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COGNITIVE ANALYTIC THERAPY
& RELATIONAL MENTAL HEALTH

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‘Patients can enter therapy because they are seeking to recover a sense of lost agency or to find new psychological resources to enhance their sense of agency. Before they can be helped instrumentally through the use of effective and safe psychological techniques, they need to recover their agency, their motivation, and their sense of “I am, I can, I will”.’

Am I someone or something? Agency and Alterity in Cognitive Analytic Therapy by David Crossley

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What is ICATA?

It is a federation of national associations promoting training and supervision in the practice of cognitive analytic therapy from Australia, Chile, Finland, Greece, Ireland, Italy, Malta, Netherlands, New Zealand, Spain, India, and the United Kingdom. There is an executive made up of two delegates from each member country or organisation with established or newly developing training programmes in CAT. The executive meets regularly and organises a biennial international conference. Further details are available on the website internationalcat.org

Aims of ICATA

To develop knowledge, use of and further development of cognitive analytic therapy.

To offer support, training and supervision internationally and oversee national accreditation programmes and procedures.

To publish the *International Journal of Cognitive Analytic Therapy and Relational Mental Health*.

Aims of the Journal

To promote the use and evaluation of CAT and its further integrative development across a range of settings, cultures and countries, and to publish novel and challenging material relating to this.

It also aims to promote cross-disciplinary dialogue within the broad field of relational mental health thereby contributing to further psychotherapy integration and the further development of CAT.

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As well as the five volumes of this journal other CAT books are listed and available.

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Editorial

WELCOME to the sixth volume of the International Journal of Cognitive Analytic Therapy and Relational Mental Health. This much delayed volume marks a point of transition. After nurturing it into existence the editorship is being handed over to Alison Jenaway and Caroline Greenwood Dower. They will draw together a new editorial group. For my own part it has been a rewarding eight years and much learning from the process of article submission, collating and passing on peer reviews and seeing through the step-by-step process of production.

Many thanks go to Ian Kerr who was the driving force behind the creation of the journal and co-editor of all the preceding volumes. Also to Derek Roger who has done an expert and sustained job of layout and preparation for publication. More recently for this issue many thanks to Anna Laws, Steve Kellett, Claire Regan and Elaine Martin and all the peer reviewers.

The journal is one of the products of the international Cognitive Analytic Therapy Association (ICATA) and the watching and guiding hand of the ICATA executive has been a constant value.

We are indebted to Harriet Fleetwood who singlehandedly has transformed our backlog of 40 articles over the five previous issues from pdfs to tml.

This issue brings the following rich mix of contributions.

Krystina Jacobs takes up a neglected but vital element of CAT's active use of time in therapy. She reports on her research into the use of follow up sessions. In detailed study, with recommendations for training, the therapist stance is a key variable (whether more cognitive and standing outside the follow up session or more analytic and feeling inside the follow up session).

Hanna-Marie Hilden and Sami Kivikkokangas take us to the heart of imagery rescripting as part of CAT technique in ways that help think about CAT as an activity-based therapy with a variety of means of joint activity within the therapy relationship.

Andy Horan theorises and shows CAT working with caregiver and child dyads as the focus of therapy. He writes: a key aim within dyadic CAT is to work towards caregivers offering a different relational experience to their child. The push and pull of mutuality and asymmetry of power from top and bottom ends of reciprocal roles both within and between the young person, carer and therapist as co-learners in relational therapy is described.

David Crossley explores the idea of

agency and otherness from a CAT point of view. He gives agency a new and relational space within CAT's approach.

Niall Power, Jo Varela and Caroline Wojnarowski offer the first of three articles on distinctive applications of reflective practice. They focus on work with Evaluating reflective practice in a intensive support, learning disability team. They point to the need for more research but stress the potential for reflective practice to reduce burnout and enhance team cohesion.

Siobain Bonfield and Laura Hayes explore the contribution of reflective practice and a relational mapping approach using CAT tools to increase relational awareness, emotional intelligence and clinical and therapeutic work.

Laura Bridges, Jenny Marshall and Divine Charura show the use of CAT reflective practice groups for team leaders in the British National Health Service. They draw out the double benefit of a more contextual relational awareness of the system and more internal and compassionate awareness of their internal stresses and conflicts. Their article echoes a theme in several contributions to this journal of both using reflective practice and focusing on the provider end of the helping equation.

Rebecca Kelly, Steve Kellett and Mel Simmonds-Buckley report on the development of cognitive analytic therapy guided self-help for depression. It builds on similar work done with anxiety. They point out the lack of choice and its

importance for retention of patients.

Agatha Payne, Stephen Kellett and Peter Taylor also focus on the provider in exploring therapist perspectives in a specific treatment choice. CAT can zoom in and out. Their focus is on brief CAT and their research design brings out key themes for facilitators that echo leaders' reflective practice in the article by Bridges et al.

Thank you to all these contributors writing as practitioner researchers and demonstrating the vitality and versatility of Cognitive Analytic Therapy as a distinctive therapy model and a general framework for working relationally. They all point to further research and to clinical innovation. Good practice is built and enriched in this way. CAT offers an integrative, overarching and pragmatic approach to working with the multiple causes of distress and disorganisation that we carry individually and collectively in current society.

Writing and research require curiosity and courage for practitioners. I hope the journal grows to attract diverse international voices. Please spread the word about the journal, its archive of past contributions and its openness to new contributions.

For the next issue of the journal, anyone with submissions, proposals or enquiries to the editors please send them to Journalicata@gmail.com The deadline is November 15th 2026 for publication in the spring of 2027.

Steve Potter
May 2026

Therapeutic CAT follow-up sessions

DR KRYSTINA JACOBS, CLINICAL PSYCHOLOGIST,
CAT PSYCHOTHERAPIST

Abstract

As the evidence base for Cognitive Analytic Therapy (CAT) continues to develop, one area of CAT practice which has been frequently named in the literature but has not been researched is follow-up sessions. A qualitative methodology, Enhanced Critical Incident Technique (ECIT), was therefore used to explore CAT follow-ups. 10 CAT psychotherapists were interviewed to explore what helps and hinders follow-ups, as well as their wishes and recommendations going forward. Using the ECIT methodology, 64 incidents were extracted from 10 interviews, and sorted into 4 helping, 4 hindering, and 2 wish list categories. Categories included: Continuing life guided by the CAT tools, Therapeutic Relationship and Working Alliance, Therapeutic Relationship and Ending, Follow-up practicalities discussed, Therapeutic relationship and countertransference, CAT without follow-up, Unclear client progress, Extending CAT, Noticing the therapeutic relationship, and Structuring the follow-up. Two key findings from the categories can be summarised as 'The cognitive of CAT', defined as shaping the follow-up as a space for checking-in on life events, challenges, and consolidating learning, alongside 'The analytic of CAT', defined as shaping the follow-up as a space for reflecting on wellbeing, change, relational dances, with the comfort of gradual ending. Overall, the findings from the study offers insights into the helpfulness of CAT follow-ups as part of the CAT model, and the results are discussed guided by reflections upon methodological limitations, existing literature, and clinical implications. It is hoped that the findings and learning from the study will support CAT trainees, practitioners and supervisors to reflect upon and enhance their practice.

Key Words: CAT, follow-ups, ECIT, endings

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Introduction

Cognitive analytic therapy (CAT) is a relational framework and ‘whole-person’ approach, based on theory of the social and cultural formation of the self (Ryle & Kerr, 2020). This research study explores the ending phase of CAT, specifically focusing on follow-up sessions, as clear definitions appear to be missing, and perhaps follow-ups are a neglected and overlooked aspect of CAT. This invites questions including whether follow-ups are suitable and beneficial for all, and if there are times when these sessions might be approached in an unhelpful way which does not meet the client’s individual needs, and how do we prepare CAT trainees seeking guidance on approaching the follow-ups.

Three case examples illustrate the variety and differences noticeable across CAT follow-ups. Firstly, Katie (pseudonym), a White British woman in her early twenties, attending an outpatient eating disorders clinic, to continue progress with weight restoration, following a hospital admission for anorexia, plus fluctuating symptoms of compulsive handwashing. Katie expresses preference for a relational therapy and is offered a 24-session CAT with 4 follow-ups (spaced at monthly intervals), which is the typical contract offered by the clinic. Katie’s upbringing is described as lacking affection, with examples of neglectful parenting, and RRPs include hiding her feelings and needs, and striving to perfectly please. During CAT, complementary techniques include self-compassionate letter writing, and CBT concepts are introduced within the CAT framework to support behaviour change with meal planning and reducing handwashing. Throughout all 4 follow-ups, Katie brings her diagrammatic reformulation, directs the conversation towards strengthening exits, reflecting on symptom change guided by outcome measures, and suggests creative possibilities for relapse prevention and maintaining motivation.

Secondly, Diane (pseudonym), a woman in her early forties, of Black Caribbean ethnic background, is offered a 24-session CAT with 3 follow-ups, by an NHS psychological therapies team, following a diagnosis of emotionally unstable personality disorder (EUPD). Diane described her upbringing as ‘traumatic’, describing numerous examples of physical and emotional abuse, and identifying current states of switching between feeling extra special, enviously rageful, emotionally distant and humiliatingly needy. During therapy, Diane engages with journaling, art, empty chair conversations and exploring dreams. Throughout CAT, ruptures are repaired, including lateness to sessions, and noticeably fluctuating attendance increases during the ending sessions. Diane attends the first follow-up, one month following the end of therapy, presenting as

preoccupied with the end of therapy, with several angry outbursts as she retells the story of a recent argument with her sister, and verbalising her need for open-ended CAT. Diane does not attend the second follow-up, and after no response to reminder letters, she is therefore closed to the service and discharged back to the care of her GP, in line with service policy.

Thirdly, Harry (pseudonym), a man in his early thirties, of mixed heritage Chinese ethnic background, contacts a private practice clinic, requesting a 16-session CAT. Harry describes a childhood of striving throughout his boarding school years, with increasing struggles with low mood and low self-esteem, following the recent end of a romantic relationship. RRPs include unconfident anxious avoidance of social interactions and social isolation. During therapy, Harry focuses on self-monitoring and rating sheets to guide recognition and revision, making noticeable rapid change, alongside a no-send letter to his ex-partner. As therapy approaches ending, follow-ups are discussed and negotiated. Harry requests a follow-up after two months, following his holiday abroad, and a further follow-up after six months, following the start of a new job. Harry attends the first follow-up reporting improvement in wellbeing and confidence to begin online dating. However, a week before the second follow-up, Harry makes contact to cancel, confirming further progress with his wellbeing but explaining new financial commitments, including an ‘exciting’ house move, now means he is no longer able to afford the final follow-up.

CAT literature

Unique to CAT, as a therapeutic model, is the emphasis on formally offering a follow-up session. Follow-up is offered 3 months after CAT, with the expectation that the experience of termination and separation has been completed, feelings of achieving and disappointment, ending anxiety and gratitude, and with the hope that the effects of therapy have stabilised and been internalised, perhaps evident on symptom measures. The hope is that during this follow-up meeting, a decision can then be made on the need for further follow-up, top-up sessions, or further therapeutic intervention, with reduced likelihood that the therapist will be drawn into collusive responses of avoiding painful feelings of therapy ending, although case examples include clients not attending follow-up, perhaps choosing the abandoning role to avoid being abandoned (Ryle & Kerr, 2002).

During the early development of CAT, Ryle explored 12-16 session CAT contracts, shorter interventions of 6-8, and longer 24 session contracts with a single follow-up (Ryle, Poynton, & Brockman, 1990). He emphasised that as a brief therapy, the ability to hold on to newly learnt understandings and apply them to daily life was essential, with the goodbye letter highlighting what remains to be done, to be discussed at follow-up after 2-3 months. He suggested that goodbye letters are tools to keep the therapy active in the client's mind through to follow-up and beyond. Ryle describes how, as ending approaches, with time devoted to issues of separation, follow-up functions as a reassessment of the client's problem progress, and for clients who lack the confidence to cope without weekly sessions, a further meeting helps them to continue to use what they have learnt and realise they can cope alone. Ryle offers case examples of reviewing the target problem and procedures, to explore what has been achieved, gained, and retained from therapy, during the follow-ups. Ryle also suggested that during follow-up, typically 1 in 4 clients would be identified as needing top-up sessions, further follow-up or further intervention (Ryle, Poynton, & Brockman, 1990).

More recent developments in CAT emphasise that as an intensive effective therapy for an under-resourced health service, the length of therapy should be modified to adapt to the needs of differing clients, and the later phases including follow-up allow a more open style, as the CAT approach is not formally manualised, but guided by appreciation of structure and sequence, to be reflected upon in supervision. The CAT time-limit supports 'ending well', avoiding therapist drift and unhelpful dependency, and although separation anxiety may take the form of reoccurrence of initial symptoms, progress is regained and expanded by follow-up (Ryle & Kerr, 2020).

Concerning clients with a diagnosis of a personality disorder, 24 sessions of CAT, with four follow-ups at 1, 2, 3 & 6 months is recommended, although case examples suggest flexibility with this guidance (Ryle, Leighton & Pollock, 1997). It is recommended that increasing intervals are helpful, allowing separation to feel more tolerable, contributing to a balanced internalisation of the therapist, as an honest imperfect figure, and the client is encouraged to draw on conceptual tools developed during therapy, to continue to move from recognition to revision, which may not be far advanced in the time-limit. The need for extended follow-ups is in recognition of the extreme difficulties around separation for 'needy' clients, often desperate to extend the therapy, allowing expression of anger and disappointment, allowing

grieving, surviving the separation and completing the work, and then reviewing progress including reduction of TPs and revision of TPPs, likely to be reviewed more reliably after interval (Ryle, Leighton & Pollock, 1997).

Furthermore, it is emphasised that an extended ending phase gently prepares clients for the transition, following meeting weekly, as some clients experience feelings of abandonment and rejection, whilst trying to hold on to what has been learnt, with the ending of each weekly session offering insight into how a client might respond to the eventual ending of therapy. Clients may therefore present with new difficulties, as the ending approaches, which may be attempts to avoid ending and may pull the therapy off course, so a series of follow-ups as pit stops to check-in and review if the client recovery journey is still on track is helpful, and supervision is invaluable for noticing whether a delayed ending is a re-enactment of procedures (Corbridge, Brummer & Coid, 2017).

Taken as a whole, recent reflections on the CAT literature emphasise the importance of follow-up as part of the model, although identify that there is minimal guidance available for CAT trainees or therapists to guide structuring CAT follow-ups, and research into follow-ups is strongly recommended. It is acknowledged that the recommendation of a single follow-up, three months after a 16-session CAT, and four follow-ups after a 24-session CAT, can be taken literally, and actually considering clarity of ending, separation anxiety, and the client's ZPD is perhaps the priority. It is suggested that follow-up may be introduced at the beginning of therapy to set the frame, or during the ending phase, as part of preparing for a 'good-enough' ending as weekly therapy is completed, offering up to four follow-ups, including collaborative and flexibly negotiating with the client a timeframe for spacing which feels most helpful. It is also acknowledged that the fourth follow-up is felt as the real end, so it can feel the hardest, as it is a final letting go. And it is further suggested that, instead of the temptation for a news update, follow-ups should be approached as a space to consolidate the work, the diagrammatic reformulation as a prominent tool of reflection, to make sense of struggles and success, and firming up independence (Turpin, 2019).

