"You're changing the Pattern": Cognitive analytic team formulation with learning disabilities care staff

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Structured abstract

Purpose

The study explored how care staff working with people with learning disabilities experienced psychologist-facilitated team formulation sessions in a cognitive analytic style (contextual reformulation).

Design/methodology

Eleven participants attended at least one contextual reformulation session regarding a client their team referred due to challenging behaviour. Post-intervention semi-structured interviews were analysed using qualitative inductive thematic analysis.

Findings

Five themes were developed: (1) multiple roles and functions of sessions and clinicians; (2) challenging behaviour in relationship; (3) making links – understanding can be enlightening, containing and practical; (4) the process of developing a shared understanding and approach; and (5) caught between two perspectives. Findings suggested contextual reformulation helped staff see challenging behaviour as relational, provided them with the space to reflect on their emotions and relate compassionately to themselves and others, and ultimately helped them to focus their interventions on understanding and relationally managing rather than acting to reduce behaviour.

Research limitations

Qualitative methodology allows no causal inferences to be made. Ten of eleven participants were female.

Originality/value

This qualitative study adds to the limited research base on team formulation in learning disabilities settings and specifically using a cognitive analytic approach.

Introduction

People with learning disabilities are commonly referred to professionals by carers for behaviours that challenge services (Emerson, 2011). Over time, understandings of learning disabilities and challenging behaviour have evolved. Humanistic, psychosocially-informed formulations recognise people with learning disabilities are influenced behaviourally and affected emotionally by relationships and environments (NHS England, 2015). Lovett (1996, in Lloyd & Clayton, 2014) has highlighted the social construction of challenging behaviour, reframing to "behaviours that challenge" thus emphasising the relationship with carers and environment. Environments that provide limited social support, use restrictive interventions and do not enable meaningful activities, have been described as challenging themselves (McGill et al., 2016) and can increase incidence of challenging behaviour. These settings are contrasted with capable environments, which encourage positive social interactions, meaningful activity, consistency, choice, and are staffed by competent carers who are supportively managed in an effective organisation (McGill et al., 2016).

Psychological formulation has become an increasingly central approach in modern learning disabilities settings. Specifically, formulation facilitated by psychological staff and developed collaboratively with staff (team formulation) can help staff combine and apply their experience and knowledge as a team to understand behaviours more relationally and systemically, promoting effective and compassionate management of challenging behaviours (Royal College of Psychiatrists et al., 2007).

Most research on team formulation consists of small-*n* studies and evaluations focusing on staff-focused outcomes such as increasing staff satisfaction (Allen, 2015; Chiffey et al., 2015), improving team functioning (Craven-Staines, et al., 2014), generation of psychologically-informed care plans (Wainwright & Bergin, 2010), self-efficacy (Maguire, 2006) and perceptions of "stuckness" (Allen, 2015). Research on team formulations and systemic consultations (which similarly intervene at the system level) in learning disabilities suggest staff experience sessions as helpful for developing a

shared understanding of clients, allowing space to think and reflect, and developing new clinical strategies (Rikberg Smyly *et al.*, 2008; Ingham, 2011; Wilcox, 2013; Fennessy *et al.*, 2015; Whitton *et al.*, 2016; Johnson & Viljoen, 2017; Turner *et al.*, 2018).

Findings regarding client outcomes of team formulation are limited (Geach *et al.*, 2017; Short *et al.*, 2019), however a focus on team outcomes is appropriate for a team-focused intervention, and these outcomes are likely an important mediator of client outcomes. Furthermore, challenging behaviours in people with moderate to severe learning disabilities settings may not always reduce in frequency despite intervention (Emerson, 2011). The paradoxical theory of change (Beisser, 1970) argues aiming to reduce behaviours, however humanely, may inadvertently promote frustration and thus maintain or aggravate behaviours. It may therefore be most helpful to see team formulation as a staff intervention, which aims to influence staff perceptions and behaviours (Johnstone & Dallos, 2014). Research into the management of challenging behaviour in learning disabilities services has not explicitly considered the relationship between staff and clients, and largely does not focus on staff approach towards or understanding of challenging behaviour. This risks focusing too narrowly on the client and overlooking the emotional impact on staff, which influences how they intervene (Greenhill, 2011).

