different ideas held by the team. It was hoped this would then help the team to jointly create new ideas or perspectives.

It was also important to help the team focus on the presenter’s hypothesis and experience before delivering their views on the case. Lastly, I wanted to place the presenter in a different context, one that allowed them to actively contribute to the development of new ideas without having to field a range of diverse, often disconnected ideas and strategies from the group.

**Effects of First and Second Order Contexts on Isomorphic Processes**

When a therapist is struggling with a case, it is natural to offer one’s own pathway out of confusion, but if it is not the natural path for the therapist, further confusion usually follows. If the team were to decide to try to offer pathways to each other, based not on their own preferences, but on that of the one presenting, what would that be like? (Boston, 2010, p. 37).

As mentioned earlier, isomorphic responses are seen as naturally occurring processes; however, this paper suggests that the context in which they occur is all-important. For example, when isomorphic responses emerge in first order or modernist contexts, therapists are more likely to believe in the existence of an objective external reality and to view their approach and its attached hypothesis as correct. Because their formulations and hypothesis are not seen as representational but as truths, a monocular or singular view of events will ensue. This may elicit competition between the different approaches in the team, or confusion because other approaches may be similarly offered in this monocular, modernist way. Certainty in one’s position is a natural effect of such stances and this will seep into the team discourse.

A recursive, reinforcing pattern may then develop over time, in which first order views are expressed with a corresponding form of dialogue, one that is certain and closed to the ideas of others. Trimble (2002, p.276) speaks of this as follows: ‘Once established in monological positions, however, they become cut off from emergent, not-yet-spoken possibilities for action. Their relationships become thin as they engage only with others who support their monological positions, resisting those who contradict them and avoiding those who are open to seeing things in new and unexpected ways’.

However, when isomorphic processes occur in second order and postmodern contexts, a different picture emerges. Here, therapists are more likely to view reality as constructed jointly with others through dialogue. For first order cybernetics, there is a belief one can stand outside the object being observed and define one’s descriptions as objective facts (Hoffman, 1985). However, a second order view
proposes it is impossible to separate the observer from the observed, so a description of a system involves an act of observation (Maturana & Poerksen, 2004). For example, diagnoses or formulations constructed within second order frames are viewed as hypotheses, not as objective truths or facts.

In other words, reality is open to multiple versions and to negotiation. Therapists are more likely to view their formulation as a personal construct that has been socially constructed with others. This breeds a more open dialogue as it is easier to be speculative about one's ideas in relation to those of others. As Bertrando (2007, p. 89) says: 'We may define our therapy as “dialogic” ... only if the therapeutic conversation acquires the characteristics of dialogue as delineated by Bakhtin (see also Seikkula, 2003): that is, a polyphonic cohabitation of different discourses and different visions from which a new vision — a new language — may possibly emerge, but where the difference of discourses is accepted in any case'.

Bertrando's quote on the dialogical response illuminates its relevance to multidisciplinary teams. It suggests that, by remaining open to the discourse of others and tolerating the discomfort this may bring (to one's beliefs, identity, position), an assimilation of these different discourses may emerge through the team dialogue. The appeal of this idea for teams is that a new perspective develops, carrying within it the contributions of the varying team discourses. This outcome reflects one of the key ideas of the dialogic stance, which is that individual team members do not have to silence their views or hypothesis, but be willing to engage in a struggle to both be understood and to understand the view of the other. Out of this engagement, the views and the discourse of the interlocutors alters as it encounters the responses of others.

Now, one way of inviting teams to participate in this dialogic environment is to use a reflecting team approach, with second order and postmodern ideas. The next section looks at this in more detail.

The Reflecting Team Process and Dialogue

The RTP offers a way of creating dialogic contexts for multidisciplinary teams. Reflecting teams created a swift and radical shift for family therapists. Before their advent, the team and supervisor sat behind a one-way screen, with the therapist returning to the team for feedback in a mid-session break. This protocol was broken when Tom Andersen (1987), struggling to effect changes in a supervisee's relationship with a family, decided to allow the family to hear the team's responses and views by switching the lights and sound between the two rooms. This creative and practice-sensitive response initiated the adoption of reflecting teams by many family therapists and teams, worldwide.