Overall, the CAT literature appears to offer brief paragraphs emphasising follow-ups as essential, although the lack of detailed description about this unique aspect of the model raises questions concerning its importance and value, and the delivery of a 'good-enough' follow-up session. Specifically, the lack of clarity on the content and process recommended during a follow-up is noticeable, compared to

the guidance available for the beginning through to ending phases of CAT, noticing even the absence of guidance on when follow-up should be first mentioned to the client. And there is no research available comparing the effectiveness of varying the number and frequency of follow-ups, or the impact of absence of follow-ups upon the model.

There is also a confusing message CAT perhaps conveys to clients, as we exchange goodbye letters and emphasise ending well, whilst communicating that during the upcoming follow-ups we will be saying 'hello again' and 'goodbye again'. And therefore, is there a strong enough rationale for follow-ups to continue to be part of the CAT model, especially if multiple follow-ups introduce repeated loss and grieving the end of therapy, and when clients might not attend which then leaves the therapist with incomplete closure and mixed emotions.

Beginning research into understanding CAT follow-ups therefore seems of importance, to explore the numerous questions and queries, and specifically capturing the perspectives of those extensively experienced in CAT practice who can offer in-depth insights, seems a helpful starting point. The hope therefore is that follow-ups, a fragmented out-of-dialogue aspect of CAT, evidenced by the CAT literature, can be explored by inviting the voices of the CAT community to participate in a research study. This can then begin a dialogue, create a richness of meanings, going beyond just naming this aspect of the ending, to follow-ups becoming more integrated into the CAT model.

Methodology & Results

Participants

The current study focused on 10 CAT psychotherapists' perspectives of CAT follow-ups, separating out facilitators and barriers, aiming to explore and understand important events or experiences that psychotherapists identify and perceive as helpful, hinderances and wishes during follow-ups, including considering the strength of outcomes, to offer concrete recommendations. Participant recruitment included email contact with CAT psychotherapists whose contact details were listed on the ACAT website (www.acat.me.uk). There were no exclusion criteria.

From the demographic data collected, the sample included two men and eight women (age range 40-75), seven described their ethnicity as White British and 3 were from other ethnic backgrounds. The

psychotherapists reported their number of years offering CAT which ranged from 8 to 36 years, with five psychotherapists offering CAT in both private practice and for the NHS, three psychotherapists offering CAT solely to the NHS, and two psychotherapists offering CAT solely in private practice. All ten psychotherapists reported typically offering 16 or 24 sessions of CAT, although six reported occasions where they have offered 8, 12 or 20 sessions of CAT. All 10 psychotherapists reported typically one follow-up after 16 sessions of CAT, and three follow-ups after 24 sessions of CAT, although choice and negotiation was emphasised, for both the total number of follow-ups needed for the client and the spacing of follow-ups.

The study was guided by the Enhanced Critical Incident Technique (ECIT) methodology. ECIT involves primarily conducting interviews, forming categories based on the data, deciding on the specificity of categories, followed by labelling categories with operational definitions and self-descriptive titles. ECIT has several strengths and distinctive features including its strict and structured process, ability to provide tangible outcomes and concrete recommendations, focus on percentage and strength of categories (which are less interpretative than themes), and its focus on enhancing the trustworthiness of the data interpretation with nine credibility checks (Butterfield et al., 2009).

ECIT is a qualitative framework that specifically focuses on identifying Critical Incidents (CIs), defined as participant perspectives on what is critical or significant for helping and hindering the effectiveness of an activity or experience (Butterfield et al., 2009). ECIT integrates quantitative and qualitative aspects during data analysis to identify the impacting and influential features of little understood activities. Extracting 50-100 CIs from participant interview data is deemed to be satisfactory, rather than needing a specific number of participants, and incidents are then grouped and organised to develop categories (Flanagan, 1954). ECIT is described as a valid and reliable, efficient and practical methodology, used with a range of research studies including psychology (Butterfield et al., 2009), developed from Flanagan's Critical Incident Technique approach (CIT), where it was originally used for selecting and classifying aircrews in the army (Flanagan, 1954).

Data collection procedure

During the current study, 10 individual semi-structured interviews were completed, with each interview lasting an average of 30 minutes. Virtual

interviews were conducted over the Zoom platform. Participants were invited to tell their story of their experience of follow-ups throughout the interviews, supported by an Interview Guide based on the ECIT template (Butterfield et al., 2009).

Led by the Interview Guide, participants were first asked background information about their experience of offering CAT, to provide context for the ECIT-related questions, which involved asking participants the following three specific questions:

1. What do you think helps a CAT follow-up session to be experienced as useful, valuable or therapeutic?
2. What do you think hinders or makes it difficult for a CAT follow-up session to be experienced as useful, valuable or therapeutic?
3. We have talked about what helps and the things that make it more difficult, are there other things, a wish list or wishes, that you believe could help a CAT follow-up session to be more useful, valuable or therapeutic?

While answering the above three questions, participants were encouraged to offer specific examples and supporting information, when discussing each important factor mentioned within their answers. Participants were also asked to elaborate on their answers for the three questions, until they were unable to identify any further CIs for helping and hindering. Follow-up questions and prompts were used, to clarify and ensure sufficient detail. Lastly, to describe the sample, demographic data were collected from each participant, at the end of each interview.

All interviews were recorded using an audio recorder, which were then transferred to a secure computer. The recordings were transcribed verbatim, then individually each transcript was coded for analysis.

Data analysis

ECIT data analysis involves first clarifying the Frame of Reference, defined as the use that will be made of the data. The current study's Frame of Reference was to identify factors that could help inform CAT practice and CAT training courses. Secondly, ECIT data analysis involves extracting CIs and wish list items from the interview transcripts. In the current study, each individual incident (helping, hindering or wish) identified by the researcher from the transcripts, was coded by giving a brief summary description to capture its meaning, and then placed into

categories. The categories were derived by grouping similar incidents. Specificity and generality was considered, when forming the categories, considering if they made sense or overlapped, or needed to be merged into fewer categories.

To increase confidence in the analysis and results, the data were subjected to the nine ECIT credibility and trustworthiness checks (Table 1). The seventh credibility check, which involved contacting each participant by email, one to two months after their interview, was used to enable participants to review the interpretations made about their data. Participants were asked whether the interpretations needed revising or if anything was missing, and to confirm that the categories made sense and their CIs had been appropriately categorised. During this cross-checking, participants were given the opportunity to provide further feedback on their interpretations by email if needed.

Table 1: Summary of Credibility Checks

Credibility Check	Details
1. Descriptive validity	Audiotaping all the interviews to accurately capture each participant's words
2. Interview fidelity	The researcher's personal tutor reviewed every fourth interview transcript and provided feedback to ensure fidelity to the interview guide
3. Independent extraction of CIs by an independent person	25% of interview transcripts are randomly selected (ie four transcripts from the current study) and 100% inter-coder agreement rate was found between the researcher and two other CAT therapists (who were independent of the research)
4. Exhaustiveness	Point of exhaustion was achieved after the third interview transcript, as no new categories emerged for the fourth through to the tenth interview, suggesting a sufficient number of interviewees were interviewed
5. Participation rates	Ensuring credibility of categories by confirming that at least 25% of the participants contributed to each category
6. Placement of CIs into the pre-existing categories by an independent judge	Two CAT therapists (independent of the research), were provided with 25% of the CIs, to try to match them under the category headings, 90% agreement was found between the researcher and these independent judges, and the remaining differences were resolved by discussion (match rate of 80% or better is recommended)

Credibility Check	Details
7. Cross-checking by participants	A second contact with participants to ensure that the researcher has correctly understood each participant's story, '100% of participants responded, the majority indicated that the interpretations and categories were appropriate and fitted with their experiences (only two minor changes to specific CIs were suggested by two participants which did not impact upon the categories themselves)
8. Expert opinions	Two experts (i.e. CAT course directors), were asked whether the derived categories were useful, surprising, or if anything was missing (they independently agreed that the categories were useful – elaborated further in the Discussion section)
9. Theoretical agreement	Reviewing scholarly literature to find support for the emergent categories (this is considered and elaborated within the Discussion section)

Results

After analysis, categories with self-descriptive titles and operational definitions were finalised. The researcher extracted a total of 64 incidents from the 10 participant interviews. The incidents included 25 helping incidents, 23 hindering incidents, and 16 wish list items. The data were organised and sorted into 10 categories for CAT follow-ups: 4 categories of helpful critical incidents, 4 categories of unhelpful (hindering) critical incidents and 2 categories of wish list items.

The helping, hindering, and wish list categories, generated from the interviews, with examples of participant critical incidents, are listed in tables 2, 3 and 4. The tables also show participation rates, which indicates the strength of a category, defined as the percentage of participants contributing at least one critical incident towards the category. Preceding the tables, directly below, the 10 categories are listed with operational definitions and participant quotes taken from interview transcripts to illustrate the categories.

1. Helping Category: Continuing life guided by the CAT tools

The follow-up supports the client to hold the therapy in mind, as they step into becoming their own therapist, equipped with transitional

objects, including letters and diagrams.

'Saying goodbye is hard but we are teaching the client to be their own therapist. . . during follow-up we are checking how it is going applying the learning from therapy, the client has a good map of the patterns, you might put your hand out to touch the map, look at it carefully, re-read a goodbye letter. . . we are remembering the journey we have been on, spotting the patterns more deeply, how will you handle the patterns in the future, pointing the way forwards. . .'

'I am always curious how people got on. . . a recent example, a mum of four, she found therapy very helpful, having that space for herself, she felt very anxious about ending. . . I did one follow-up after six weeks, things weren't miraculously better, nor were they catastrophic, but she felt better equipped. . . and the looking back over therapy, alongside the letters and diagrams allowed reinforcing, reconnecting, reminders that hopefully helps to sustain the work. . .'

2. Helping Category: Therapeutic Relationship and Working Alliance

The cognitive of CAT: the therapist offers a space for reviewing, checking-in and consolidating learning, and the client is often pleased and proud to share their progress.

'I think most people appreciate being able to update me. . . if people have really carried on the therapy they are proud of themselves and excited to share that with me, they say I knew we were meeting so I have been thinking about this, they are aware this is the time to bring this into the dialogue. . . it is an opportunity for them to voice how the next stage of their journey is going, and bring any questions or concerns. . .'

'A client told me that as she knew she was coming back, she actively anticipated what we might talk about, the focus of the work, it really helped her keep it in mind, it kept the therapy alive as an extension to the work. . .'

3. Helping Category: Therapeutic Relationship and Ending

The analytic of CAT: the client fears abandonment or feels anxious about coping alone, so the follow-up offers the comfort of a gradual ending, aware of the attachment with the therapist.

‘After all the time spent together, up to the end point, it can then feel like the client is then left out in the cold, the follow-up is a cushioning around endings. . . there is someone I am coming to end with at the moment, she did come with a lot of anxiety, and was worried about continuing the work alone, three follow-ups has helped her with ending. . .’

‘Follow-ups seem to be quite holding and containing, there can be a fear of being unable to manage after therapy, uncertainty of progressing on your own without regular sessions. . . I suppose there is a feeling of relief to not be flung out on your own, left with feelings of rejection and loss. . .’

4. Helping Category: Follow-up practicalities discussed

The client is aware of the follow-up due to the goodbye letter, dates may have been discussed, and the follow-up has been explained as part of ending, a session to review and reflect following CAT, which may include checking-in on wellbeing, recognition and revision of patterns, asking questions, reviewing risk, and perhaps in-session writing, and outcome measures.

‘I think agreeing the date and time at the last appointment is helpful. . . and discussion about what the follow-up is about, it isn’t an extension of therapy, we aren’t going to be picking up any of the leftover stuff, we will check-in on how you are getting on, progress with change, is there anything else you might need from another service. . .’

‘If my supervisees are inexperienced therapists, I am keen they think about what they are trying to achieve. . . follow-up is not just to find out how the relationship ended, but what gains have they kept, you want to look at outcome measures, what do they remember about the therapy, do they turn up with a folder, and if they want more therapy then what for, what are their aims. . .’

5. Hindering Category: Therapeutic relationship and counter-transference

Client attachment needs arise during the separation and ending, including patterns of abandonment, helplessness, appearing lost, and seeking more support.

‘I am thinking of a client who really wanted to keep seeing me in

private practice, why can’t I pay you to see me, if the ending is difficult the follow-up is likely to be difficult. . . the client enacted a please help me, I am helpless and stuck. . . my default procedure is wanting to help and look after people, I needed to take that to supervision. . .’

‘It is difficult when someone is more attached, they want to continue longer, any aspect of the separation is difficult, follow-up brings up the reality of ending even more, they are coming to terms with I won’t ever see you again. . .’

6. Hindering Category: CAT without follow-up

Client engagement fluctuates at follow-up, as the client perspective is that the therapeutic work already seems complete and/or the usefulness of follow-up is not clear.

‘I have had people who didn’t want the follow-up, the end was the end, they have already said goodbye at the last session, exchanged goodbye letters, most people are quite thankful though. . .’

‘There might be an argument to not having a follow-up, just have the goodbye session, that’s the ending, there is something about knowing when it is done and sorted. . . the transference needs to be paid attention to, or the person attends follow-up to oblige the therapist, whilst actually thinking I am satisfied with the therapy and learning, I have got it and we are done. . .’

7. Hindering Category: Unclear client progress

The client’s progress appears minimal, they may have had a setback, or are coping with the impact of social factors and distressing life events.

‘I guess when someone has declined, feels a lot worse, maybe they are having a mental health crisis, it is very difficult from an organisational point of view. . . in the NHS they aren’t really on your caseload anymore, what do you do, it is a difficult balancing act, as follow-up isn’t therapy. . . if care coordinators are involved that is helpful, it is tricky if it is just you. . .’

‘The other point is when a person is displeased in some way, they haven’t got what they wanted, it is a disappointing experience. . . we have tried against the odds, but there are challenging social circumstances, they still have a lot of difficulties in their life, it isn’t a joyous moment. . .’

8. Hindering Category: Extending CAT

The therapist is left with the dilemma of considering the possibility and usefulness of extending CAT, or offering extra follow-ups, to enhance revision of relational patterns.

‘I am thinking of someone who had a very difficult history, we planned 16 sessions, but things emerged we didn’t know about, we held to the contract, but I went into the ending knowing it wasn’t enough. . . we had a series of follow-ups, I framed it as working at change, potentially we should have fully re-contracted, I generally trust the frame but when do we extend. . .’

‘I am thinking of a client who had experienced the death of their parents quite early in life, there was a maternal transference, she didn’t want to end therapy. . . I did offer extra follow-ups, so it was a prolonged ending, giving her the chance to practice the things we talked about. . . probably was helpful, but it was difficult due to the trauma, she probably would benefit from a long-term psychodynamic therapy but that isn’t offered in this NHS Trust. . .’