Contextual reformulation, a model of team formulation which explicitly formulates relationships, is informed by cognitive analytic therapy (CAT). CAT integrates theory from dialogism, object relations theory and personal construct theory among others (Lloyd & Clayton, 2014), conceptualising the development and reinforcement of behaviours within relationships, and therapeutic relationships, explicitly formulating them using dyadic conceptualisations called reciprocal roles (Ryle & Kerr, 2002). These roles, for example, *perfectly helping-perfectly helped*, derive from early experience, and form more or less helpful schemata for behaving in relationships with others, who respond with the corresponding more or less powerful role in the dyad. Reciprocal roles are drawn out to create a reformulation map, in its final form called a sequential diagrammatic reformulation (SDR), and as it is

developing, known informally as a CAT map. The map delineates patterns such as vicious circles, and highlights new approaches or exit strategies (Lloyd & Clayton, 2014). At a process level, CAT clinicians engage in the Helper's Dance (Potter, 2014) with clients or consultees, collaboratively noticing and sidestepping clinical dilemmas between unhelpful polarities. Contextual reformulation does not aim to change client presentation, but helps staff manage their own distress in relationship to client difficulties, enabling them to develop alternative, relational strategies for managing client difficulties (Lloyd & Clayton, 2014).

Research on contextual reformulation is in its infancy. Most studies employ small-*n* and case study designs. Carradice (2013) outlined a five-session model of contextual reformulation in a community mental health team; anecdotal findings showed increases in staff's understanding of client behaviour, feelings of containment and confidence. Kellett *et al.* (2019) applied the same model in CMHT settings across three trusts and two studies, using a pre-post intervention and case series design: findings demonstrated increased staff competence and reduced exhaustion, and improvements in client presentation and alliance with staff. Staff in a psychiatric inpatient team received contextual reformulation including a theoretical training component and felt significantly less emotionally exhausted and more accomplished at follow-up, more engaged with clients, and more cohesive as a team (Caruso *et al.*, 2013). A randomized controlled trial in assertive outreach showed contextual reformulation comprising theoretical training and CAT team supervision led to improvements in team cohesiveness, communication and shared understanding between staff at 3-month follow-up (Kellett et al., 2014). While some studies involved the client in formulation development (Carradice, 2013; Kellett *et al.*, 2019), other studies worked solely with the team (Caruso *et al.*, 2013; Kellett *et al.*, 2014). Carradice (2004) highlights that contextual reformulation's focus of intervention and change is the staff team's approach to care, rather than the client. Client formulation is inherent in care planning, and inclusion of the client in team formulation is ideal where possible and practical (Rowe & Nevin, 2014). One study explored contextual reformulation in a Tier 4 personality disorder service where CAT is the primary model (Stratton & Tan, 2019), and

collaborative client formulations and contextual reformulations were built into service delivery; this is ideal practice, but is the exception rather than the norm. In cases where teams seek external consultation, and either the team or clinician cannot make the time or arrangements for a client to be involved and the team would otherwise receive no support, there is an argument for intervening solely with the team (Carradice, 2004). Equally, Carradice (2004) argues that some clients with certain presentations, such as severe learning disabilities, may be more distressed than helped by being directly involved.

There is only descriptive literature concerning contextual reformulation in learning disabilities settings (for example Lloyd & Williams, 2003; Lloyd & Clayton, 2014), indicating a need for formal research.

Therefore, the current study focused on contextual reformulation with care staff teams in learning disabilities settings, exploring the question: *what are staff perceptions of changes in their approach, understanding of and ability to manage challenging behaviours in their learning disabled clients after contextual reformulation?*

Method

Design

A cross-sectional qualitative design was adopted; participants were interviewed using semi-structured interviews and data was analysed using thematic analysis.

Materials

A semi-structured interview schedule based loosely on one used by Kellett *et al.* (2014) was developed in consultation with the project supervisor. Questions explored areas including: staff perceptions of presenting problems (e.g., "what problems were going on when your team decided to refer?"); experience of formulation sessions ("What do you remember about the sessions you did attend?"; "Were there specific parts/activities that you remember finding helpful?"); the nature of learning disabilities and challenging behaviour ("What does the term challenging behaviour mean to you?"); and how or whether participants thought formulation sessions had changed their understanding or approach to clients ("Has the way you work with your client changed in any way?"). Participants completed a staff demographics form and service managers completed client demographics forms.