The RTP as practiced today is more deliberate and involves an interview occurring in front of a silent and observing team. At any particular point, but commonly half way through, the interviewer and interviewee cease their conversation. The team turns towards one another to discuss their responses to the issues explored during the interview, whilst the therapist and family listen to these team reflections. Once the observing team has finished its conversation, the interviewer resumes the interview and explores the interviewee's responses to the team. The reflecting team observes this final phase in silence.
In this part of the paper, I want to illustrate how the ideals and structure of the RTP encourage a dialogical context, which, in turn, may help multidisciplinary teams to integrate their different approaches and skills during clinical reviews.

Though the RTP began as a response to a supervisory difficulty and, therefore, could be viewed as more practice driven than theory driven, it nevertheless carried within it influences of the time, such as Milan systemic therapy. When Andersen (1987) switched rooms (in the late 1980s) postmodernism was also making its presence felt in family therapy. One wonders whether the then novel feature of inviting families to respond to the team’s ideas was a sign of this emerging framework. As Flaskas (2011, p. 90) writes: ‘Postmodernism is in part a frame for how we think about our relationship to the world, what it is we are trying to “know”. In this sense, postmodernism is meta to any specific social theory and postmodernism is an epistemology as much as it is a meta theory frame’.

The question arises: Would an openness to, and an interest in, the family’s feedback have been possible in the earlier modernist days of family therapy? A postmodern and social constructionist epistemology guides many reflecting teams today. Here, the role of language and emphasising context and relationships are primary in understanding how meanings (reality) are negotiated and constructed. This influences the type of dialogue and interactions one has with others, as well as how differences are responded to.

The dialogic offshoots of postmodern influences include a questioning of assumptions, which metaphorically ‘turns things upside down’ in order to explore other possibilities and interpretations. To do this, therapists relate to their hypotheses as constructs (not facts), and recognise being continually influenced by their own history and biases and their position within a context, while remaining sensitive to the recursive processes between themselves and the family they are working with.

Reflecting teams operating within these postmodern frames strive to remain open to hearing different meanings and avoid assuming to know the reality of the other’s experience. A dialogic offshoot of this, as Seikkula, (2011, p. 184) comments, is a shift from asking questions in order to intervene, to asking types of questions that focus on ‘listening and responsively responding’. These postures view the world in a more open way and encourage a tolerance of uncertainty. Holding uncertainty is even framed as a value, not as a deficit: ‘I would suggest that when we become less certain we are more likely to become receptive to other possibilities, other meanings we might put to events. If we can become more open to, the possible influence of other perspectives, we open up space for other views to be stated and heard.’ (Mason, 1993, p. 193). For social constructionists, language and knowledge are intertwined with a resistance to ‘knowing too soon’ (Anderson & Goolishian, 1988), and efforts are made to keep the conversation open.

In a multidisciplinary team context, this means its members stay within the parameters of their colleague’s request, and team dialogue is expressed in tentative, suppositional and speculative ways. This intertwining of language and knowledge also leads team members to connect their responses to what has been heard and to strive to deepen understanding by asking questions in relation to a current theme or expression. This intention again echoes the influence of Bakhtin, who states: ‘Each word “tastes” of the context and contexts in which it has lived his socially charged life; all
words and forms are populated by intentions. Contextual overtones (generic, tenden-
tious, individualistic) are inevitable in the word' (cited in Bertrando, 2007, p. 156).

Another important dialogic feature of reflecting teams is they resist giving advice
and, instead, focus on creating a dialogue through which everyone jointly examines,
wonders, questions, and reflects on the dilemmas presented. This allows curiosity
and exploration to prevail over solution finding, which demonstrates a respect for
the autonomy of the listener. A dialogic approach includes a different type of listen-
ing, which is tilted towards understanding the therapist's intentions; grabbing the
words and language used to describe experiences; listening out for feelings, strug-
gles, and the meanings ascribed to actions and the overall situation.

Finally, reflecting teams, especially when they take a narrative therapy focus,
listen for situations and times in which the problem was not as strong or was absent
(White, 2007), and display curiosity about these differences.