9. Wish List Category: Noticing the therapeutic relationship

The Analytic of CAT including the ‘good enough’ ending, emotions surrounding endings, and reflecting upon invitations into enactments and relational dances.

‘In CAT we create space for a unique relationship to develop, we aren’t performing a task or skill like a physio or nurse, the uniqueness of the relationship needs to be brought into the follow-up. . . read up on the notes, get a real living sense of the person, a follow-up shouldn’t just be stuck on the end of therapy, it needs to flow naturally and organically from the work already done, with awareness of enactments. . .’

‘I think it is something about coming into the follow-up aware of your client’s patterns and your own, trying to stay on the helpful creative productive side, watch out for the pulls. . . occasionally a client can turn up in despair, you might feel compelled to help them sort things out, hold the ending. . . I would be wary to offer an extra session, as a therapist we should give the message I trust you to continue to use what we have done. . .’

10. Wish List Category: Structuring the follow-up

The Cognitive of CAT including balancing curiosity about the client’s wellbeing and recent life events, with reviewing CAT learning, progress and challenges, the therapy ending, and revisiting CAT diagrams and letters.

‘The worst thing is client and therapist unprepared, and meeting for the sake of meeting. . . it is a follow-up on the work we have been doing together, evidenced by the reformulation and goodbye letters, the plan is to meet to talk about how things are going in light of what we have focused on. . . the follow-up is integrated into the therapy, the follow-up is linked to the goodbye process, it is task focused, bring in the maps and letters, it is a reminder of the tools, it needs to have an element of risk assessment. . .’

‘As therapists we naturally find our own way, the follow-up needs to be slightly fluid, not too prescriptive, but there are perhaps key questions and areas to cover. . . looking back on the therapy, how have you used the tools, key moments of recognising or revising patterns, sometimes it is just focusing on what the client wants to bring. . .’

Table 2: Helping Categories

Helping Categories	Examples of Critical Incident	Participation Rate
Continuing life guided by the CAT tools	‘Letters and diagrams support the client to feel better equipped’ ‘Consolidating the self-help phase of the client becoming their own therapist’	60%
Therapeutic Relationship & Working Alliance	‘Pointing the way forward’ ‘A space for checking-in and assessing the client’s goals’ ‘A space to reflect on the CAT process, affirm progress, and scaffold progress’ ‘Updating the therapist and voicing how the next stage of the journey is going’	60%
Therapeutic Relationship & Ending	‘Healthy attachment & detachment’ ‘Holding & containing feelings’ ‘Easing the ending with a staggered ending’	50%
Follow-up practicalities discussed	‘Client is informed that follow-up is part of ending to say goodbye and process the work’ ‘Therapist needs to be clear on what they would like to achieve including reviewing diagrams and outcome measures’ ‘Follow-up date is in the diary, and client is informed it is a chance to check-in, review and reflect’	40%

Table 3: Hindering Categories

Hindering Categories	Examples of Critical Incidents	Participation Rate
Therapeutic relationship & counter-transference	'Follow-up reignites the client's attachment need' 'The reality of the final ending is hard' 'Separation and enactments'	60%
CAT without follow-up	'Client does not take up the offer of follow-up' 'The last therapy session is the end' 'The goodbye letter has been enough'	60%
Unclear client progress	'Client has deteriorated' 'Client is dissatisfied' 'Client's life has collapsed'	50%
Extending CAT	'The journey of healing continues beyond 16 sessions and perhaps the client could benefit from more CAT' 'Holding the frame or extending sessions' 'NHS limited resources become challenging when clients need top-up sessions'	40%

Table 4: Wish List Categories

Wish List Categories	Examples of Critical Incidents	Participation Rate
Noticing the therapeutic relationship	'Awareness of client and therapist patterns including pulls to offer extra sessions' 'Trust in the CAT structure as the final ending may bring disappointments' 'Bring the uniqueness of the therapeutic relationship to follow-up and allow it to flow naturally'	70%
Structuring the follow-up	'Scaffolding the follow-up includes revisiting the CAT tools' 'Balancing the follow-up tasks including exploring what has gone well and been difficult' 'Clarifying the purpose of follow-up which differs in rhythm to therapy'	60%

Discussion

The current qualitative study aimed to explore the critical factors that CAT psychotherapists perceived as helpful, hinderances and wishes during CAT follow-up sessions. The study found using the ECIT methodology useful for CAT research as it is an exploratory structured approach, although the limitations include that most likely only those who were interested in the topic of follow-ups agreed to be interviewed, and it relies on some retrospective recall, which introduces bias into the data. Also, methodological limitations of the current study include the small sample of psychotherapists from the UK, the majority were white females, which raises questions on whether the perspectives are representative of other CAT psychotherapists including outside the UK, and the generalisability of the study findings. Further research could involve replicating the study in other areas outside the UK, and capturing client perspectives of CAT follow-ups.

Support for the current study's findings was obtained from the Expert Opinions (eighth ECIT credibility check), provided by two CAT course directors, who after reviewing the categories, concluded that all were useful and nothing was missing. Also, the study's ten categories align with the limited available CAT literature (ninth ECIT credibility check),

including the article focused on CAT follow-ups (Turpin, 2019), and can be embedded into existing literature.

Overall, across the helping, hindering and wish list categories, identified in the current study, there appears to be two key findings which capture key messages, for CAT therapists including trainees, regarding approaching follow-ups. The key findings (with accompanying explanations) are:

1. **The cognitive of CAT** (dates are discussed in advance, and follow-up is shaped as a space for checking-in on life events and challenges, consolidating learning, including becoming your own therapist equipped with letters & diagrams, as well as reviewing risk and repeating outcome measures)
2. **The analytic of CAT** (follow-up as a space for reflecting on wellbeing & change, reviewing minimal progress & considering extending sessions, a space where attachment needs arise during the separation, including possible fluctuating engagement, and a space for reflecting upon relational dances & emotions, with the comfort of gradual ending)

These key findings lead to reflections on CAT competence, and the ten ingredients of the CAT therapist role, as summarised in the ten-domain CCAT measure, and how they may present differently in the follow-ups of differing clients. Follow-ups may therefore emphasise the ‘analytic’ competencies, such as maintaining the external framework, basic supportive good practice, respect with collaboration and mutuality, assimilation of states and emotions, plus the therapist’s management of their own emotions. Alternatively, they may tilt more towards the ‘cognitive’ competencies, involving phase specific CAT tasks, CAT specific tools and techniques, theory and practice links, making links and hypotheses, plus managing threats to the alliance (Bennett & Parry, 2004).

Noticing how the ten categories, discovered in the current study, each seem to lean towards the ‘analytic’ or ‘cognitive’ of CAT, also invites reflections on whether there is space to balance both thinking and feeling during follow-ups, and to what extent therapists make choices. In particular, it has been suggested that a CAT therapist makes a therapeutic choice to decide on the timing to move between ‘outside’ and ‘inside’ positions in therapy, so perhaps the same occurs during follow-up. To either stay with the ‘outsideness’ of letters and the observing eye, to guide recognition and revision using diagrams, or to move from the mind to the ‘insidiness’ of shared humanity, being with feelings, the body,

and empathetic countertransference (Hepple, 2010). Also, shaping the follow-up, for each individual client, perhaps slanting more towards the ‘cognitive’ or ‘analytic’, should be guided by Zone of Proximal Development (ZPD), defined in CAT as therapists positioning themselves just ahead of their client, scaffolding their therapy experience by changing the level of support as needed for the individual (Vygotsky, 1978). The ZPD can become a shared playing zone encouraging therapeutic progress and elaborating ideas during CAT, whereas exceeding the ZPD exceeds client capacity for self-understanding leading to therapy setback and alliance ruptures (Zonzi et al., 2014). Therefore, the priority for a CAT therapist would be to consider ZPD, to guide the follow-up session, which can be further modified by considering the client’s adult attachment style and strategy. It has been suggested that the therapeutic need of a client with an anxious-avoidant self-sufficient dismissing strategy, is support to access unexpressed emotion and bodily experience, whereas a client with an anxious-ambivalent (either fearfully clingy or angrily distressed) strategy, needs to be guided towards mapping including the observing eye and self-reflection (Jellema, 2000).

Additionally, as we have been encouraged to debate and develop the model, such as questioning the CAT narrative reformulation, as the letter is presented possibly as ‘expert therapist giving’ to ‘anxious client receiving’, instead of the CAT therapeutic stance of inviting collaborative dialogue. In the same way, perhaps we should also wonder whose needs are being met by the follow-up meeting, and can we shift to therapist ‘curiously suggesting’ to client ‘empowered to negotiate’ (Jenaway, 2011), and perhaps in supervision the usefulness of follow-up for each client should be discussed rather than routinely and automatically offered.

Furthermore, perhaps the further depleted NHS resources noticeable in recent years, has shifted aspects of the original function of CAT follow-up. Especially as, more than thirty years ago, Ryle identified that during follow-up typically 1 in 4 clients should be offered top-up sessions, further follow-up or further therapy (Ryle, Poynton, & Brockman, 1990), and whether this figure now remains the same or differs, perhaps client needs are inevitably left unmet due to organisational pressures which prevent offering more. In particular, if the system has responsibility for one third of the relational dance, a dance shared with the client and the therapist, with ever-growing demands on the NHS, fewer resources inevitably limits the input for individual clients, and perhaps there is now a stronger emphasis for follow-up to be a bounded ending, encouraging new beginnings, and more quickly moving into a new chapter of life without therapy (Potter, 2014).

Moreover in the NHS, as we see increasingly complex people within a 16-session CAT, those who have multiple painful stories of loss conveyed in their narrative reformulations and reciprocal roles of rejecting-rejected or abandoning-abandoned on their diagrammatic reformulations, collaboratively negotiating more than one single follow-up may be beneficial to support a gradual ending, in the same way that the reformulation guides scaffolding the middle sessions of therapy. And bringing follow-ups into the supervision conversation, especially in private practice, is essential, where flexible boundaries with the structure of CAT may influence decisions with time-limit and follow-ups, and perhaps the CAT model developed for the under-resourced NHS, should be structured differently in private practice, including frequency and spacing of follow-up sessions.

To conclude, this qualitative study focused on CAT follow-ups using ECIT to uniquely add to the current literature, and the findings offer insights and considerations to support CAT therapists and psychotherapists in the NHS and in private practice. The clinical implications include that the study offers an encouraging message of possible ways of enhancing current practice and enhancing the learning of CAT trainees (i.e. scaffolding follow-ups guided by the ten categories discovered by the research). It also offers suggestions for newly accredited CAT therapists as they explore consolidating their identity as a therapist, with awareness of the developmental stage of the therapist, specifically the movement from anxious trainee, seeking didactic guidance and needing clear structure to learn micro-skills, to the experienced autonomous therapist who experiments with creativity within a framework and develops their own professional identity (Stoltenberg & Delworth, 1988). Overall, it is hoped that the findings and learning from the current study will be transferable to CAT training courses and support reflective conversations in CAT supervision. □

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Imagery rescripting as part of cognitive analytic training therapy

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Abstract:

In Cognitive Analytic Therapy (CAT), experiential methods are employed to support emotional processing (Ryle & Kerr, 2020). Imagery rescripting has been applied as part of cognitive psychotherapies, such as schema therapy (Morina et al., 2017; Farrell & Shaw, 2012). This article explores how imagery rescripting can be integrated within the framework of CAT.

Key words:

CAT, imagery rescripting, creative methods

Introduction

CAT and schema therapy draw upon partially overlapping theoretical foundations and share overlapping features in their conceptual frameworks (Ryle & Kerr, 2020; Young et al., 2003). CAT is an integrative framework in which the therapist and client collaboratively seek to develop an individualised understanding of the psychological processes underlying the presenting problem (Ryle & Kerr, 2020). It focuses on identifying reciprocal roles and related procedures that emerge during early developmental stages. Like CAT, schema therapy also investigates early maladaptive patterns, focusing on the identification and modification of schemas and coping styles developed in childhood (Arntz & van Genderen, 2009; Young et al., 2003). Schema

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activation is conceptualized through the framework of modes, which are classified into parent modes, child modes, maladaptive coping modes, and the healthy adult mode.

CAT understanding of reciprocal roles offers points of convergence with the schema mode model. The closest parallels appear in the earlier phase of CAT's development, particularly in Sequential Diagrammatic Reformulation (SDR) diagrams, which delineated a 'core state' marked by intolerable emotions or core pain. These formulations often incorporated positions for the internal child and internal parent (Maple & Simpson, 1995). Over time, CAT shifted toward the concepts of reciprocal roles and reciprocal role procedures (Ryle & Kerr, 2020). CAT emphasises reciprocity in all positions (Leiman, 2015), whereas in schema therapy, reciprocity tends to manifest more narrowly in the dynamic between parent and child modes, in a manner reminiscent of SDR configurations. Notably, in CAT, reciprocal roles inherently allow for positional shifts, such as moving from one pole of a reciprocal role to another (Ryle & Kerr, 2020).

The two approaches diverge more clearly in their views on the mechanism of therapeutic change and the therapist's positioning. Within the classical model of CAT, emphasis is placed on a progression – guided by the client's pace – toward the unbearable position, facilitated through the recognition of warning signs and defensive patterns (Leiman & Stiles, 2001). Therapeutic work is grounded in the client's zone of proximal development (Ryle & Kerr, 2020) and the therapist should avoid pressuring the client to confront emotional experiences prematurely or beyond their proximal developmental zone, as such an approach is considered unproductive or potentially detrimental to the therapeutic process. When therapeutic progress becomes stalled, the client is supported by engaging in detailed exploration of their experiences and recurring patterns of behaviour, while collaboratively identifying new ways of acting and experiencing. The exploration also focuses on patterns that emerge within the therapeutic relationship. This process aims at the development of the client's observer position, which supports a shift from an object position toward a subject position. Through this shift, the client gains a sense of agency in relation to emotional experience (Leiman, 2012).

Schema therapy, in contrast, adopts a more therapist-directed stance, seeking to directly engage core emotional pain through experiential work and the use of limited reparenting (Arntz & van Genderen, 2009; Young et al., 2003; Farrell & Shaw, 2012). Limited reparenting entails the

therapist responding directly to unmet developmental needs associated with the client's 'inner child' – for example, by offering comfort, protection, or validation (Farrell & Shaw, 2012). The therapist may explicitly model the idea that emotional experiences are not dangerous and may encourage the client to engage in experiential processing (Young, Klosko, & Weishaar, 2003; Farrell & Shaw, 2012). At the same time, it remains essential that such emotional work remains within the client's window of tolerance (Hayes & van der Wijngaart, 2020).