Analysis

Inductive thematic analysis was used to analyse the interview data. This analysis stays close to the data and builds themes from the ground up, and is appropriate in areas where there is less research and more open-ended investigation is required (Braun & Clarke, 2006). Latent coding and theming were adopted, as meaning was informed by psychological theory, clinical experience and clinical context.

Participants

Participants were paid direct care staff from four separate learning disabilities care home teams in the community. Ten participants were female, one male. Participants were aged from 26 to 57 years. Their experience in care work ranged from nine months to 40 years. Teams had referred to CAT-trained psychologists for support with a client's challenging behaviours. Aggregate characteristics of the four referred clients are shown in Table 1.

<Table 1>

Intervention

CAT clinicians provided between one and ten sessions of contextual reformulation to participating teams. Clinicians delivered contextual reformulation in line with guidance outlined by Carradice (2004), which includes aspects of consultation, psychoeducation, and a collaborative formulation developed with the aid of a CAT map. Clinicians did not follow a protocol, but adapted intervention according to each team's needs, thus staying true to the ethos of CAT. This approach prioritised clinical and ecological validity.

Procedure

Participants were identified via UK-based CAT clinicians who delivered contextual reformulation. Three suitable CAT clinicians via professional contacts and a CAT special interest group for clinicians working with learning disabilities. University ethics approvals and Health Research Authority research and development approvals for four national sites were sought. All participants were

interviewed by telephone. A post-interview debrief encouraged staff to express any questions or concerns. All interviews were completed in one sitting and lasted between 22 and 70 minutes. Interviews were transcribed verbatim and anonymised.

Quality and Reflexivity

Quality guidelines (Elliott *et al.*, 1999; Mays and Pope, 2001) informed the process. A reflective journal was kept by the first author throughout the project, and reflection in supervision informed interpretive processes. This helped reduce bias and encouraged reliable coding. Themes were grounded in examples and reviewed in supervision. All participants were invited to feedback on themes developed; two participants from separate care homes suggested themes helpfully articulated participant experiences.

Results

Five themes were developed from interview data analysis (see Figure 1). Participants and clients have been given pseudonyms.

(1) Multiple Relationships to Sessions and Clinicians

Staff described different ways of relating to reformulation sessions and CAT clinicians, suggesting multiple functions. Sessions were called "*lessons*" (Sital), "*training*" (Mandy), and "*therapy for the staff*" (Daniel) that could "*move things forward*" (Sally; Karen; Lizzy).

Different conceptions seemed partially to reflect differing referral reasons, but it was also clear that the clinician held multiple roles in relationship with staff. Staff valued having "*another pair of eyes*" (Mandy), "*somebody from outside*" (Sally), who made suggestions (all) and gave "*advice*" (Sally; Jennifer; Daniel; Sarah; Emily), as a clinical supervisor might do:

> *She wants to know…what's next, what's worked, what hasn't, anything else that's come up.* (Sarah)

The clinician was also seen as a teacher, who taught staff new concepts to apply clinically and develop their understanding:

> *She was talking about the templates…you know, when you're a child…you're nurtured, and you understand that feeling so you can offer that to somebody else…* (Karen)

The clinician also adopted the role of containing staff's feelings, allowing them to express themselves:

> *It felt good to erm…be able to get things off our chest, about, erm, how like, dealing with it and stuff, cos she was asking about our, how we felt and stuff like that…and generally when you're in work, you don't really get to feel, er think about how you feel…she was quite understanding…about it all really.* (Chelsea)

These multiple functions of formulation sessions reflect the multiple roles/functions care staff adopt in serving their clients with learning disabilities, who themselves have multiple needs.