A Structure for Reflection and Dialogue
In my opinion, the RTP structure holds much value for multidisciplinary team
discussions. When teams decide to use it for their clinical reviews, they simultaneously
decide to sit, talk, and listen differently from their usual review process. The RTP
process is often more unplanned and 'free flowing.' For example, in a reflecting team
clinical review, the presenter may agree to be interviewed by a team member in front
of their colleagues, who then sit back to listen and observe this conversation. This
clear role clarification allows the interviewer and presenter space and time to jointly
develop and connect a variety of ideas and themes together. The structure orientsthe
interviewing colleague towards developing a discourse that is focused on the presen-
ter's case and is open to the influence of his or her response, so that new connections
are more likely to emerge for both participants. This contrasts with more traditional
team reviews, where the presenter is placed in a position of responding to a diverse,
disconnected range of ideas from the whole team.

The RTP structure also has influence on the team, who, separated from the
interview and freed from asking questions, can observe and listen. Instead of
propping up one’s ideas, listening occurs in order to understand the other. Here,
Lowe (2005, p. 70) refers to a response that I believe is common in unstructured
clinical reviews: ‘We can easily fall into the habit of listening in order to speak, in
the sense of listening for opportunities to ask the next question in the sequence. We
may listen just enough to cue our next question, and then cease attending to what
the client is saying’.

It is when the interview breaks for the team reflections, that individuals in the
team can face each other and converse with one another. This shift in seating arrange-
ments acts as a spatial reminder to connect responses to one another and boosts the
dialogic aspect of their efforts. Knowing that their presenting colleague is sitting back
and listening to their conversation also affects their direction and language. It becomes
easier to remain focused on the presenter’s wishes, to be nonjudgmental, and to
concentrate on developing ideas that may be useful for their colleague.

Lastly, separating presenters from the team’s conversations and placing them in
an observing and listening position frees them from having to listen in order to
respond. This position helps the presenter to mentally step back from the case and the struggle, so that they are more able to reflect on their colleagues’ responses. From this more relaxed position, new images, metaphors, and ideas may emerge. This is similar to family therapy sessions in which family members, when listening to the reflecting team, reflect on their positions in relation to the problem and to one another. Out of this process, new perspectives may emerge.

**Implementing a Reflecting Team Review Process**

Typically, in consultation/supervision groups, members are eager to share their expertise (whether in the form of questions, suggestions, etc) with the presenter; when this is done too enthusiastically, the presenting therapist may, like a client, feel overwhelmed as well as judged, incompetent and so forth. (Anderson, 2007).

This section outlines the map and general steps I take when using an RTP for multidisciplinary clinical reviews, and also provides a detailed example. Figure 2 illustrates the RTP for reviews.

**Part 1. The Presenter is Interviewed in Front of the Team**

*Step 1. Negotiating the focus for the review.* A team member is invited to present a case, along with a genogram, which maps the helping network, the family, and significant others. The presenter is then asked to choose the type of review he or she would prefer. There are (at least!) two ways in which this can happen. They may choose to have a colleague interview them, with the rest of the team forming a reflecting team, or they may prefer for the group to ask questions, reserving their

![Diagram](https://via.placeholder.com/150)

**FIGURE 2**
The RTP for reviews.
hypothesis and suggestions for intervention for a reflecting team discussion. (See Map 2, page 295).

If the presenter chooses to be interviewed by a colleague, teams may want to work out beforehand how the interviewers will be chosen. Some teams select colleagues who know the least about the case and/or who are not familiar with the presenter’s work. The presenter and the interviewer sit together, whilst the rest of the multidisciplinary team form a circle and sit apart from this pair. This spatial arrangement facilitates the distinction between the two roles of the reflecting team and the presenter–interviewer dyad. Team supervisors join the reflecting team, and external consultants who may be facilitating the process may either sit apart to assist with the interview or join the reflecting team.

In order to create a context for the review and to gain clarity about the presenter’s wishes, the presenter is asked these three questions: Why was this particular case chosen? Why now? What are your hopes for the review? For example, they may want new hypotheses as well as ideas about how to take a different position with the family. The presenter’s hopes for the review are written on the whiteboard to act as a reminder for the ensuing questions and discussions. If the nature of the presenter’s concerns alters during the interview, the interviewer can check in to see if the original request has altered.

**Step 2. Exploring the wider context, the referring system, and the family’s relationship to change.** This highlights the involvement and role of other helpers and understanding the context of the referral. Going back to the beginning may help to understand the current impasse. This step accrues information on the family’s ideas about change, their referral to the service and opinions about the involvement of other helpers. For example, it may elicit information about differences between parents concerning their child’s diagnosis (the mother may perceive her son as having an obsessive–compulsive disorder, but the father may see the same behaviours as defiance), and the influences of those different views on their interactions with their child and the agency.