Experiential methods are employed to support emotional processing (Ryle & Kerr, 2020, Arntz & van Genderen, 2009; Farrell & Shaw, 2012). Imagery rescripting is an experiential therapeutic approach that, according to empirical evidence, has demonstrated efficacy in the treatment of various psychiatric disorders, including post-traumatic stress disorder, social anxiety, body dysmorphic disorder, severe depression, bulimia nervosa and obsessive-compulsive disorder (Morina et al., 2017). Typically, imagery rescripting begins with a current emotionally charged experience and proceeds, via an affect bridge, to an emotionally salient memory from childhood or adolescence. This facilitates access to primary emotional states and, through corrective intervention by the therapist, enables the emergence of a more adaptive emotional experience. Imagery rescripting is believed to modify maladaptive emotional memory through various mechanisms. These may include desensitization through exposure, the generation of more adaptive internal images, reduction of the intensity of negative images, or the internalization of a corrective emotional experience in which unmet needs are addressed (Simpson & Arntz, 2020). Furthermore, this process may contribute to the development of a secure attachment in therapy (Hayes & van der Wijngaart, 2020).

Methods

This article illustrates the use of imagery rescripting through a case vignette from session 27 out of 120 in a cognitive analytic training psychotherapy. The illustrative vignette is based on an audio recording of the session, which was subsequently transcribed for the purpose of detailed analysis. The session and the specific excerpt selected for analysis were identified by the trainee therapist as a potential turning point in the therapeutic process, warranting closer examination.

Case

‘Lynne’ (pseudonym) is a 36-year-old woman who has engaged in cognitive analytic training psychotherapy due to depression. Her childhood was largely characterised by emotional deprivation and a sense of insecurity. She has experienced acceptance and recognition primarily through being useful and accommodating to others. Lynne has developed a protective position within a reciprocal role pattern of ‘being-for-others or being emotionally controlled – accepting’. Spontaneity is associated with a risk position that exposes the client to the unbearable position, characterised by a reciprocal role of ‘abandoned – abandoning’. Within the therapeutic relationship, Lynne has largely remained in a protective position, in which she avoids taking a position of need in relation to the therapist. Examination of reciprocal roles and procedural patterns alone has not sufficiently accessed her emotional experiences and the therapist has experienced that sessions tend to revolve around the same themes without progression. The therapist has applied imagery rescripting to support access to emotional experiences, employing a version of the method in which the therapist takes on a role within the imagery to respond to the child Lynne’s emotional needs. Lynne has reported imagery rescripting as helpful and the therapist has also found it beneficial; however, the therapist noted that imagery rescripting appeared more therapist-directed compared to the CAT framework, which created a sense of tension regarding the therapist’s positioning as a ‘rescuer’ in the process. The therapeutic relationship seemed to oscillate between Lynne maintaining self-reliance and – during imagery rescripting – the therapist adopting a position of a ‘rescuer’, rather than achieving a more flexible and reciprocal co-agency. The therapist recognised this dynamic; however, Lynne’s protective position made direct exploration of the relational pattern challenging. Attempts to bring attention to it did not meaningfully alter the process. This observation informed the decision to explore imagery rescripting as an alternative therapeutic pathway.

During the session, Lynne reports feeling recently exhausted and lacking the energy to support a relative, which leads to feelings of guilt accompanied by physical symptoms such as a burning sensation in the throat, shortness of breath, nausea, and stomach pain. She recognises her guilt as excessive and struggles to resist it. In the therapeutic relationship, she appears primarily self-supporting. This is illustrated when Lynne initially describes the difficult emotional experience but then shifts to a neutral, brisk speaking style, seemingly to distance herself from the affect and avoid burdening the therapist.

Lynne recognises a corresponding emotional experience linked to a memory from when she is approximately 13–14 years old and receives an unexpectedly large sum of money from her grandmother as a reward for helping with yard work. At home, her parents react critically to this, which leads her to experience feelings of shame and fear of being perceived as greedy. The therapist proposes exploring this memory through an imagery exercise, in which adult Lynne would address child Lynne’s needs and Lynne agrees to this approach.

The therapist asks Lynne to close her eyes and directly observe the childhood situation. Lynne describes child Lynne as distressed, uncertain, and disoriented and her parents as overwhelming figures, as if seen from the vantage point of a baseboard, experiencing them as tense and somewhat shaming. The reciprocal role configuration is characterised as ‘distressed, helpless – controlling, disappointed’.

The progression of the first part of the imagery exercise is summarised in vignette 1.

Vignette 1

Literation	Reciprocal roles (the client’s identified position is bolded)	The therapist’s focus and its effect on the therapeutic framework
T: How does it feel when you look at these giant parents who are tense and embarrassed, and then there’s this child who feels insecure and ashamed – how does this whole situation feel?		The therapist guides the client to examine the relationship between the child and the parents, and to reflect on the emotions this relationship evokes in her.
C: Really, like unbalanced and kind of unfair.	Unfairly treated – unfairly treating	The client accesses the experience of the child not being acknowledged in the situation. The therapist reinforces this with a validating ‘yes’ and further guides the client to explore the needs associated with this feeling.
T: Yes. What does that child’s feeling bring up to you?		
C: I feel like I want to intervene – and say it straight		

The therapist guides Lynne to act in accordance with the emotional need expressed in the imagery. She begins speaking to her parents, continuing to address them directly: 'It is, I don't know how to start but it's up to granny and grandpa if they want to give money for something. . .' The content of her speech involves advising and providing justifications for her perspective.

Subsequently, the therapist directs the client to examine the reciprocal role configuration between the child and the parents. The client reports that the parents appear to understand her, and that the previously imbalanced dynamic between child Lynne and her parents feels somewhat alleviated: 'For some reason, the size difference between my parents and me has normalised'. At the same time, she acknowledges that child Lynne still experiences guilt about wanting something solely for herself. The reciprocal role configuration is represented as 'guilty – accusing'. The therapist asks what the client wishes to say to child Lynne. The client responds to child Lynne: 'It's not my responsibility to take care of the family finances, and if I have worked, I deserve to enjoy the reward from it. . .' The speech is expressed in the first-person perspective, instead of directed from adult Lynne to child Lynne. The therapist then invites the client to re-examine the appearance of child Lynne, to which the client describes the child as looking uncertain. Lynne's speech to child Lynne has not affected the reciprocal role configuration which appears as 'uncertain – threatening'. The therapist again guides the client to examine how child Lynne appears, to reflect on the emotions evoked in adult Lynne by child Lynne's emotional state and to consider how adult Lynne wishes to respond. This is expressed in vignette 2.

The client then continues speaking to her parents, her tone of voice becomes more assertive, and she now expresses opposition toward her parents more directly. The therapist once again invites the client to observe child Lynne. Lynne describes child Lynne as 'stubborn, somewhat more confident, more balanced or steadier, with a straighter back, better posture, and more spirited'. The reciprocal role configuration has shifted, now appearing as 'relieved – defending'.

The therapist then asks the client to reflect on how she feels when child Lynne looks at adult Lynne, after she has defended child Lynne. Lynne identifies feelings of pride, joy and courage. She describes child Lynne as appearing relaxed and carefree. The therapist encourages Lynne to notice what this evokes within her, at which point she becomes tearful and responds, 'A lot of tenderness and protectiveness, and joy that it feels like I can breathe again.'

Vignette 2

Litertion	Reciprocal roles (the client's identified position is bolded)	The therapist's focus and its effect on the therapeutic framework
<p>T: Yes. So, what comes up for you when you look at this child who's feeling –'all' unsure like that?</p> <p>A: I feel really sorry for her. . . And it makes me furious, how a young child (<i>sighs</i>) can feel so knocked about and all on edge like that.</p>		
<p>T: Have a listen to that anger you're feeling. What do you wanna say for this child? Just tell the parents straight, okay?</p>		<p>The therapist guides the client to hold onto the emotion and to speak to the parents.</p>
<p>A: Well, it's not right to put big expectations on little children. They're not mini-adults, they shouldn't have to worry or feel guilty about stuff like this. . .</p>	<p>Defending – defended</p>	<p>Speaking from this emotional standpoint shifts the focus of the speech from advisory to more clearly defending.</p>

After the imagery exercise, Lynne reports that the burning sensation in her throat has subsided, and she finds it easier to view the initial situation with greater freedom: 'Somehow, my own well-being now weighs more heavily on the scales than the well-being of others'. Lynne reflects on how, in her childhood home, her parents' attention was primarily directed towards external matters and other people, while both the parents' and children's own needs remained secondary. This forms an explanatory framework in Lynne's understanding for why she tends to

prioritise others' needs excessively and experiences guilt over being unable to meet others' needs in accordance with her own heightened expectations.

The therapist observed a parallel between the parental stance in the imagery (controlling, disappointed) and elements of the therapeutic relationship, in which the therapist's active guidance during earlier imagery exercises may have inadvertently replicated a similar dynamic. This observation informed a shift toward more strongly supporting Lynne's own agency in the present exercise.

Discussion

Imagery rescripting proceeds cyclically by continuously examining the effect of actions on the inner child's experience and continuing the process until the client reports relief from the challenging emotional experience (Simpson & Arntz, 2020). From the CAT framework, change in imagery work can be observed through shifts in the client's reciprocal roles. During the therapy session, the therapist guided the focus according to changes in the reciprocal roles until the reciprocal role related to the unbearable position had eased. The therapist initially directed the client to observe the reciprocal role linked to the experience and the emotions it evoked. Examining the reciprocal role configuration (helpless, distressed – controlling, disappointed) between child Lynne and the parents elicited appropriate feelings of anger in Lynne, enabling her to take a position to defend child Lynne. After this, the therapist encouraged her to tune into the action impulse arising from the feeling of anger and to respond accordingly. Following her response, the therapist guided Lynne to re-examine the reciprocal role and the emotions it evoked in her. During the imagery exercise, Lynne's first speech to the parents was more advisory and lacked strength. When reflecting on the effect of her speech, she recognized that the parents heard her, but child Lynne still appeared uncertain, and a maladaptive reciprocal role (guilty – blaming) and feeling of guilt were still present. The therapist then guided Lynne to speak to child Lynne. She spoke to child Lynne in the first person, which blurred the distinction between the adult and child selves, keeping the reciprocal role challenging. At this point, the therapist guided Lynne to re-examine the countertransference (pity) evoked by the reciprocal role and to act again from the emotion, after which her speech to the parents became more openly challenging and assertive. Lynne recognised that the reciprocal role had changed (defending – defended) and that it

reflected both the positions of adult Lynne and child Lynne.

A new element in the corrective imagery work involved directing the client's attention to her countertransference in moments when the child-self showed a positive response to the client's nurturing and defending efforts. The aim was to strengthen commitment to the child-self and foster self-compassion. This approach proved effective as Lynne responded by expressing stronger compassion toward child Lynne, and her emotional reaction changed (tearfulness) in response to the work.

The imagery exercise utilised the CAT-specific precise conceptualisation of emotional experience as reciprocal roles, which appeared in the imagery between the client's child-self and parents, the internal reciprocal role of the child-self, the reciprocal role of the child-self in relation to the adult self, the reciprocal role of the adult self in relation to the child-self, and the internal reciprocal role of the adult self. In CAT, this subtle and precise delineation is considered helpful in moving the client toward change through developing the observing position (Ryle & Kerr, 2020), and this mapping now occurs within the imagery rescripting. In CAT this is considered to enable new modes of relating to emerge and expand the repertoire of reciprocal roles (Ryle & Kerr, 2020). In schema therapy, change is thought to arise from addressing unmet emotional needs and supporting the client's capacity to meet their own emotional needs (Young, Klosko & Weishaar, 2003; Arntz & van Genderen, 2009). Imagery rescripting in this article can be seen as manifesting all these elements: delineating reciprocal roles helped the client to discover a new observational perspective, through which she accessed a new way to understand the child-self's experience. The therapist supported the client's ability to defend and soothe herself, which created a new relationship with the self, manifesting as a new way of being in relation to another. After the imagery work, the client's observing position was strengthened and there was a shift from an object position to a subject position in the current situation. The client was no longer bound by feelings of guilt but could view the situation more freely. She recognised that the childhood atmosphere had contributed to turning her thinking excessively toward others at the expense of meeting her own needs.

The work proceeded based on the client's experience and needs, with the therapist guiding the focus and the client directing the action. The therapist continuously evaluated her actions through the relational roles emerging in the therapy relationship. In imagery rescripting, the extreme positions could be either the client being left excessively alone or the therapist holding the client too much. Secondly, the therapist

assessed the client's tolerance: how far it was possible to go and where to stop. The risk here would be pushing the client into a situation exceeding her tolerance or excessive caution, which might communicate that emotional experiences are dangerous. In the CAT framework, the client should not be pressured to face emotional experiences (Leiman & Stiles, 2001). The work advanced through the therapist's ongoing reflection and clinical decision-making about whether to support the client to act independently or to provide support herself, rather than proceeding strictly according to theory. In reflective and flexible functioning, both client and therapist can take active roles alternately, making it unclear which parts are therapist-led, and which are collaborative. This may be seen, for example, in a therapist's question about whether the client wants the therapist to defend them in the corrective imagery or whether the client prefers to defend themselves.

The roles of therapist and client in the training therapy had previously fluctuated strongly, either with the client being largely self-reliant or, in imagery rescripting exercise, the therapist appearing as a strong defender. The CAT framework emphasises collaboration rather than therapist dominance, supporting the client's autonomy, a sense of competence, and the safety of the therapeutic relationship (Ryle & Kerr, 2020). The client's agency was supported by choosing a working method in which she acted as the defender and comforter of the child-self. The change in working method equalised the previously imbalanced roles between therapist and client. At the same time, the client was able to adopt a position of need rather than being left alone with a vulnerable emotional experience. Imagery rescripting may facilitate client progress toward developing a secure attachment relationship (Hayes & Wijngaart, 2020). In this case, the contrasting relational dynamics – between Lynne's habitual self-reliance and the therapist's earlier positioning as a rescuer – remained an implicit backdrop rather than being explicitly addressed in the session. The therapist's awareness of this pattern informed the clinical decision to shift toward a working method that supported Lynne's active agency. Although the relational dynamic was not directly named, the change in method itself constituted an implicit response: by positioning Lynne as the defender rather than the recipient of rescue, the imagery exercise provided an experiential resolution to a relational tension that had not yet been accessible through direct exploration or focus. The shift to active agency in imagery work supported the strengthening of self-compassion and increased the client's sense of competence in responding to her emotional experiences, which was evident during the imagery work as the client described feelings of

strength and joy when successfully defending her child-self.

Pitfalls in the work could include the therapist's rigid way of conceptualising the process. Insensitivity in exploring reciprocal roles or the client being left too much on her own might repeat the client's reciprocal role of being alone and helpless without being defended. Excessive support, on the other hand, might convey that the support is externally imposed and reduce the development of personal agency. A strongly therapist-led approach may overly direct the process, potentially obscuring the client's own experiences and needs, and pushing her into emotionally overwhelming material beyond her zone of proximal development. This session exemplifies how different theoretical frameworks can be used simultaneously in therapy work, allowing flexibility according to client needs. □

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Working Together Towards Overcoming Transgenerational Trauma

Using Cognitive Analytic Therapy With Child-Caregiver Dyads

DR ANDY HORAN

Abstract:

Children, young people, and families who seek support from community Child and Adolescent Mental Health Services (CAMHS) have experienced a disproportionate number of childhood adverse experiences. Many families continue to endure uncertainty and adversity due to the global events and political context (e.g., racism, poverty, and gender-based violence). Building trust within this context requires therapists to work in trauma-informed ways that focus on establishing effective therapeutic relationships. Cognitive analytic therapy (CAT) is an approach that mainly focuses on relationship patterns to help people overcome psychological distress and develop positive ways of relating that encourage emotional wellbeing. Whilst offering therapy within a child and adolescent mental health service, CAT was extended to focus on both young person's relationships and the relationship between caregiver-child; also referred to as a child-caregiver 'dyad'. Theoretically, 'Dyadic CAT' offers advantages such as the opportunity to influence and overcome transgenerational patterns that may not be possible within individual sessions with young people. There are several adaptations to individual CAT that therapists may consider when offering a dyadic intervention including: (a) identifying the target for therapy, (b) power imbalances, and (c) balancing the needs of three learners to promote discovery within therapy. Early outcomes and anecdotal evidence indicate that CAT can be a successful intervention for caregiver-child dyads in promoting change and healing from transgenerational trauma. Further practice-based research is needed to develop the structure and practice of Dyadic CAT including the integration of other relational theories.