(2) Challenging Behaviour in Relationship

Staff found sessions supported them to understand how challenging behaviour was learned, experienced and reinforced by people in relationships rather than being an individual property of clients. Sessions helped staff reflect on the personal impact of working with challenging behaviours:

> *She just generally asked us how his behaviours can lead to staff feeling afterwards…it can leave you…exhausted, it can leave you confused…it can leave you upset, it can leave you in lots of different ways.* (Jennifer)

CAT theory helped staff understand how behaviours were learned in formative relationships and repeated in current ones, eliciting similar emotions in staff to those experienced by the client:

> *[Clinician] will say "this is now, then, why she rejects you when she's, you know hitting, getting quite agitated, this is the reason why she starts to reject you, cos…that's what people have done to her".* (Daniel)

Staff learned their own emotional reactions could be challenging for the client:

> *If you act out, and start, you know shouting or ranting or raving...you are reacting as her mother would have reacted, therefore she's gonna react to you straight back.* (Karen)

This new perspective helped staff feel more accepting of the behaviours and take them less personally. Other effects included increased feelings of empathy towards clients, more realistic expectations of their own influence, increased calmness and differences in how they responded:

> *You kind of get a bit frustrated yourself, you think, "why is she being like this? I'm trying and trying", but, with knowing that information we've got from the session, I kind of know to just sit back and allow her to…kind of vent…* (Sarah)

Staff learned it was important to relate to themselves and their colleagues in a caring way, as well as clients:

> *It is ok to step outside afterwards for 5 mins and have a cigarette…stamp your feet for a little bit yourself and then go back in….make a cup of tea, sit with the person who's supported Bob through the behaviour and just talk about it…and just say…"what you did was ok, it was good."* (Jennifer)

As new understanding of behaviours and emotional containment provided by the clinician helped staff manage the emotional impact of challenging behaviour, they saw how this would help the client:

> *If you can keep your cool, if you can not get upset by what she's doing, and ride the storm out with her, you're changing the pattern.* (Karen)

They were encouraged to see themselves as attachment figures, serving multiple functions of containing clients' emotions, working pro-actively, setting clear boundaries, and engaging in meaningful, relationship-based intervention:

> *As a mother, you, you bit firm with your children, but you show love as well, so it's like, when she demands something, then we say "ok, we work, we do this way, that, that, do this one", …supportive …and whatever I say, I always do this, she know that.* (Sital)

(3) Understanding can be Enlightening, Containing and Practical

Reformulation sessions gave staff tools and concepts that led to new insights and strategies. Asking particular questions helped put clinical information in meaningful context:

> *[Clinician] was asking questions…things that make him start behaviour…we said to her that this is unpredictable…but…knowing his, um, previous history…in his previous maybe care*

home, or, the places he has been, they have stolen his stuff…maybe he…keeps remembering then, he keeps recalling that, and then, that makes him angry…and frustrated. (Edie)

Some staff contributed ideas that were incorporated by the clinician:

I suggested…that it's as though she's trying to fill a void…and then we've kind of ran with that. (Sarah)

Sessions helped staff make cross-sectional and developmental links. This helped them identify triggers for behaviour as well as understanding how clients might feel and what functions behaviours served for them:

Just helping us understand…how Betty was trying to…regulate that, that feeling and that emotion…that could link back to…some of their historic abuse…and past. (Emily)

The CAT map was seen as a visual and memory aide, helping the team integrate, understand and retain information:

She'll actually do diagrams, or like, words…I think that's a good thing because um, you can see it visually, as she's explaining it…I think it sinks in a bit more that way…she can flip back to what we've done before, and…it's just like bringing it all together. (Daniel)

The CAT map also helped staff recognise predictable patterns and cycles of behaviour and use that information to intervene at the most helpful:

Find at what point within that cycle we can intervene and, and, de-escalate the situation. (Daniel)

The map was complemented by psychological concepts that were intellectually interesting, practical and containing for staff. The concept of reciprocal roles helped put words to intuitive understanding and helped staff make sense of behaviour in the moment:

> *When she put in the…template form…of nurturing, being nurtured, feeling nurtured, all that kind of thing…and rejection…all them different aspects of all the different emotions…it kinda just joined all the dots up. It put it in…an educational form I suppose, in a format that made you think – yeah. And so now when you look at her doing things, you can relate it back, to "well yeah she's doing that because she was taught that".* (Karen)

Many staff found the concept of the amygdala hijack (Goleman, 1995) helpful in understanding behaviour and informing their response:

> *[Clinician] basically told us that, like, their mind's still like, high up and, like agitated and stuff, so you should leave it until they've calmed down, to speak to them about why they've behaved in that way…if you're after them straight away after the incident, you're not gonna get…any answer, or, they just don't wanna talk to you, but if you leave it a little bit, you do, you do tend to get more out of them.* (Chelsea)

In line with clinicians' suggestions, staff found they could share aspects of reformulation with clients in a way that provided containment:

> *[Clinician] mentioned as well maybe, um, talking her through her emotions as well…she's kind of like "oh right, that's why I'm feeling that way!" and it's calmed her down.* (Sarah)

However, some staff mentioned it could be difficult to remember and apply reformulations in the heat of the moment:

> *You do try and think of what you've been taught…but actually…in the situation when the typewriter's going across the room, y'know you're thinking of safety for the other guys…for the person…for the staff.* (Sally)

(4) Developing a Shared Perspective and Approach

Sessions were seen to integrate each staff member's perspective into a shared understanding that informed a consistent clinical approach. Staff felt everyone could have their say in sessions, with the clinician balancing and integrating different views:

> *It's like making a cake…putting all the ingredients in, to come up with, a bigger picture, what'll suit best for the person.* (Lizzy)

> *[Clinician] took everybody's view into account…and it kind of worked for everyone…she always had a suggestion to please everyone.* (Sarah)

Staff recognised the importance of making time to meet and coming together in their thinking. The clinician's input was described as helping staff develop a shared understanding that increased clinical consistency:

> *Just having that time basically to, group together [helped]…I don't think we would've been able to…come up with…such a consistent way of managing it…* (Emily)

Whilst some felt ideally all service staff should attend, this was sometimes considered impractical for various reasons. These included staff needing to cover the shift during sessions and some staff knowing the client better. Clinicians in all settings worked towards developing a collaborative formulation with staff in session, that could be shared with the rest of the team. Conversations, ideas and CAT maps were shared in team meetings and in practice:

> *We…have staff meetings as well, so we discuss…what we're coming away with from…sessions with [Clinician].* (Emily)

Some staff indicated concerns about their ability as care staff to accurately convey reformulations without the CAT map.

> *I would need the CAT map, to say, "this is what we talked about with this, and this is how it works, this is why we've done it", and there's a visual guide to also show them, because I*

think trying to talk about it, just first hand, without the information…it could get confusing, or misconstrued. (Mandy)

(5) Caught between Two Perspectives

Seven participants expressed conflicting perspectives on clients and how to relate to them; it seemed difficult to hold these in mind simultaneously. There was a self-consciousness about how behaviours were labelled, suggesting staff were careful not to pathologise. For example, while staff acknowledged the role of perceptions in whether behaviours were deemed challenging, some behaviours seemed clearly challenging in themselves:

I mean I know, we kind of have to call it, behaviours that may *challenge, because of* how *they're punched in the face…someone else might not be challenged, something along those lines, which I think's ridiculous…yeah, I think it's…I think, erm…<pause> <sigh> oh it's so…I dunno, I s'pose any, anything where it's…<pause>…er…I don't wanna sound ridiculous – just say anything that's challenging, but, er, anything…I s'pose it's sort of your interpretation of what's…what is challenging, I guess…you know…behaving…I dunno…I dunno…* (Daniel)

CAT clinicians reminded staff of the limits of intervention, with no "fix" for learning disabilities and challenging behaviours, but it sometimes seemed difficult to accept:

She also reminds us that…there's no cure to this. You know, we're just talking about how we can manage this, but it's never gonna stop…and…sometimes you have to try different things…if it doesn't work, then move onto the next kind of thing…so sometimes [I] think "oh god…are these sessions helpful?" But they are…when you look at it as a whole, they are…but then, you think "uh…nothing's going to work, because she just, she's obsessed about that item, and that's it". (Sarah)

This was also reflected at the systems level. While staff were making good use of sessions based on clear need for support, they also felt just the right amount of consultation could be the "answer" that would alleviate the emotional challenges of the work:

> *It would be great if we could all sit and talk about it for five hours…we can't.* (Karen)