This step also explores the relationships within the helping system and the presenter’s position within that system (Reder & Fredman, 1996). For example, in some instances, the agency would like to close the case, but reactions from the family and the helping network prevent this from happening, and the clinician’s struggles need to be considered within this larger context.

**Step 3. Exploring the clinical impasse.** This explores several levels, including the nature of the impasse, the presenter’s hypothesis about the problem, and how this affects the position the therapist takes with this family. Using the ideas of punctuation (Keeney, 1983), it is helpful to understand what distinctions the therapist is drawing, as informed by premises or habits of thinking. This determines how we describe an episode, which, in turn, constructs our experience of those events. The significance of these distinctions is they point towards a belief or explanation held by the therapist that is helpful to understand and evoke.

In practice, this implies being curious about what is experienced as difficult for this clinician: What is particularly worrisome about this work at the moment? How come this is a problem for you? Likely answers fall into categories such as: ‘This
impasse signifies my incompetence’, ‘I feel hostile towards this family, which means that I am unsympathetic’, ‘I want to tell this family what to do, but I know that giving advice is wrong, I don't know what to do next.’ The responses given to these answers are significant in helping the reflecting team understand any particular expectations that may be held by their presenting colleague and in exploring whether those expectations are restraining the colleague from resolving the impasse. For example, some clinicians may feel that giving direct advice is to be avoided, yet the situation may benefit from openness and directness.

**Step 4. Exploring the presenter's relationship and position with the family.** This assumes a second order perspective, in which the views and reactions of the therapist and the agency are included in the overall understanding of the case. Dyadic circular questions (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980) are useful in helping the presenter become an observer of the relationship. For example: If the family were here, and I was to ask them how the work was going, what do you think they would say? How would they describe the position you have with them? How would they describe their relationship with you?

**Step 5. Exploring the presenter's preferred picture of the therapeutic relationship and direction for the work.** This exploration moves the conversation towards the future and begins to invoke difference and new possibilities. (Bateson, 1972). It helps the presenter envision a preferred picture that narrows the gap between their hopes for the work and the current situation. (de Shazer, 1991) For example: What would you like to see different in the relationship and in your therapy with the family?

**Part 2. The Reflecting Team Reflects on the Conversation**
When the interview comes to a natural break, the team begins a reflecting conversation. In most cases, the interviewer and presenter stay out of this discussion. The stance and type of dialogue created by the team is guided by the ideas about RTP mentioned above. With teams that are new to reflecting team processes, the external consultant gives guidelines to help with this stage. These guidelines are, generally speaking, ones that encourage the team members to connect their ideas with one another: to frame questions and feedback in tentative and speculative language, to be guided by curiosity, so that the overall intention is to deliver and perceive their suggestions as 'offerings' for their colleague. Team supervisors who may be guiding this process for their teams can also outline these guidelines for their teams.

**Part 3. The Presenter's Response to the Team's Reflections**
At the end of the team's reflections, which can last up to 10 minutes, the interviewer turns to the presenter and asks for a response to the team's ideas. The interviewer may also add another question to help develop unspoken and emerging new ideas: During this conversation and in listening to the team, have any new ideas or questions surfaced, either around seeing or doing something differently? The presenter then 'has the last word' and shares any new thoughts or decisions about the case.

Below is an illustration of the RTP process in an adult mental health clinical review. I was an external consultant to this clinical review, and began by providing guidelines for the interview and for the reflecting team. I was also a reflecting team member.
Roxanne Garven

Illustrating a Reflecting Multidisciplinary Team Review

Jane is a social worker in a community mental health clinic in Perth, Western Australia. She is presenting her client, Robert, a 29-year-old man referred to the clinic by his G.P. for anxiety treatment. Her team consists of two clinical psychologists, a psychiatrist, two mental health nurses, and an occupational therapist, all of whom are present at this weekly clinical review. They decide that Sarah, one of the team’s mental health nurses will interview Jane in front of the others, who form a reflecting team. Throughout the interview, I took the position of an ‘in-room consultant’, which meant that I sat close to Sarah, and slightly behind her. Any questions or comments I had were directed to her, for her to ask Jane. Sarah also had the option of turning to me if she wanted to discuss a particular issue arising from the interview.