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Introduction

Many young people and families working within community child and adolescent mental health services (CAMHS), describe histories of violence, abuse and neglect. It is acknowledged that children, young people and families who seek support from CAMHS have experienced a disproportionate number of adverse childhood experiences when compared to the general population (Reay et al., 2015). Given the uncertainty and adversity endured by many young people, it is unsurprising that they link their anxieties and distress to the cost-of-living crisis, global warming, education provision, long-term austerity, gender-based violence, classism, and racism amongst other circumstances outside their immediate control (Blundell et al., 2022; People et al, 2014).

Working together towards change in this context can present challenges to establishing trust and effective therapeutic relationships. It is not uncommon for families to report that public services, such as education and health and social care re-enact past trauma-related patterns. For example, the long wait for a CAMHS worker may be experienced as depriving, causing, the young person's unmet mental health needs to worsen, resulting in the family feeling increasingly desperate, and potentially humiliated if their attempts to seek help are declined. Hagan, Armstrong, and Bostock (2018) have described how such experiences can shape a person's sense of self, exacerbate difficulties, and mirror the adverse history of service users.

Many young people report self-harm, suicidal feelings, anger, low self-esteem, anxiety, and low mood. Cognitive Analytic Therapy (CAT) is a helpful approach to support young people with these difficulties, including working proactively to prevent the re-enactment of harmful patterns with services. Some young people and their caregivers (a child-caregiver *dyad*) express a need and preference to work together towards improving the young person's mental health *and* the relationship between them. Three such families were offered a 'dyadic' version of CAT, and there are the initial reflections and ideas about how this innovative approach could be used to overcome transgenerational trauma within a community CAMHS context.

Working with Caregiver-Child Dyads

Although working dyadically with adolescents involves an extension of current CAT practice, there are several areas of overlap with current

approaches. For instance, working with care-coordinators and service-user dyads has been the focus of Cognitive Analytic Consultancy (Carradice, 2013). Jenaway (2007) also proposed an approach to working with parents focused on exploring their relational patterns with their child. Theoretically, dyadic therapy offers several advantages including opportunities to influence and overcome trauma-related difficulties across generations that may not be possible within individual sessions with young people.

In other modalities, dyadic interventions are offered to looked-after and adopted children using Dyadic Developmental Psychotherapy (DDP; Hughes, Golding, & Hudson, 2019). Systemic approaches have proposed an integration of systemic theory, attachment theory and narrative theory in the development of Attachment Narrative Therapy (ANT). ANT is offered to couples, dyads, and families, and has been used to address a wide range of problems including trauma, loss and eating distress (Dallos & Vetere, 2021). There is increasing evidence supporting the effectiveness of individual CAT or CAT-informed interventions with adolescents, particularly with young people who have experienced complex developmental trauma who may develop behavioural patterns that meet diagnostic criteria for so-called 'borderline personality disorder' later in life (Chanen et al., 2008; Chanen & McCutcheon, 2013; Chanen, McCutcheon, & Kerr, 2014). It is plausible that this client group may benefit from extending and developing this approach to include parent-child dyads. Ryle & Kerr (2020, p.66) suggest that CAT provides more comprehensive and clinically applicable tools than attachment theory and offers a 'structured relational framework from within which to understand complex and challenging disorders'. Therefore, the integration of CAT with current dyadic practice may benefit young people and their families.

Dyadic Therapy or Individual Therapy with a Co-Therapist

The extent to which parents are involved with an adolescent's therapy varies. A common approach to including parents is to support the therapist and child to successfully complete an intervention that is predominantly offered on an individual basis with the child. This approach typically aims to share information about the child's mental health needs, teach the parent tools used within therapy (e.g., graded exposure) and to prevent parental beliefs negatively impacting progress within the child's therapy (Cardy, Waite, Cocks, & Creswell, 2020). This

approach aims to enhance individual therapy and support generalisation, as the parent takes the role of ‘co-therapist’ in support of the young person’s progress within therapy. In contrast, dyadic therapy involves caregivers throughout the intervention and invites them to bring more of themselves, as caregivers and individuals, into the work of therapy. The approach intentionally focuses on the relationship between caregiver and young person in addition to their relationships with others. Figure 1 depicts the differences between these approaches.

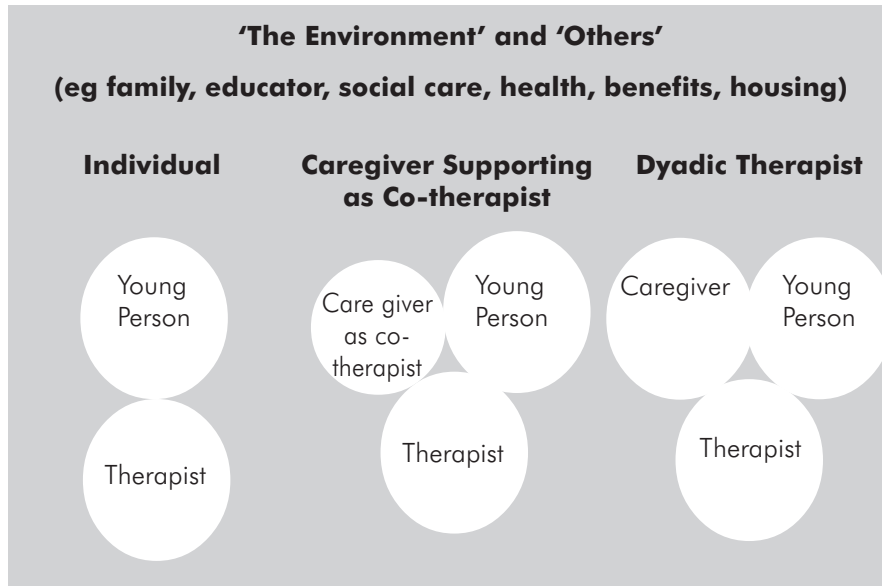


Figure 1: A diagram depicting the microenvironment within therapy of individual therapy, individual therapy with caregiver as co-therapist, and dyadic therapy.

CAT in CAMHS

Young people are usually offered 16 sessions of CAT, and adolescents with more complex presentations may be offered 24 sessions (Chanen, McCutcheon, & Kerr, 2014). CAT is divided into three tasks, described as the ‘3 Rs’ of CAT: Reformulation, Recognition and Revision. Reformulation involves working collaboratively within therapy to develop an understanding of the client’s presenting concerns. The therapist works with the young person to identify the patterns that contribute to their distress. The recognition phase focuses on noticing these patterns in their everyday lives and within the therapy room. Finally, revision both involves implementing changes to ‘exit’ these patterns and tasks aimed at preparing for the end of therapy (Corbridge, Brummer, & Coid, 2017).

‘CAT-informed’ work may digress from this format, such as completing a reformulation only with parents (e.g., Jenaway, 2018).

Key Concepts within CAT

CAT uses several ‘tools’ to facilitate therapeutic tasks within each phase, two of these ‘tools’ are considered key concepts within CAT – namely, procedural sequences and reciprocal roles (Ryle & Kerr, 2020). Reciprocal roles are learned in our earliest experiences in relationships with caregivers. Ryle and Kerr (2020, p.9) outline that:

‘CAT theory focuses principally on the way in which early relational, including socio-cultural, experience is internalised in the developing Self as a repertoire of (“formative”) reciprocal roles and the emergence of “responsive,” “coping” patterns or reciprocal role procedures.’

Reciprocal roles (RRs) encapsulate a child’s early relational experiences, internalised and subsequently replayed in later relationships, with others and with oneself. RRs have two poles which describe two relational experiences, with the top pole representing the more powerful ‘parent’ role and describes an action, or omission, and the lower pole is how the less powerful ‘child’ experiences this. RRs can be enacted from self-self, self-other, and others-self. Figure 2 outlines an example of a RR and a diagram outlining the possible enactments.

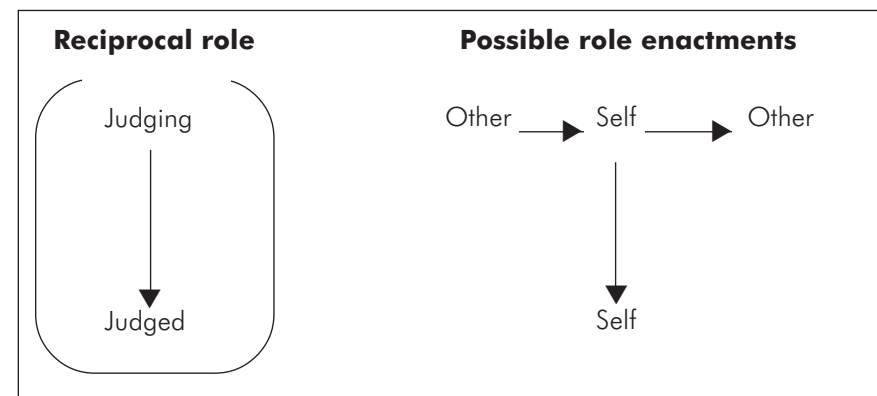


Figure 2: Left is a diagrammatic representation of a reciprocal role. Right is a diagram outlining the possible enactments that can occur within a reciprocal role.

Procedural sequences refer to the idea that people who experience psychological distress are caught in repeated patterns of responding that are initially aimed at alleviating their distress, however eventually serve to exacerbate their difficulties. *For example*, an adolescent who is fearful of judgement may keep their feelings to themselves and become self-reliant. This develops into a sense of responsibility that feels too overwhelming, resulting in them feeling unable to cope. Eventually their feelings pour out in a way that they experience as out of control, leaving them feeling judged and embarrassed. These ‘procedural sequences’ are learnt in childhood in response to the relational environment in which we develop. With repetition, procedures begin to operate outside our conscious awareness and only draw our attention when they result in difficulties or distress in ourselves and/or others

Dyadic CAT

The preparation phase for both 16-session CAT and ‘CAT-informed’ work with young people and their parents is important to a successful intervention. This is an opportunity to determine whether Dyadic CAT would be of benefit, make expectations and goals explicit and agree a collaborative plan for therapy. Whilst young people should be offered a choice, where possible, in how their therapy is completed (some adolescents may wish to attend alone to exercise their independence and focus on their self as a developing individual Marcia, 1993), if it is agreed that a dyadic approach may be more beneficial, the following are helpful in considering whether Dyadic CAT is the most suitable intervention.

Suitability of Dyadic CAT

Hagan, Armstrong and Bostock (2018, p.40), suggest that ‘It is assumed, but rarely spelled out in therapeutic writings, that people seeking help in adulthood have significantly changed their position in the world from childhood, making their habitual patterns of coping no longer relevant or necessary’. This applies to both the parent and adolescent attending dyadic work, although the adolescent is likely to have relatively fewer changes in their circumstances, and less ‘real’ power, be that material or personal resources. Within the therapy, it is important to recognise that the early survival strategies may still be an adaptive response in the current family and social context and that this may impact on the scope of therapy

(Hagan, Armstrong, & Bostock, 2018). If this is the case, then any therapy risks locating the problem in the person or family when change is required elsewhere. A response focused on changing the educational, employment, financial, or the social context of the person may therefore be more beneficial.

A key aim within dyadic CAT is to work towards caregivers offering a different relational experience to their child. To assess the viability of this there are caregiver-specific areas to explore including whether the caregiver themselves have unmet needs, including mental health needs, that may impact on their ability to access a reflective therapy. For instance, a parent’s post-traumatic experiences of domestic violence, may reduce their reflective capacity when exploring the young person’s early relationships. As dyadic therapy focuses on the caregiver-child relationship, and not on the caregiver’s mental health, these post-traumatic difficulties may need to be addressed outside of dyadic sessions (i.e., within adult mental health services). Another consideration is the role of the neurobiology in caregiving and trust between caregiver and child. Hughes and Baylin (2016) describe how adversity and trauma can interrupt attachment processes, to such an extent that caregiver’s experience ‘blocks’ in their ability to care for their child. In this case, individual sessions with the caregiver, focused on psychoeducation and exploring these blocks, may be beneficial, followed by revisiting the suitability of individual or dyadic therapy.

Using Dyadic CAT

The aims of Dyadic CAT are to prevent the re-enactment of harmful patterns, including between services and families, and to develop alternative ways of relating that facilitate change and healing. Moving from individual to dyadic CAT involves additional tasks early in therapy. In their approach to combining attachment and systemic approaches for families, Dallos and Vetere (2021) proposed four phases of therapy: (1) Creating a secure base; (2) Exploring the problems; (3) Exploring alternatives; (4) Integration and maintaining contact. Phases 2-4 are similar to the phases of dyadic CAT, however more attention is given to preparation for therapy through establishing a ‘safe base’. Approaches to creating a safe base vary greatly and depend on the dyad’s needs, and ‘talking about the talk’ and use of systemic ideas including ‘relational reflexivity’ can help set the scene for dyadic work (Burnham, 2018). A common theme in establishing safety in both ANT and DDP is the need

to adopt an open, non-blaming, playful, and slowed-down approach. This is explicitly named and encouraged within DDP through the use of PACE - Playfulness, Acceptance, Curiosity, Empathy (Hughes, Golding, & Hudson, 2019).