While sessions were focused on helping staff manage their own responses to current patterns which might not change, there was also the idea that change could happen further in the future:

> *[Clinician] said…"this isn't a thing that's gonna happen over six month to a year, this is a five year thing"…she's…changed a lot, from…when I first met her…she's completely different…so I do know that over the stage of six years, change can happen…I'm just hoping that that can happen again in the next five years.* (Sarah)

<Figure 1>

Thematic Map

Figure 1 illustrates the thematic map. The outer circle illustrates how *opposing perspectives* represented in practice and society (as discussed below) define and reinforce the multiple needs of people with learning disabilities, reflected in the *multiple relationships* of staff receiving contextual reformulation. Sessions help *develop a shared understanding and approach*, comprising a balance between *conceptual understanding* and the process of *relating to clients and challenging behaviour*. These latter aspects are mutually influential, as new understandings influence behaviour in relationship, which in turn influences what is known.

Discussion

Findings reflected the complexity of psychological formulation at the team level, in this case contextual reformulation. This was described by staff as comprising various techniques and processes at multiple levels including learning and applying psychological theory, collaboratively creating CAT maps and developing a shared language for understanding learning disabled clients and their behaviour. Staff also described process-focused elements including the relationship with the clinician and how this informed staff's relationship to themselves, their clients and the way they understood and responded to behaviour. Referrals from staff, carers and families to psychology seeming to centre around client behaviour can unwittingly combine motives, perspectives and needs from different stakeholders in the system (Haydon-Laurelut, 2011). Furthermore, clients' complex needs and the all-encompassing and multiple roles staff play in their lives, are reflected in the multiple needs staff themselves experience, an example of parallel processes (Cardona, 1975). Contextual reformulation itself is designed to serve multiple functions, supporting the development of concrete knowledge within consultees' "zone of proximal development" in the context of relationship (Lloyd & Clayton, 2014), and drawing from psychoanalytic principles, allowing staff to explore and process emotional impact of the work. Staff indicated this helped regulate their emotions; having clinicians validate theirdistress helped staff validate themselves and each other, and hopefully respond more compassionately to clients. Reformulation therefore, has the capacity to foster features of capable environments: proficient carers, effective management, staff support, and effective organisational context (NICE, 2015; McGill et al., 2016), thus promoting good care and reducing risk of challenging behaviour.

Psychological concepts and tools combined with emotional reflection allowed staff to understand challenging behaviour on multiple levels, as: responses learned in early relationships, serving a function such as emotional expression, repeated in staff-client relationships, and impacting emotionally on staff thus leading to unhelpful interventions. Linking these elements helped staff see

behavioural sequences or "procedures" (Lloyd & Clayton, 2014) that without reflection, perpetuated unhelpful relationship patterns and thus challenging behaviour. This understanding contained staff and inspired new approaches. Some staff integrated information from multiple levels of formulation, while others made initial links at one or two levels, for example between behaviour and client history, or between their own emotions and behaviours. This indicated developmental and relational understandings of challenging behaviour, and seemed to inspire interventions focused more on how staff could contain themselves and clients rather than changing behaviour. This is congruent with the paradoxical theory of change (Beisser, 1970). Furthermore, distress can mediate the relationship between experiencing challenging behaviour and burnout (Mills & Rose, 2011), so emotional regulation seems vital in providing effective and consistent care. This suggests that staff in learning disabilities settings would benefit from having regular protected time to reflect on the impact of the work where possible, whether facilitated or not, knowing this has the potential to improve staff self-competency and wellbeing in tandem with clinical effectiveness,

Staff described discussing and integrating clinical information to develop a shared understanding of the client and challenging behaviours. This supports the aims of team formulation (Johnstone & Dallos, 2014) and requirements for teams working with people with learning disabilities to provide consistent, joined-up care (NICE, 2015). Staff felt encouraged to express their views, which the clinician skilfully integrated with psychological concepts, creating a shared, collaborative formulation staff could refer to during conversations outside of sessions, providing consistency in clinical approach. This reflected another aspect of capable environments: increased predictability and consistency (McGill et al., 2016).