Step 1. Negotiating the focus of the review. Sarah asks Jane why she has decided to review her work with Robert: ‘What is it about this work that helped you decide to pick Robert from your caseload?’ Jane describes feeling irritated, confused and describes the work as ‘going nowhere’. She tells Sarah that she has been working with Robert for six months, since his referral to the clinic for anxiety management. Robert visited the G.P. with concerns about chest tightening and difficulties in breathing. The team learns that Robert lives at home with his parents and works as an IT consultant for a large mining firm. Robert has never had a relationship with a partner; however, he has many friends. Jane tells Sarah that Robert had lap band surgery two years ago and has lost 80 kilograms. In the last year, he has become attracted to a woman at work, and feels anxious about asking her out.

Sarah asks Jane how she would like the review to help her, and also enquires why she has brought Robert for review at this time. Jane replies that she wants new ideas for helping Robert to ‘get on with his life’, as well as some ideas to help her understand his reluctance to move forward; for example, asking his work colleague out. Regarding ‘Why now?’, Jane has felt increasingly frustrated with Robert; she was feeling impatient with his cautiousness and was scared of becoming ‘pushy’.

Sarah writes these key points on the board.

Step 2. Exploring the wider context, the referring system, and Robert’s (and his family’s) relationship to change. The genogram is drawn on the board, which includes Robert’s family, his employment, and his relationship with his G.P. and with Jane and her system. Important dates and timelines are also noted, for example, the date of the lap band surgery and his first symptom of anxiety.

Sarah and the team learn that Robert is the youngest of three brothers, his parents are from Northern England and that according to Robert his parent’s marriage is ‘fragile’. Robert’s two elder brothers are living in other states, the last son departing three years ago. Robert saw this as a distressing time for his mother. He describes being his mother’s confidante, as she will often complain to him about his father. He often stays at home to keep her company and goes to films with her. Jane tells Sarah that Robert believes that his mother has had depression for many years but won’t seek help. He feels both sad and angry about this.

Sarah asks Jane if relationships have changed for Robert since his surgery and weight loss. Jane replies that, since the surgery, Robert complains that his parents are not supportive of his new eating plans. When he asks for lighter meals, he
believes his mother sees him as demanding and ungrateful. He describes both his parents as overweight and unhealthy and believes his father drinks excessively. Robert does not express his disappointment with the perceived lack of support, and tells Jane that he feels more upset with them than before.

Robert wants Jane to help him feel less anxious and more confident. He would know this was happening when he saw himself asking his female colleague out. When he thinks of doing this, or sees her, he experiences the symptoms of chest tightening.

**Step 3. Exploring the clinical impasse in detail.** Sarah asks: ‘Jane, what is the most troublesome aspect of your current work with Robert?’ Jane replies that, while on the surface her interventions (cognitive behaviour therapy, psycho-education) seem to work, in that they raise awareness for Robert, there is no change in his behaviours. She feels frustrated with this lack of progress and wonders whether Robert can change, or whether she is skillful enough? Jane believes he should start taking risks, for example, asking his colleague out, but though he agrees, he stalls at each opportunity. Another distressing aspect for both Jane and Robert is that he is now beginning to feel despondent, and tells Jane that he knows he is letting her down.

**Step 4. Exploring the nature of Jane’s relationship and position with Robert and his family.** Jane is working with Robert alone because he has refused to have any family involvement. Sarah then asks Jane: ‘How does Robert see your efforts and work with him? What would he say your thoughts are about the state of progress?’ She says that Robert would say that she is energetic and positive and would describe her as a ‘motivator’. He would say that she wants him to be more courageous and to start taking risks.

At this stage, I speak to Sarah about my curiosity about Robert’s parents and their ideas and feelings about Robert attending the clinic, their views on his diagnosis and his relationship with Jane. Sarah follows this up and asks Jane: ‘Jane, what do you think Robert’s parents think about your work with him and him being a patient of this clinic?’ Jane seems surprised with this question and says this is an interesting area. She isn’t sure, but wonders whether his mother may feel uncomfortable with her son coming here, and talks about their closeness. Robert has mentioned that his father sees this help as unnecessary and Robert feels he is disappointing his father. This area of exploration seemed to be of value as it served to connect the agency’s actions and relationship with Robert in a broader, familial context. It had the potential, therefore, of offering an additional perspective on the ‘problem of Robert’s reluctance to change’.