Managing Shame and Blame Through Early Mapping

Blame and overwhelming shame can present a threat to the 'safe base' of therapy, particularly when parents feel blamed for their child's mental health problem by services. When transgenerational patterns emerge in the parent's life, even if they become aware of their attachment response patterns towards their child, these patterns can be very difficult for them to alter, leading to a 'double sense of failure' that can result from their own childhood trauma and current shame (Dallos 2019). 'This is especially the case when their attachment scripts and corrective intentions are driven by powerful traumatic states. It is as if the trauma from their childhood has been abusive twice over: once as part of their own childhood and now again despite their best intentions.' (Dallos 2019, p.135). In dyadic CAT, caregivers' descriptions of their childhood are responded to with respect and curiosity, focussing on relational themes and patterns rather than a detailed description of events. It is important to continually locate these experiences in the time and place they occurred – that is, the caregiver's childhood. One way of describing the internalisation of these experiences is to refer to the 'inner child' of the parent, which acknowledges the relative powerlessness of the parent at this stage in their life and invites compassion within the therapy. This approach often reveals transgenerational patterns of relating that can be identified as 'the problem' and be worked on together. Typically, this involves inviting young people and caregivers to consider relational patterns that have been 'handed down' across generations, highlighting the impact of distal influences on their distress (e.g., governmental policy, and discrimination) and thus extending the 'field of vision' within therapy beyond that of proximal relations (e.g., relationships with family, friends and school; Hagan & Smail, 1997). Within CAT reformulation letters to dyads, it is useful to include a paragraph focused on the caregiver's experiences of being parented and any links to transgenerational patterns and distal influences. At this stage in the work, caregivers may wish to share information outside the session, with the therapist, including more information about the abuse they have endured. There may be several reasons for this, including making the therapist aware of their limits within therapy (e.g., concerning sensitive or distressing content and

'reminders' of the abuse), to provide further context to the therapist's understanding of the caregiver, to seek additional support for themselves, and to problem-solve how to share important parts of the family narrative with the child. With these needs in mind, both young person and caregiver should be made aware that space can be made outside sessions for telephone or in-person discussions if requested.

Reformulation: Agreeing the Focus of a Dyadic CAT

As depicted in Figure 1, working dyadically introduces additional relational dynamics within therapy. Initial sessions aim to identify target problems and target problem procedures which then constitute the focus of the therapy. Within the cases studied to date target problem procedures related to: (a) child self-self, (b) child-other, (c) caregiver-child, and (d) dyad-other. It is important to name and maintain the boundary of CAMHS work and adult mental health care by not targeting care-giver's relationship with self or others, except in relation to their child and others related to the young person's care, although these may be acknowledged in the work. One way to structure and clarify the focus of dyadic work is by grouping target problem procedures at the end of the reformulation letter. An anonymised example of grouped target problem procedures follows: (permission was sought and granted from the young person and caregiver for its use.)

To cope with these relational experiences, it appears that Sarah has relied on the following patterns:

(a) Things need to be big to be taken seriously

Due to having repeated experiences of being dismissed, it's difficult for me to feel confident that others will attend to and help me manage my feelings. When distressing feelings come along, I worry about being dismissed and rely on things being big so that they are noticed. In these moments however I'm not sure what I actually need to feel cared for or 'taken seriously'. This means that, regardless of what people offer me, I struggle to 'let in' other people's care. Consequently, I don't feel cared for and believe that I need to be even more ill to get what I need, resulting in me competing to be 'the most ill'. This however means that people focus on the 'big thing' (e.g., illness) and miss what is truly going on for me in that moment, causing me to feel even more dismissed.

To cope with experiences that you have **both** been through, it appears that you have both relied on the following patterns:

(b) Bottling Up Feelings and Hiding Away to Avoid Judgement

Due to having few experiences of our feelings being responded to in helpful ways, we experience an urge to protect ourselves from judgement by 'just getting on with it', bottling-up feelings, avoiding, or joking to avoid being seen. This may offer some relief in the short-term, however repeatedly bottling-up feelings means they build up over time. The feelings then become overwhelming and burst out, resulting in feelings of judgement.

Grouping target procedures in this way allows more precision in the reformulation letter and acknowledges the difference in relational experiences between caregiver and young person.

Asymmetry in Relationships Within Dyadic Therapy

In its original form, RRs are presented diagrammatically, as in figure 2, with the more powerful role at the top and the response at the bottom of the role. Through experiencing this relational dynamic, the person internalises both poles of the role and therefore has a capacity to enact both the top and bottom poles (Ryle & Kerr, 2020). It is not uncommon to find that people are frightened of enacting the top pole of an abusive role and therefore behave in ways that avoid enacting the abusive dynamic at all costs (i.e., a fear of enacting attacking roles leads to avoiding any behaviour that could be seen as attacking including assertiveness, thus resulting in passivity). Within dyadic therapy, the caregiver often has more power than the child, meaning that the top role is less available to the child (e.g., the child is less able to act in a depriving or neglecting way towards the parent). This relational asymmetry is not reflected in traditional CAT diagrams which implicitly suggest that both poles are equally available to parent and child. Brown (2019) emphasises the need to 'factor in' power differences into RRs including familial power inequalities, and power imbalances in relation to the therapist and wider society. Brown proposes three groups of RRs: Top-heavy roles, Bottom-up roles, and 'the middle ground'.

Top-heavy roles describe when 'power lies exclusively in the enacting pole. These interactions may start as encouraging or containing, but can slip into infantilising, patronising, coercive or abusive styles of relating. The recipient of such treatment has limited options and tends to capitulate or collapse, which we sometimes describe as feeling 'crushed', or to explode and unsuccessfully retaliate' (p.29).

Bottom-up roles are reciprocal roles that represent the attempts of those without power to organise and elicit the input they need. For example, a young person may use their limited bodily power to enact a 'bottom-up' role through starvation and self-harm.

'In *the middle ground*, we find consensual relationships of mutuality and reciprocity' (p.29). Integrating these ideas into diagrams with dyads is useful and they can be used in a variety of ways to symbolise differences in power including using colour, changing the size of text and co-creating symbols.

Brown (2019) proposes that drawing arrows within the RR can help signify which end of the RR someone is 'pulled' towards as a consequence of imbalances in power. In a recent dyadic session, we drew an A4-sized spotlight alongside the diagram to symbolise the judgemental gaze of powerful professionals. This symbol was an analogy for the 'top-heavy' [Judging-Judged] reciprocal role that professionals occupied in crisis situations, such as the dyad attending Accident and Emergency. In these moments clinicians directed a bright spotlight towards the young person and her mother, resulting in them feeling shamed; an interaction that was not readily reversible given the imbalance in power. This opened up conversations related to the structure of mental health services, and the experience of 'light' within the therapy room. Exploration of exits included considering how the light could be dimmed, and how distress could be helpfully responded to without judgment or blame.

Managing Three Zones of Proximal Development

Within Dyadic CAT, there are three learners in the room focused on developing relational knowledge and awareness. CAT theory emphasises the need to match a therapist's intervention with the person's level of development or skill in the area. Vygotsky (1978, p.86), described the zone of proximal development (ZPD) as the difference between a child's 'actual developmental level as determined by independent problem solving' and the child's 'potential development as determined through problem solving under adult guidance or in collaboration with more capable peers'. The concept of a learner's ZPD can be applied to understand the emotional and cognitive 'reach' available to an individual. That is, the 'zone of discovery' available that is just ahead of a person's current understanding or capability. Working in this zone feels uncomfortable as it results in change and new learning, and to go beyond someone's ZPD can feel 'too much', and result in feelings of shame,

disengagement and non-internalisation of what was learnt. Working with dyads means that there are three ZPDs in the room: (a) Child, (b) Caregiver, and (c) Therapist. Each person has their own perspective and understanding of the current situation, and a different zone of discovery. Working together to stay within a collective ZPD can be difficult, however caregivers and young people are resourceful in helping each other learn within therapy. For example, the parent of Tanya who had been identified as autistic would re-phrase sentences to support her learning. A young person's zone of discovery outside sessions may be extended with the scaffolding and support of their caregiver. For example, collaboratively completing between-session tasks, such as noticing 'overlooking' RR enactments, may be more easily completed when two watchful family members are observing than when completing the task alone.

Change Within Dyadic CAT

Change within Dyadic CAT may be experienced by the child, parent, and in their relationship. Outcome questionnaires aimed at measuring change in psychological distress and wellbeing in adolescents are widely available (e.g., Young Person-CORE, Twigg et al., 2016; Warwick-Edinburgh Mental Well-being Scale, Tennant et al., 2007). Creating idiosyncratic measures (e.g., goal-based outcomes) and seeking qualitative feedback can be the most relevant approach to assessing change related to the child-caregiver relationship. Often, dyads describe change in their CAT goodbye letters and Sarah (a 17-year-old female) wrote: 'You've really had an impact on the place I'm in now, from the first appointment in the middle of the pandemic where everything was scary and I was in such a bad place, to where I am a lot better and have gained my freedom and life back'. Alongside in-session feedback, a separate telephone call with a different member of the team was offered after young people and caregivers completed their dyadic CAT. During her phone call, Sarah stated the following:

'I did struggle with opening up to my mum at first but over time it got a lot easier and has helped our relationship. Now I feel like I can open up to my mum and say how I'm feeling. [. . .] The work has also helped me build a relationship with my dad and he has also commented on how more confident I seem. I am also able to say my opinions and can stand up for myself. I now have a voice and I'm not as overly shy or anxious as I used to be.'

In the final session, Sarah's mother said, 'You have helped me to

listen and connect with my daughter without feelings of judgement'. Anecdotally, caregivers have reported improvements in their relationship with their child. For instance, Tanya's mum provided feedback as follows:

'We have noticed lots of changes due to the work. . . Tanya is more confident, can express her opinions, can speak up when people say things she does not agree with and does not let things build up anymore. Her communication with her boyfriend and family members have improved. I feel the progress made and the work done will continue to help her for the rest of her life. Also, Tanya can recognise that her poor relationship with her father is something that she can't control. I feel more closer with Tanya, we are more open with one another and can talk about anything. I feel able to challenge her with getting her to express her feelings.'

Developing tools specifically to evaluate the outcome of Dyadic CAT may be beneficial, and therapists may consider using single case (N=1) research designs (Kratochwill & Levin, 2015).

Recommendations For Future Development of Dyadic CAT

Dyadic CAT, working with young people and their caregivers, offers a non-blaming approach to working with complex trauma and CAT tools can be used to promote change and healing with dyads. There are several adaptations that CAT therapists may consider when offering dyadic CAT including: identifying what to work on within therapy, exploring ways of factoring in power imbalances, and balancing the needs of three learners to promote discovery within therapy. CAT with dyads may also benefit from an additional phase focused on creating a 'safe base' prior to the reformulation phase of CAT. This may include an integration of ideas from systemic therapies (e.g., Dallos & Vetere, 2021) or the use of ideas from dyadic therapy within care-settings (Hughes, Golding, & Hudson, 2019). Researchers may consider exploring young people's and caregiver's experience of Dyadic CAT to inform further development of its structure. Once developed, comparisons between individual and dyadic CAT could support decisions related to care planning for young people under the care of community CAMHS. □

All examples used in the paper have been anonymised

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Am I someone or something?

Agency and Alterity in Cognitive Analytic Therapy

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Abstract:

The concepts of agency and alterity (otherness) are examined in relation to Cognitive Analytic Therapy (CAT). The enquiry is set within the contemporary debate about the relationship between instrumental and exploratory values in psychotherapy. An account of psychopathology, understood as failed dialogue, and the role of moral ontology are used to broaden CAT's theory of agency, develop its understanding of relational meaning and bridge instrumental and exploratory values. The implications for CAT technique and its dialogue with related therapy models are explored. A clinical illustration of these implications is offered.

Key words:

agency, alterity, cognitive analytic therapy, instrumental values, exploratory values

COGNITIVE analytic therapy (CAT) is an evidence-based integrative and relational therapy widely used in the UK with an international practice base (Corbridge, Brummer and Coid, 2018; Chanen, Jackson, McCutcheon et al., 2008). It is a goal-oriented approach focussing on problematic relational patterns, called reciprocal role procedures (RRPs), which are assumed to originate in early life but are unhelpfully re-enacted in adulthood in self-to-self and self-to-other configurations.

Therapy explores the origins and expression of these patterns and seeks ways to revise them through a collaboration between therapist and patient to make and use narrative and diagrammatic reformulation of the patient's difficulties.

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An understanding of agency is an important clinical issue for psychotherapy and mental health work in general but gets little attention as a focus in its own right in the literature on CAT. Patients often present feeling stuck in patterns of living that block their capacity for change and development. Agency can be understood volitionally as a capacity for self-originated activity (Mackrill, 2008; Frost and Hoggett, 2008). It is usually experienced as something which is co-created and co-owned with the patient which contributes to their sense of self. Patients can enter therapy because they are seeking to recover a sense of lost agency or to find new psychological resources to enhance their sense of agency. Before they can be helped instrumentally through the use of effective and safe psychological techniques, they need to recover their agency, their motivation, and their sense of 'I am, I can, I will.'

CAT has an explicit view about what primarily motivates us and an implied account of the phenomenology of agency (Kerr and Ryle, 2006). The theory of primary motivation is derived from object relations principles. It asserts that primarily we are relationship seeking, which can be described in terms of aim-directed activity expressed in procedural form following certain steps. In CAT this is the so-called procedural object relations model. For CAT, a key feature of the phenomenology of agency – what the experience of being an agent is like – is the experience of dialogue. To be an agent is to be reflexive and relational, that is, to have the capacity to be in dialogue internally, with ourselves, and externally, with others. Forming relationships is formative for the self as we seek and learn to live in the lives of others. We create and discover our agency, developmentally speaking, when we live in the presence of carers attuned to our agentive potential, who can shape the expression of our pre-verbal intentions into meaningful gestures and signs. Our sign making enables us to become inducted into a language community, pre-verbally then verbally, learning at first from the other what subsequently we can do for and with ourselves. On this view, thought is considered as originating in and having the phenomenology of internalised speech. CAT would suggest that from a phenomenological point of view, agency therefore has a dynamic social origin and a dialogical intentionality as we seek to make psychological coherence of our internal and external relational worlds.

Agency: integrating who with what

CAT can be understood as an integrative therapy in a number of ways

(Kerr and Ryle, 2006). Firstly, by the way cognitive and analytic contributory theories fit together. These represent the analytic and cognitive components in the therapy's name. Secondly, CAT can be regarded as integrating patterns of relationship into a theory of personality.

However, there is a third sense in which CAT could claim to be integrative insofar as it tries to reconcile potential tensions between the values embedded in those contributory theories (Brown, 2008; Taylor, 1991). Value tensions, such as those that could be described as instrumental and those that are more exploratory, may be given different emphasis in different therapy models.

The instrumental (means-ends) values of effectiveness and efficiency are embedded in treatments whose primary aim is to relieve distress and suffering. They underpin evidence-based practice. There are also exploratory and insight-oriented values embedded in therapies whose primary concern is to improve self-knowledge, understanding and self-awareness. These domains are not so easily measured and therapies that centre themselves on them may not fit into an evidence-based practice agenda as easily. Therapy models with a stronger instrumental orientation (such as cognitive behaviour therapy) can be underpinned by theories of change involving psychological tools (psychotherapy techniques) applied to objectified psychological domains such as cognition, mood, and behaviour. Agency per se is unlikely to become the unit of analysis; however secondary characteristics of being an agent, such as having a diagnosis, can offer instrumental leverage to enable outcome measurement of symptomatic or functional improvement.

Therapies in the 'exploratory' camp, on the other hand, stress the development of a synoptic perspective, fostering interpretation, promoting the value of the examined life, the self in dialogue with itself, and in so doing they raise the question of what makes for human agency. These therapies may be exemplified in psychodynamic or humanistic therapy models. (e.g., Wachtel, 2023; Rogers, 2003)

The tensions between instrumental and exploratory perspectives could be expressed in terms of differences between the styles of approach of an applied psychological theory and those of descriptive phenomenology. We could say the values in play emphasise different features of what it is to be self-conscious agents: we are both something and someone. All therapies may have instrumental and exploratory dimensions to some degree but the distinction can help to describe

differences in practice. and, for an integrative psychotherapy like CAT, create a conceptual challenge as to how to work with these different agendas at a theoretical level too. The question remains how well CAT is attuned theoretically and practically to both these instrumental and exploratory values.