Unsurprisingly, staff who attended several regular sessions appeared more socialised to CAT principles and processes of change. Even these staff, however, sometimes felt uncertain communicating psychological knowledge to others, and some highlighted challenges in remembering and using reformulations in the moment. This shows producing, applying and revising

formulations is a complex skill requiring time to learn and integrate, preferably during ongoing supervision in sessions but also in service meetings with colleagues, as practiced by some participating teams. This is essential to long term implementation and improvement, which can take years (Georgiades & Phillimore, 1975) as some participants recognised. Although resources are limited, providing regular psychologically-informed support or supervision to learning disabilities care home staff likely has significant systemic and clinical benefits. These teams would also benefit from reviewing written or diagrammatic formulations such as CAT maps regularly as a team in service meetings or supervision, updating them when necessary, as well as uploading them to client records so they can be easily referred to, reflected on and applied continually.

The final theme of care staff's accounts reflected the conflict between two apparently opposing perspectives: the traditional, individualist view of locating a problem (such as challenging behaviour) and reducing it, contrasted with the paradoxical theory of change (Beisser, 1970), accepting the problem, thus changing one's relationship with it, often affecting the problem as a result. This dilemma is relevant to two parallel and related contexts: the process of learning (for example via the consultative or therapeutic relationship) and the position of people with learning disabilities in society. It has been argued in philosophical, psychodynamic and cognitive-behavioural literature (Hegel, 1816/2004; Johnstone & Dallos, 2014; Linehan, 1995) that we learn through ongoing conflicts between opposing feelings and concepts, which eventually synthesise to form an integrated understanding, which is defined against a new opposite and so on. It is tempting to avoid the uncertainty and cognitive dissonance of learning and maintain an idealised worldview by identifying with one position and ignoring inconvenient exceptions (Festinger, 1957). This is demonstrated in society's relationship to people with learning disabilities; social values of individualism, choice and self-sufficiency are easily accepted by the majority. However, people with learning disabilities are socially and physically dependent on others, on the less powerful end of a reciprocal role relationship more often (Psaila & Crowley, 2006), and inherently *less able to choose* or embody societal values, which clearly exclude them. This creates frustration for people with learning

disabilities and those around them, perpetuating the misattribution of problems within them. Care staff are forced to navigate both realities, despite their incongruence. This was reflected in the confusion and frustration in some staff's accounts. Contextual reformulation helped staff manage these dilemmas with its own dual approach: mapping and understanding the concrete reality of the client's challenges and offering practical strategies, while acknowledging the limits of traditional intervention and fostering emotional and relational intelligence in the face of challenging situations and behaviour. When team formulation such as contextual reformulation is provided as a relatively short-term intervention, this may inadvertently imply it provides a quick fix or lasting answer. However, if funding was adequate and clinical need was prioritised, support for formulation would be integrated into standard practice as a vital tool requiring ongoing input and refinement.

Limitations

The intervention was not standardised and there was variation in how staff teams experienced reformulation sessions. This seemed to vary as a factor of how many sessions were offered/attended, how they were structured, and the extent of CAT theory taught in initial sessions. Furthermore, due to the qualitative design, observed changes could not be reliably attributed to contextual reformulation.

Participants were predominantly women; this may have made findings more applicable to women, who are socialised differently in terms of relationships and emotional expression. Teams who received sessions may have been more organised and more able, in that they were willing to participate and easier to contact than more struggling teams, and thus may not represent the average team. Future research would benefit from investigating what proportion of care homes receive regular consultation, or clinician perceptions of difficulties engaging teams, as contextual reformulation may need to increase its accessibility to these harder to reach populations.

Conclusions

Findings appeared to suggest that contextual reformulation enables several features of capable environments (McGill et al., 2016), including meaningful intervention, consistent care, modelling of helpful relating, proficient carers, effective management and staff support, and effective organisational context. Systemic limitations, such as shift patterns preventing regular session attendance, or some teams having weaker links to consultation teams, can present challenges regarding contextual reformulation's optimal delivery; future research could explore this and influence practice and policy.