**Step 5: Exploring Jane’s preferred picture of the therapeutic relationship and direction for the work.** Sarah asks Jane: When you think of your work with Robert and the way the therapy is progressing, are you comfortable with how things are at the moment? This question seemed to help Jane take a step back from the work, as she became silent for a while to reflect on her response. She replied in the negative, saying she feels useless as well as pushy and impatient. She can see the great potential in Robert and feels saddened by his ‘stuckness’. Sarah then asks Jane how she would like to see it differently, to which Jane replies that she would like to feel more patient and believes she is not understanding Robert fully; and that, if she did, she believes she may have more patience.
Part 2. The Reflecting Team Give Their Responses

At this stage, Sarah and Jane sit back to listen to the team conversation that lasts for 10 minutes. The team begins by commenting on Jane's persistence and energy to help Robert. They are impressed with the difficult feelings she is experiencing (feeling incompetent, pushy), and yet how she strives to consider different ways to help him. They wonder how she has resisted giving up and still has energy for the work with him.

The team remind themselves of the parameters Jane has given them: new ideas to understand Robert's reluctance and to help him 'move forward'. As a reflecting team, they begin to converse and speculate around the following themes:

- Was there more or less anxiety before the lap band surgery and weight loss? The team speculated whether the loss of weight had made it easier for Robert to consider entering into a relationship, as well as his noticing others being attracted to him, and whether these have possibly brought new doubts about how to handle these new experiences?

- The team was then curious about how Robert relates to uncomfortable feelings. They wondered about the role of food in Robert's life, and wondered whether, in the past, Robert used food to 'self-soothe.' This lead to more questions on wanting to know which situations bring on difficult feelings and, in the past, before the surgery, how Robert would have related to them and responded to them.

- The conversation then expanded to consider how such anxiety makes sense: What if this was the first time Robert was learning about responding to emotions without resorting to food? A team member then speculated on the role of medication — is there a possibility it could prevent Robert from learning? Would the medication be in danger of replacing food? This introduced ideas around framing the medication as a stepping-stone and as time limited.

- A team member referred to an image of anxiety as a 'parachute', slowing Robert's transition so that he could adjust to a self through whom he learnt about relating to new circumstances (e.g., attraction to the opposite sex) and to the new feelings they may bring.

- Another team member reflected whether Robert wasn't the only one that needed time to adjust to the lap band changes. She wondered about the changes that would occur in his relationships at home, and whether he may feel 'disloyal' to his mother as he ventured into a future with partners, whilst also demonstrating his difference and individuation through eating differently.

- Another team member speculated how this reframe of anxiety would affect Jane? If she were to decide to view it like this, would there be differences in her work?

Part 3: Jane Comments on the Reflecting Team's Responses

Sarah asks Jane how she felt about the team's conversation, and whether there were a few aspects and themes that struck her as interesting and useful. She replied being struck with the metaphor of anxiety as a parachute for Robert and believed he would enjoy that image as well. This change of perspective made her consider the sense in Robert's caution, and she speculated her efforts may be pulling against this. As a result, Jane wanted to explore with Robert how his feelings were managed in...
the past, whether food played a role and how it felt now, since making a decision to lead a healthier life.

Jane was asked whether there was anything else that stood out for her. Jane said she was also interested in exploring with Robert how he believes his changes (weight loss, therapy, and interest in developing a relationship) would influence his relationships with his family. She was interested in how he felt about any distance that may develop between him and his parents and how he would like to perceive and respond to them. She said she was also beginning to see him as a caring, sensitive man and son.

Lastly, Jane said she wondered whether Robert felt that the therapy had placed him in a dilemma. He may have been aware of her wanting faster progress, whilst also aware of his own anxiety and his parents’ possible discomfort about this. Given he comes across as a caring and kind person, it is possible that he felt he was ‘in the middle’ and not able to please either party. It was likely that he would not speak of this either. She wanted to explore this with him as well. She thanked Sarah and the team for their helpful reflections, saying she felt less despondent and ineffective and had some new pathways to explore with Robert.

Although the above illustrated one map for implementing an RTP review, the next section presents an alternative map.