This article will outline how a theory of alterity might help creatively to bridge value tensions such as these and in so doing develop CAT's understanding of agency. It will suggest a theory of alterity is involved in CAT's understanding of agency by constructing a relational account of meaning-seeking. In proposing this account within one therapy model (CAT) wider implications for other therapies can be drawn out. Specifically, a theory of alterity can make bridges in an integrative spirit to neighbouring therapies on either side of the analytic-cognitive divide such as mentalization and cognitive therapies. The issue also raises questions about contested assumptions about human nature that underpin therapy models and in particular whether a therapeutically oriented account of agency can disregard the existential concern of moral ontology (who it is good to be). Finally, we will look at some implications for the techniques and practical delivery of CAT.

Alterity

Alterity can be defined as the experience of the other. There are multiple ways to address the idea including in philosophical, political, social, artistic, theological, and psychological fields (Hazell, 2009). Stanghellini (2017) has outlined a volitional model of alterity to underpin his understanding of psychopathology. This is of relevance to CAT. He begins his project by outlining a philosophical anthropology upon which to develop a theory of psychopathology and a value-based humanistic approach to psychotherapy. Psychopathology, in Stanghellini's view, is the consequence of a failed dialogue with alterity. If agency implies that the self is volitional then alterity can be found in the experience of the unchosen and the involuntary. We are not fully in charge of many of our experiences; they come to us unbidden. This presents us with a description of an existential condition. He roots his ideas in the field of interpersonal existential and hermeneutic philosophy but in summary, he says, we dialogue. There is something unavoidably 'other' about parts of us, reflected in our dialogical nature. This alterity can be disclosed to us in our internal encounter with our emotions, drives (needs and desires) and embodied habits which involuntarily impinge on our inner

world. It is also encountered in the experience of external realities – traumatising events but also in the unpossessable presence of other people. This view of the volitional background character of alterity, its unchosen involuntary nature, shapes the way it is presented to us. The dialogical response we make to it shapes and configures our identity and raises the possibility of psychopathology.

How might this account of psychopathology, as a failed dialogue with alterity, inform CAT? CAT also has a dialogical account of psychopathology; one described in relational and procedural terms. Reciprocal role procedures (RRPs) are patterns of aim-directed behaviour fashioned by expectations. Each reciprocal role procedure can be enacted in three different ways: others in relation to me, I in relation to myself and, I in relation to others. These are formatively shaped by interpersonal experience. Roles are considered to be compositional, combining action with affect expectations and communication. They elicit the presence of other roles that stand in complementary relationship to them in ways that are analogous to but not identical with the process of projective identification (Ryle, 1994). If problematic, a role in a RRP gets enacted in a recursive process that returns the role position back to where it started. In that sense there is a sort of failure – a failure to move on or beyond.

These procedures therefore occur within a dialogical space in which we address ourselves to an 'other' and experience ourselves as addressed. We are dyadic subjects in which an agentive 'I position' – the role where we speak from – can shift between poles within the reciprocal roles, sometimes occupying a more active position, sometimes a more passive one. For example, I may identify myself as being controlled in relation to another role experienced as controlling. We could say that the 'addressed alterity' has the form of a counter position, sometimes being internally located, sometimes externally that is to say the 'controlling' other could be experienced changeably as an aspect of myself and/or another person. Commonly a patient might identify themselves as problematically occupying one role position and sometimes this is the child-derived role with a compromised sense of agency: we could call this their dominant 'I position'. This discloses something about their sense of agency living within the relational frame of a reciprocal role.

In Stanghellini's terms the sources of the alterity with whom/which the failed dialogue takes place can be located in the internal phenomenology of unchosen moods, drives and unacknowledged habits or the external world of the interpersonal and traumatic. This broadens the

usual conception for CAT about the sources of the self which often have largely looked to the origins of the reciprocal roles in the historic attachment experience of the patient's caregivers, although cultural sources are acknowledged as a potential background that fashions the self-other dyad. A way of introducing Stanghellini's perspective would be to say that we can be in the presence of and therefore in potential dialogue with component features of what CAT describes as a role: our moods, drives, and habits. These then come to be experienced as agentive, and this informs how we configure reciprocal role procedures and our fluid 'I positions' within them (Rowan, 2012).

From agency to alterity

From a phenomenological point of view, if we experience our inner life as dialogue then we experience a felt sense of an implied addressee. This 'inner other' shapes the agency of that I position. The intrapsychic addressee also has an agentive quality – implicitly capable of communication, bestowing an alterity that could become a source / resource for the self. Agency is disclosed by my position: where I speak from. But it is shaped and resourced by the counter position. An 'I' is not a thing but a relational term involving a 'you'. I am an I to myself in so far as I am a 'you' to another. This implies we find our account of ourselves in our social origins and through the history of our dialogical experience. It also implies the assumption that we are always 'in the presence of' another experienced in the patterns of our I-you relations even when the addressed other is oneself. Roles are compositional constructs offering agentive sources for the self – not just via relationship history or socio-cultural context but also in the experience of what is unchosen and involuntary in us.

Recognising these communicative qualities of alterity can inform CAT's understanding of the psychological development of our capacity to develop and search for meaning within the reciprocal role construct. Let me try and illustrate. To take an immediate example from my current agentive experience – writing this paper. If I take stock of the phenomenology of the experience, I notice a struggle for words. I am wanting to express I know not quite yet what to, I know not quite yet who. 'Struggling' encapsulates something of a role position but who is my addressee? Who am I in the presence of? They may be known and unknown to me – a critically demanding peer reviewer perhaps, or my upcoming professional appraiser or a parentally derived authority figure.

But in the mix, there may also be the phenomenology of mood, habits of life and drives enrolled into those counter positional voice(s), and these might not readily track back into a relational biography or even social context. Simply put, my drive to write speaks back to me, demanding something of me. The dominant counter position (drivenness) is experienced as an alterity with qualities that feel agentive in being both inside and outside, same and different, congruent and incongruent, chosen and unchosen. For example, we might say we are driven to write and the feeling comes to us and gives us agency but whilst inwardly experienced as an alienating relational pole.

From alterity to meaning: searching out the 'other'

Recall the question of the instrumental vs. exploratory value tension involved in integrative therapy. Are you something or someone – or in some sense both? The question could be reframed with alterity in mind as: how do we reflect on ourselves objectively, and so learn to theorise about ourselves, whilst being ourselves subjectively? (Britton, 2004) The experience of therapy often flows between these observer participant positions. I can be both something observed and so acted upon instrumentally using the tools available in a therapy like cognitive psychotherapy and I can also be someone observing and so participating in the phenomenology of holding a first-person perspective addressing and being addressed by 'the other'. As either participant or observer this suggests alterity is in play in creating new perspective and meaning. In order to be a human agent, as Ricouer suggests, I must know myself as another and in so doing, discover and create meaning (Ricouer, 1994).

Where does this fit into CAT? CAT suggests that the capacity to reflect on ourselves is both a relational and a cognitive achievement and articulates this implicitly in its combining of object relations theory with a cognitive one, Personal Construct Psychotherapy (PCP) (Winter and Viney 2005). Both theories elaborate accounts of how we achieve metarepresentational positions – seeing oneself from elsewhere when we objectify our subjective experience. For CAT there is no theoretical commitment to a developmental story like the Oedipal narrative but an analogue theory for the acquisition of the 'outside but inside' capacity is its use of PCP. In PCP, meaning is cognitively achieved when we are able to see sameness between two 'elements' (usually people or aspects of them) yet simultaneously see a difference (i.e., alterity) between them and a third element. This allows us to construct meaning and informs

the idea of reciprocal roles. For example, the drivenness to write an article like this (alluded to in the illustration above) could reflect being positioned within a reciprocal role (say critically demanding to striving to please). And that role relation could derive from an implicit reflection on three ‘elements’ (say a favourite teacher, a parent and myself as a primary school child) in which the first two elements are construed as alike (i.e. demanding) but different from the third (striving). Unlike psychoanalytic thought no developmental narrative is offered in PCP but there is the implicit acknowledgement that triadic relations develop meaning. Seeing sameness *in* difference is the heart of metaphor and symbol formation.

For CAT, the acquisition of these capacities could be described developmentally but fluidly at three levels. Leiman suggests reciprocal role procedures are relatively late psychological developments building upon an earlier state of affairs in which sign mediated agency is framed by what he terms semiotic dialogism (Leiman, 1994). Semiotic dialogism could be said to be an inchoate but primitive state of ‘being-in-the-presence-of-the-other’ prior to any crystallisation of it into reciprocated templates of mutual interaction. Following Bakhtin, Leiman claims that we can establish dialogic relations to the objects of our thoughts and actions not just to other persons. In other words, we can be in dialogic relation to what are constitutive partial features of a role (affect, expectation, action). At the other end of the scale there are metarepresentational levels of self-awareness in which the dialogical experience is made more explicitly visible: reflective self-awareness. This is cultivated in therapy.

In CAT’s case this is developed in particular methods of formulation. Reciprocal roles get recognised by the patient from an ‘observer-I position,’ looking at a view of themselves as networked patterns of I-you relations, described ‘from above’ often diagrammatically (in a so called sequential diagrammatic reformulation, SDR). This is a way of cultivating dialogue with their own dialogues. This superordinate level observes an intermediate representational layer of self-awareness – the configuration of reciprocal roles and procedures that connect them. The unrevised problem procedures are suggestive of what Stanghellini (following Bourdieu) terms our habitus – the structuring, structured structures that shape our experience of relational meaning in the world. In this way an ‘observer I’ can gain a position of thirdness. In diagrammatic form the ‘observer I’ is a relational tool to help develop a generative, created-yet-discovered caring relationship with what is experienced as both chosen

and unchosen. This superordinate template becomes a reciprocal role position sometimes symbolised by the observing eye drawn onto an SDR to signify this metarepresentational level.

The recognition of alterity does not have to be found through reading back into the psychological material preselected narratives about hidden motivation. Rather it proceeds through a phenomenological exploration of the dialogue with oneself as another. Importantly this could involve a dialectical step to generate new dialogue. When dialogue fails, it is functionally monological. The alterity is addressed but, in a sense, goes unheard and unrecognised. This is expressed by CAT in the recursive circular patterns described by an SDR in which the story of the agent is tracked round their identified procedures, a story without apparent exits. Nothing new is learned or heard or experienced. A dialectical step – the achievement of thirdness – is given cognitive resources by Personal Construct theory and its take on the production of meaning. For CAT, the dialectical achievement of a meta position of seeing oneself as another whilst being oneself, is what would be successful dialogue. This is an analogue to the concept of insight and the restitution of an openly dialogical self. Therapy is not just therefore the achievement of being accurately and validly informed in a cognitive sense (knowing our schematic propositional beliefs that we are this and others are that) nor the resolution of an unconscious internally driven conflict to enable the repossession of disowned projections into a self-contained monadic agent.

Table 1: Instrumental and exploratory values

Applied Psychological Developmental Theory	Phenomenology of agency
Semiotic dialogism	Other as inchoate counter position
Reciprocal Role Process	Dyadic agency: other as nameable and agentive
Meta-representation	Felt meaning, knowing, and being known knowledge as acknowledgement, insight, and oversight (myself as an other)

Taking an existential turn in CAT

CAT has adapted constructivist and object relations theories to form its core developmental theories about the relational self and then more recently used Bakhtin to resource the model further in a socio-cultural direction. The existential turn suggested here by a reading of Stanghellini's work centralises the issue of agency, choice and freedom in CAT – that is our moral agency (who it is good to be), our confrontation with what is unchosen in order to find meaning and our freedom to break away from failed dialogue.

Stanghellini suggests that if alterity is a non-negotiable condition of being human then any ideal of completed self-possession will always be unobtainable. To be a person is a project and a task without finality. This is a way of asserting a non-reductive anthropology. We are not just information processing systems that can be given a finalised account as if there were an itemisable number of true propositions about ourselves. The suggestion would be that if we are always in some relation to alterity, it is a state of affairs that is in some way generative. To attempt to eliminate alterity would be a form of failed dialogue and leads to psychopathology.

A psychoanalytic analogue to Stanghellini's role for the term alterity, could be the idea of the dynamic unconscious. The idea of the dynamic unconscious implies something that is unchosen, irreducible, and agentive indirectly presenting itself to consciousness. However, Stanghellini doesn't incorporate it into his more existential phenomenological view of alterity. He suggests alterity is disclosive in the way a text is: the meanings are to be read out of it from investigating the phenomenology of our lived experience as encounter with moods, embodied habits and needs rather than imposing background readings of hidden motivation and theories of normative development. CAT uses Bakhtinian dialogism as a non-reductive anthropology because it articulates a form of social generativity: we are endlessly in dialogue (Leiman, 1992). We are addressed by and respond to voices from without and from within which have no specifiable destination or origin in any finalisable sense although some of the proximate territory of these voices can be elucidated from our personal and cultural histories. It is not necessary to give a background reading about the dynamic unconscious in which the agentive centre of gravity is defensively repudiated to an unconscious location: the phenomenology of dialogue is where agency is located and can 'speak from'. The map we make in our minds of our way of being in the world remains provisional and fluid and in that sense the process is dynamic but revealed dialectically rather than disclosed because it has

become unrepressed. In this way, alterity is construed as a source of the self and a resource for the self, addressing and addressed by our repertoire of 'I positions'.

A theory of dialogical alterity such as this will also have a bearing on our sense of moral agency. Many of the reciprocal roles described in therapy are shame related. They often describe who we do not want to be in either polarity; bullying or bullied, controlling or controlled, abusing or abused and so on. These do not just have the phenomenology of being unchosen, involuntary roles. The experience of alterity, when problematically experienced, describes who it is not good to be. Shame has been described as the failed dialogical attempt to live in the mind of the other as a desirable attractive self (Gilbert, 1998). Shame is about a global evaluation of the self in the mind of a hostile or condemnatory alterity which undermines or restricts the patient's agency and gets expressed through their repertoire of reciprocal role positions. In shame the self is felt as powerless in the presence of a powerful shaming other. Therapeutic dialogue tries to help patients work through shame processes to find languages that can connect moral sources and values outside the self so as to resonate with and cultivate sources from inside it, thereby developing agency indexed to a personal vision (Taylor, 1989:510). The question of who it is good to be arises in the context of the experience of what is unchosen – our alterity – and therefore brings into the therapy questions about agency and identity.