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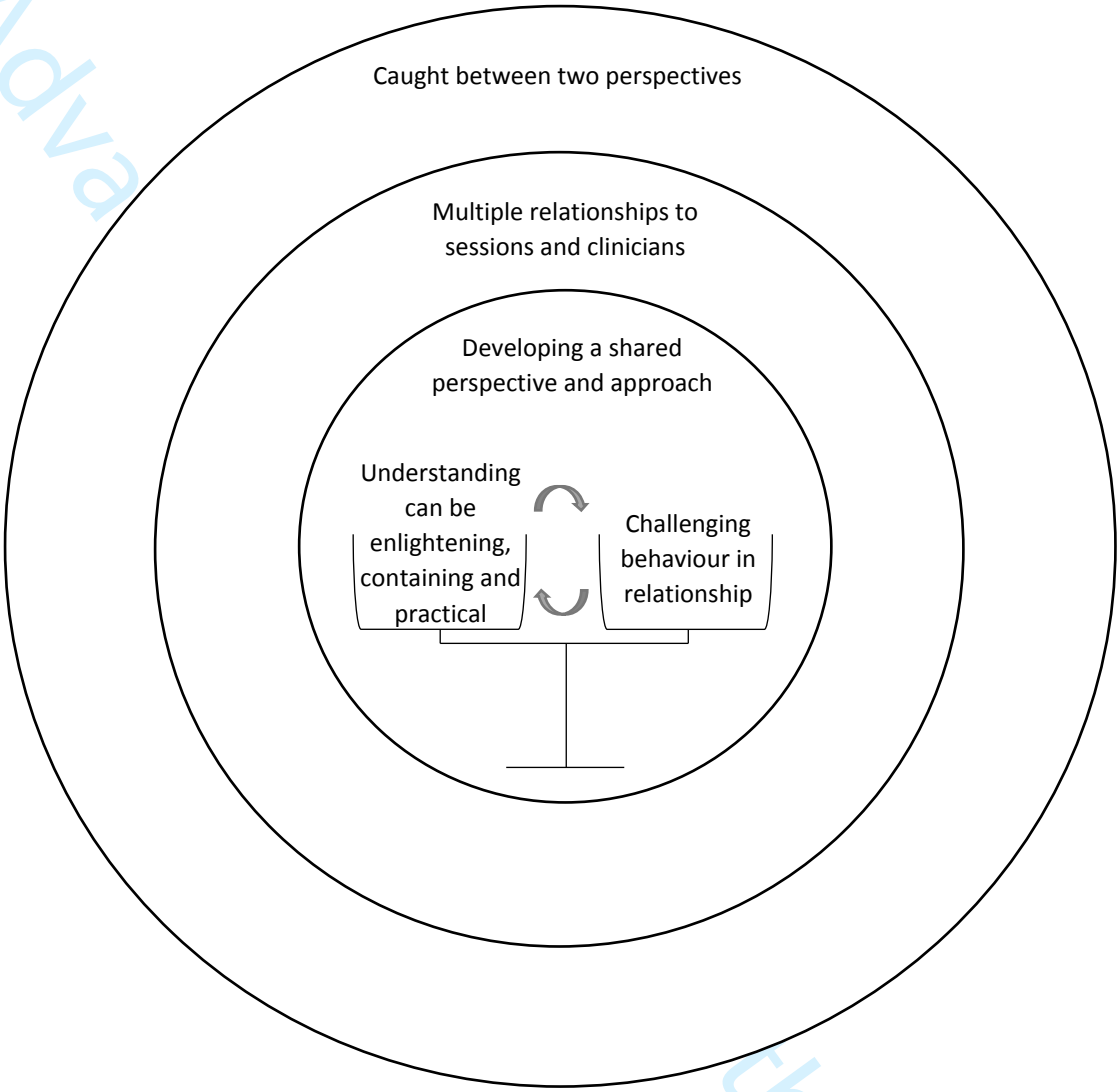

Figure 1. Thematic map of findings.

Table 1. Client characteristics

Client characteristics *(n = 4)*	
Age	26-48 years [range]
Ethnicity	White British
Gender	3 female; 1 male
Level of learning disability	Mild to moderate
Chronicity of challenging behaviour	Moderate (1-2 years) to highly chronic (2+ years)
Risk to self/others	Mild to moderate
Comorbidities	Autism (3; 1 suspected but undiagnosed) Epilepsy (1) ADHD (1) Blindness (1) Bipolar (1)