**Map Two: The Team Interviews the Presenter and Hypothesises Using a Reflecting Team Process**

In this situation, the clinician, guided by the three questions, presents the case in a similar way to the previous structure. This is an exercise designed by Gianfranco Cecchin and Luigi Boscolo; although they never wrote about it, it is described by Bertrando & Gilli (2010). The key element is separating the team’s questions from hypothesising, which occurs in a reflecting team format.

Unlike using the first map, when a team member interviewed the presenter, here, the entire team, including the external consultant, asks questions of the presenter. Similar to the previous map, the presenter is asked these three questions by the external consultant: Why was this particular case chosen? Why now? What are the presenter’s hopes for the review? Again, the responses are written on the whiteboard to remind the team of the presenter’s parameters for the review process. Other questions focus on exploring the nature of the difficulty and the presenter’s views and hypotheses, and may also include the other areas as presented in the steps for Map 1 above.

However, only questions are asked at this stage. Often, the external consultant may need to remind the team members to hold their hypotheses, strategies, and comments for the RTP. Once the team feels their questions have been exhausted, the external consultant asks the team to form into a reflecting team, whilst the presenter sits apart and listens to their conversation. The external consultant joins the reflecting team and can either interview the team about the case presented and their views and responses to it, or can join as a regular team member. After 10–15 minutes, the reflecting team members stop their conversation. The external consultant then asks the presenter for feedback on the team’s reflections. In situations in
which teams have carried this out without an external consultant, the team leader or a colleague can ask the presenter for their feedback to the reflecting team.

The main advantage of this way of carrying out an RTP for a team is that all team members can contribute and participate in the questioning and investigating stage, and therefore ask questions based on their curiosity and perspective. This can introduce new ideas for all and, in my opinion, because they are introduced as questions, not statements, these new perspectives may be received with more openness.

The presenter does have to respond to a variety of different questions, often not integrated. However, the ensuing RTP provides the dialogical context for the various hypotheses and strategies to be explored and connected.

**Variations on Using the Reflective Team Process With Multidisciplinary Teams**

Over three years, variations on the use of this reflecting team approach have evolved, and some of these are:

- Teams identify essential areas for exploration. Before commencing this process, teams can decide on the important areas to cover. For example, they may want to ensure they explore family strengths and assessments of risk.

- Inviting outsider clinicians or other helpers involved with the case to join the reflecting team. The former can be beneficial for 'cosy' teams who know each other well and are looking for increased difference, whereas the latter can be useful for coordinating new approaches with other helpers.

- Recording the reviews to share with clients and other helpers.

- Inviting questions from the group. Interviewers in the first map above can occasionally take a short break from the interview, to receive questions from their team. The interviewer can then ask these questions of the presenter.

- A variation on the above. The presenter may choose which question from the group he or she wants to respond to (Adopted from an exercise designed by Jill Freedman, Perth workshop, 2009).

- Using 'as if' clusters to appreciate other positions and realities. The reflecting group can be asked to listen to the interview from 'as if' clusters (Anderson, 2007). For example, one cluster of team members can listen as if they were the child and another as if they were the mother or father. Each of these clusters shares their responses with one another during the RTP.

- Using an observing team for the entire process. A few people can take on the role of observers and, at the end, share their observations with the team. This can be helpful to throw light on any team biases, as well as looking at what seemed to work well for both team members and the presenter.

**Feedback from Multidisciplinary Teams**

This feedback is taken from multidisciplinary teams for whom I have consulted in the last three years, and is elicited at the end of a consultation. This is done by asking for comments on the effects of the process on their thinking and on how they see team reviews. These teams are in the sectors of Child and Adolescent...
Creating Dialogic Contexts for Multidisciplinary Clinical Reviews

Mental Health Services (CAMHS), adult mental health, and disability and drug and alcohol services in Perth, Western Australia. I have split the feedback into the presenters' comments and the teams' comments, and it serves as an overview summary of the most common responses.

Presenters of cases regularly report feeling less ‘targeted’ during RTP reviews as a result of being interviewed by a colleague and being invited to give their feedback to the team's reflections. They notice the reduction in competition between the different hypotheses, as well as there being less confusion in the process. Being asked why they want to present their case and how they would like the review to help them are described as helpful and clarifying questions. Observing their team staying within the parameters of these questions makes them feel respected by their colleagues. This, they say, contributes to an increased sense of trust and enables their engagement with the development of any new ideas. Being asked questions, either when the team ‘interviews’ them or when interviewed by a colleague, is also experienced as triggering new ideas.

Staying out of the reflecting process and listening to the team is described as giving space for observing their position in the work, and so increasing self-reflexivity and curiosity about their position in the work. Presenters also state feeling validated and understood by their colleagues with this process, as well as feeling that they have more autonomy to choose the next step.

Teams report on the usefulness of the three questions to contextualise the review, which offers a shared direction for all members. The shared guidelines for remaining curious, connecting their responses with one another, resisting early conclusions, tolerating uncertainty, using speculative language, and appreciating their colleague's struggle also serve as helpful unifying themes for their conversations. Through the use of an RTP for their reviews, multidisciplinary teams comment on observing how different and seemingly divergent ideas can become linked. To quote a CAMHS team member: ‘Individual hypothesis becomes moulded by the hypothesis of other’, which is an apt definition of the dialogic process. Some notice how new meanings and explanations to clinical problems evolve within their dialogue and are often surprised with the unexpectedness of the resulting new ideas.

Teams also comment on the effect the reflecting process has on their listening and observation skills — knowing that they will be commenting on the case, encourages ‘listening hard’. Listening also changes from listening in order to speak to listening in order to understand. Lastly, the more silent members of the group find it easier to contribute when they are part of a reflecting conversation.

Conclusion

Many styles of doing therapy that would otherwise compete can crowd together under its [social constructionist] broad rim, as long as their practitioners agree that all therapy takes the form of conversations between people and that the findings of these conversations have no other ‘reality’ than that bestowed by mutual consent (Hoffman, 1990, p. 4).

I have suggested that the reflecting team process may be one way for effectively helping teams to coordinate their diverse skills, ideas, and roles in a multidiscipli-
nary setting. The postmodern and dialogic context it provides can help teams to appreciate multiple versions of reality, introduce a tolerance for uncertainty, support curiosity about events, challenge taken-for-granted ideas, and allow patience and trust to develop, out of which team creativity is more likely to emerge.

What has become of interest is how, without any formal instruction, some teams who are new to systemic ideas have adopted these second order ideas and positions through involvement with the RTP. When teams are encouraged to connect their responses to one another, to listen to words that seem to carry significance for the speaker, to keep the dialogue open, and to avoid knowing too early, they seem to be less intent on promoting their view on to others. It then seems that, as these dialogic habits strengthen, the participants experience 'binocular vision' (Bateson, 1972), which increases the noticing of difference, which then triggers their interest in other ways of seeing, listening and talking.

The reflective team process, in my experience, seems to be adopted relatively easily by teams who are new to this way of working. I believe that the reason for this is a relatively simple one. The dialogical emphasis, with its postmodern frame, encourages curiosity to prevail over 'having to get it right'. As a consequence, many teams enjoy the freedom that this permits and the creativity that arises from this way of talking. In contexts such as adult mental health and intellectual disabilities, the RTP can release curiosity into the conversation, so that more connections are made between clinicians' strategies, such as determining a diagnosis or prescribing medication, and broader, family responses. (Rhodes et al, 2011). With these added connections, it is easier to be creative, and to see new, alternative pathways out of an impasse.

This dialogic way of reviewing clinical work allows a synthesis of various approaches, one which may be more responsive to practice and the clinical situation than to a particular theoretical model (Cecchin, Lane, & Ray, 1994). For example, a reflecting team review may suggest using a narrative approach (White, 2004) to explore a family's experience of abuse and the effects of shame on their relationships, alongside the employment of a more first-order, structural (Minuchin, 1974) intervention with the parents. This serves to highlight and confirm the usefulness of integrative approaches (Larner, 1994).

As Koestler (1964) says: 'It (the creative act) does not create something out of nothing: it uncovers, selects, reshuffles, combines, synthesises already existing facts, ideas, faculties, skills. The more familiar the parts, the more striking the whole'. Placing multidisciplinary clinical reviews in a dialogic context through the reflecting team process may be one way of helping such teams engage with this creative process.

References


THE AUSTRALIAN AND NEW ZEALAND JOURNAL OF FAMILY THERAPY