Consequences for integrating other therapy models

Another consequence is how the dialogue with other contemporary therapies can be enlarged. Meta-cognitive therapy, Mindfulness and Mentalisation Based Therapy (MBT) offer perspectives that can be framed in dialogical terms with differing takes on alterity. The idea of alterity helps to make bridges between CAT and some of these therapies. Mentalisation Based Therapy, for example, describes modes of what are called pre-mentalizing – states of mind that prefigure and, if persistent and pervasive, challenge a coherent sense of self agency (Bateman, Ryle, Fonagy, and Kerr 2007). Mentalization theory describes one such state as psychic equivalence when inner and outer worlds are conflated – what is thought in the mind is felt to be automatically true. Put in the terms described above, in CAT the phenomenon of psychic equivalence would mean the agentive subject identified in the 'I position' by a reciprocal role would claim to know without doubt and precipitously the intentional stance of the other – who and what they are about – and may enact some

identified problem procedure that expresses this. In CAT terms in these circumstances a reciprocal role procedure loses any 'as if-ness' so the overview of the self is lost and thirdness never achieved. The other is not allowed to be other: alterity is not 'allowed' to be alterity. Or in another pre-mentalisation state, the so-called pretend mode, the reciprocal role procedure is entirely 'as if' and the agentive subject is always experienced as elsewhere and unreal. Again, there is no dialogue with alterity as everything is experienced as other. The therapeutic impulse in MBT to slow down, attend to and try and coherently flow between perspectives of the self and other is akin to CAT's ambition to elucidate the dialogical sequence and create empathic meta positions. Pre-mentalisation is a form of failed dialogue. Similarly, in an instrumental way, Mindfulness explicitly encourages patients to adopt an empathic witnessing 'observer' meta position: myself as a non-judgemental but inquisitive other in relation to myself as another (Segal, Williams, and Teasdale, 2013). This too could be expressed as a reciprocal role of an encounter with alterity. The point here is not to make competitive judgements between rival therapies or reductively collapse one therapy into the terms of another but to see where the instrumental expertise of various therapies offers complimentary and potentially adaptive approaches to CAT within the flexible dialogical scaffolding CAT offers.

Consequences for practice

Developing an approach to agency and alterity in CAT in this way also offers some technical differences to the practice. Conventionally the communicative tools that CAT uses, such as the reformulation letter, have principally focused on particular source materials – the trauma and relational history patients bring with them into therapy – and in what is co-produced in the exploratory therapy process itself such as the development of relational maps. Stanghellini's suggestion would be to widen these sources to try and communicate something of the patients 'lebenswelt' (their 'lifeworld') to describe how lives and bodies are inhabited, where the agentive difficulties are, who or what they find themselves in the presence of and what the unchosen and involuntary experiences are that implicitly impinge on them. It stresses the compositional contributions to the role position (the affective experience, the behavioural enactment, the cognitive expectancies). Affect has an unchosenness about it – something recognised in cognitive therapy's instrumental use of the behavioural and cognitive contingencies of an experience to bring about changes in feeling states. The exploratory style

suggested here would reshape what gets captured by the reformulation letter in giving an account of the patient's world as a failed dialogue with alterity. The target problem procedures are examples of how agency is lost, thwarted, or never found and can be elaborated to develop a sense of the implied alterity in play – their embodiment, their moods, their interpersonal relations. In this way there is an attempt to try to enter into what CAT calls 'the zone of proximal development' with agency and alterity in mind to help give a containing but not foreclosed account of the experience of the patient.

A sequential diagrammatic reformulation usually goes through several versions, not to strive for a finalised picture of complete accuracy, but to try to be faithful to the unfolding encounter with what's not yet known. The dialogue with alterity leads to iterations with some of the reciprocal role procedures becoming revised through a process of dialectical change. The therapeutic challenge to change overly fixed or harm producing, 'unmentalised' reciprocal role procedures can be achieved not simply by the therapist's or patient's non-reciprocation of them – the process of abstaining from identifying with one position or another – or by suggesting an alternative form of values-based mentalisation or mindfulness informed relational template such as caring-to-cared-for. This is not to say either of these approaches are unhelpful. The suggestion here is the transformation of a reciprocal role can occur through exploration of its composition with the aim of achieving a new relational meaning by repositioning the dialogue with alterity into a new dyadic reciprocal space. CAT can therefore be regarded as both a hermeneutic and instrumental practice by trying to develop an active dialogue with alterity: the addressed poles that the dominant I position addresses within reciprocal role procedures experienced as belonging to me but unavoidably unchosen by me – my moods, my body, my needs – as well as those role positions sometimes originating in the addressed experience derived from my interpersonal world.

There are a number of difficulties with this expansion of CAT which need to be considered. It could be claimed that the terms in which Stanghellini describes alterity are not agentive. Moods, drives and habits cannot easily be made as it were subjects of active verbs and yet this could be required if they were located into reciprocated role positions. It could also be claimed that there is a cultural specificity about an emphasis on the volitional character of the self. It could further disquiet traditional CAT practice to move outside the usual sphere of using recollection of interpersonal experience to construct the repertoire of

reciprocal roles. Nevertheless, the lived experience of moods, drives and habits can sometimes position them as experiences that are both ours and unwanted, agentive, and yet other. This way of introducing them into CAT offers an instrumental framework to recover aspects of our agency as an iterative discovered/created process: we are dialogue. It may also resource the explorative dimension of a CAT therapy by instrumentally posing the proximate but exploratory question of where are you (speaking) from, in order to gain access to the more distal, agentive questions about who you are.

CAT can be seen as an integrative project by restoring the idea of agency understood as psychological coherence, seeing how moods, drives, habits and interpersonal relations fit together. We are both subjects and objects, someone and something. This integrative project is something that many therapies promote but in CAT's case they could be encapsulated in its heuristic use of the term 'reciprocal role' as involving affect, communication, expectation and action. The suggestion here has been to investigate this term as alterity involving. In so doing, the discourse about agency and meaning enables it to be further resourced from existential perspectives.

Fictionalised case material

Martin suffered from nighttime panics waking up unable to breathe convinced of the proximity of death. Panic had become habitual, almost his default way of being in the world. He had considerable problems on his mind – a failing career, debt, the loss of his house. He reported an affectionate family background with caring parents although he remembered being pushed by professional expectations of his family into the family business.

Martin repeatedly voiced feelings of powerlessness in the face of the panic and the counter transference pressure on the therapist were to take charge and provide some order. This could be transposed into a reciprocal role position of Martin being out of control in relation to a controlling (other) but this initial way of putting it didn't feel like it obviously captured his view of his attachment history. So, the exploratory question became what (or who) was Martin in the presence of when he was in the presence of his panic? He 'knew' it was panic when he *wasn't* in it. This is what clinicians had told him. But when in it, the experience had another 'speaking reality' and it wasn't clear what it was. It felt like being with something genuinely unknown but maliciously intentional.

The therapist got an account of it phenomenologically – the experience of him suffocating, his sense of time and space collapsing, being overwhelmed by a body, as Bakhtin might put it, with a mind of its own desperately isolated from other people. Above all he gave an account in this as loss of agency. In that way the panic came to be described not just as controlling but as domineering, crushing, entrapping in relation to him feeling abused and powerless, distant from others, lost to time and claustrophobically enclosed.

As a therapist I caught something of the experience once when Martin panicked in the room. Both of us felt out of control as if in the presence of something intractably alien. But the shared commonality of witnessing and surviving created new levels of rapport. So it was when this 'controlling / domineering' pole was identified as his body speaking catastrophic pronouncements that he was able to find an 'I' position that could address and approach it from a 'concerned observer' position and see the panic as agentive yet dialogical, in other words unpleasant but not necessarily imminently dangerous. It was only when the issue of the agency and alterity of the body had been considered that distress-controlling techniques could be used. He had to identify with the position of the 'controlling / domineering' body as something that was recognisably and agentively his – something that instrumentally speaking, behavioural experimentation consequently enabled him to do. He found that his body was signalling something more than just about the body's predicament. The dialogic move that reorganised his view recognised that there were other sources of himself, ones which he had felt somewhat ashamed of that also disclosed to him that he was a controlling person – often exerting his power passively and evasively and not just when the victim of controlling states of mind. Beyond the ownership of the counter position (the controlling/domineering role) was a discovered sense of willingness to approach what had been unknown about him, a newfound courage that represented a novel chosen role position. From this place he could find agency to gain emotional contact with the grief about the wasted time he had invested his life in by pursuing work-related goals he no longer wanted but had felt resentfully aggrieved about. The real issue of Martin's evasive way of living began to be faced in a more thoughtfully open and relationally flexible way. □

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Evaluating reflective practice in a learning disability team

Evaluating a time-limited cognitive analytic reflective practice (CARP) group for practitioners working in an NHS learning disability intensive support team

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Abstract:

Aims. Research exploring and evaluating the impact of cognitive analytic reflective practice (CARP) groups is in its infancy. The current project sought to evaluate CARP sessions offered to an Adult Learning Disability (LD) Intensive Support Team (IST).

Methods. Six CARP sessions were offered to an IST over three months. N=10 practitioners attended at least one session. Valid and reliable self-report questionnaires assessed burnout severity and perceived quality of sessions at three timepoints.

A questionnaire was also completed after the final session eliciting overall experiences and feedback. Quantitative and descriptive qualitative analyses were conducted on questionnaire data.

Results. No statistically significant differences across time were found for attendee burnout, nor quality/experience of specific sessions, though average trends indicated less burnout as sessions progressed. N=5 attendees (mean years of LD experience=24.75 years) completed overall feedback questionnaires. Respondents highlighted various helpful and hindering aspects of CARP sessions. All respondents expressed an interest in attending future CARP sessions.

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Conclusions. This evaluation suggests CARP sessions have potential for various positive impacts on IST practitioners working in LD services, including potentially reducing burnout and enhancing team cohesion. Much more research is needed in this area before firmer conclusions can be made regarding the value of CARP for LD practitioners and healthcare professionals generally.

Keywords: Cognitive Analytic; Reflective Practice; CAT; Learning [Intellectual] Disability; Crisis; Intensive Support.

Introduction

UK Learning Disability Services Context

In England over the past decade, health and social care services supporting people with Learning [Intellectual] Disabilities (LD) and/or Autism (hereafter 'LD/Autism') and their carers have undergone colossal change. A powerful driver behind changing the way these services are delivered has been the Transforming Care Programme (Houlden, 2015; Elliott, 2017). This programme was a response to significant and growing concern that a proportion of people with LD/Autism who display behaviour that challenges were spending substantial periods of time in restrictive inpatient settings. As part of Transforming Care, NHS England set out guidance for how services for people with LD/Autism should be designed. One of the primary changes set out was that all people with LD/Autism should have access to 'Enhanced/Intensive Support' in the community. Enhanced/Intensive Support teams were thus commissioned and tasked with providing numerous specific 'functions' of support, including: providing assessment, treatment and support for people who display behaviour that challenges, and providing crisis response (Elliott, 2017).

Learning Disability Staff Burnout

Given the high intensity and urgency inherent in supporting people with LD/Autism in crisis, it is not surprising that staff supporting these individuals are at high risk of experiencing work-related stress and burnout (Devereux, Hastings & Noone, 2009; Ryan, Bergin & Wells, 2021). Maslach, Schaufeli and Leiter (2001) described burnout as a prolonged response to chronic stressors at work, characterised by emotional exhaustion, depersonalisation and lowered personal accomplishment. In addition to burnout being extremely challenging for

healthcare practitioners themselves, there are a range of other adverse outcomes associated with these factors; including higher staff absence/sickness (Peterson et al., 2008), lower staff retention (Spence Laschinger et al., 2009) and poorer quality of patient care (Johnson et al., 2017).

Attempts to elucidate the development of burnout in healthcare staff have been extremely valuable given that they have highlighted potential avenues to help reduce or prevent burnout in practitioners. Factors that have been shown to be meaningfully associated with staff burnout when supporting individuals with learning disabilities include individual characteristics (e.g., recreation, self-care and personal support, Aitken & Schloss, 1994; self-efficacy and resilience, Klaver et al., 2021) and organisational variables (e.g., feeling under benefitted, Van Dierendonck, Schaufeli & Buunk 1996; perceived support from supervisors, Gill-Monte & Peiro, 1998).

Reflective Practice

A source of support that may help reduce or prevent staff burnout is engagement in reflective practice. Reflective practice has been described as involving 'active attention to knowledge and beliefs, as well as focused reflection about our experiences, in relation to both ourselves and others, in order to understand them more deeply and with greater awareness' (Priddis & Rogers, 2018; p.89). Given that burnout is thought to be a gradual process of emotional exhaustion from relationally intense/challenging job roles leading to unhelpful relational patterns with colleagues and patients (Maslach, 1999), a safe and structured space to reflect on and enhance awareness of difficult feelings and relational patterns may intuitively help reduce or prevent staff burnout. It is perhaps not surprising that formal reviews and guidelines across various healthcare disciplines such as nursing (Department of Health, 2006) and medicine (General Medical Council, 2013) have emphasised the importance of reflective clinical practice.

Reflective practice groups have been structured by a variety of frameworks since early psycho-dynamically informed groups, developed in the 1950s, to support GPs to consider the relational aspects of their work (Patrick, Russell & Polnay, 2021). An approach to reflective practice that has garnered increased attention over recent years is one based on the principles of Cognitive Analytic Therapy (CAT).

CAT and Reflective Practice

CAT was developed as a time-limited and integrative model of individual psychotherapy that has a relational focus (Ryle & Kerr, 2020). Since its origin of being applied as a form of individual therapy, CAT has been expanded to inform other forms of 'direct' (e.g., group interventions; Hepple, 2012) and 'indirect' (e.g., consultation; Carradice, 2013) clinical work with a range of clinical populations (e.g., people with learning disabilities and their carers, Lloyd & Clayton, 2014). Cognitive Analytic Reflective Practice (CARP) is another example of how the core principles of CAT can be applied to help clients and the systems/individuals around them.

In common with CAT psychotherapy, there is no session-by-session manual that prescribes how CARP should be delivered. Rather, there is a collection of principles and tools that can be used flexibly to structure CARP sessions (Marshall & Kirkland, 2021). These principles (e.g., time-limited nature, clear contracting, collaboration, relationally focused) and tools (e.g., relational 'mapping') are used by CARP facilitators seeking to develop group attendees' capacity to 'reflect on actions so as to engage in a process of continuous learning' (Kirkland, 2021, p.68).

Although there has been limited research to date on the impact of CARP on individuals and teams, Priddy (2021) conducted one of the first studies exploring the implementation of CARP in a secure children's home (SCH) setting. Priddy proposed a model of how CARP may facilitate reflective thinking and awareness in SCH staff. Within the model, numerous linear and reciprocal processes are suggested to occur between facilitator and CARP group members, categorised into: 'facilitator processes', 'group processes', and 'outcomes'. The model proposed that through 'establishing a reflective space', group members were able to engage in processes that 'widened their awareness of the self, other and the system', to 'change relational dynamics and establish exits' from unhelpful patterns.

The current evaluation

Although the application of CARP to help prevent or reduce burnout in high-risk health practitioners appears intuitive, structured evaluation of the impact of CARP sessions on healthcare teams is in its infancy. The current project, therefore, was a small-scale service evaluation which aimed to evaluate a time-limited CARP provided to a learning disability IST over a period of three months. Quantitative and qualitative data were

collected and analysed in order to measure; the severity of attendees' burnout throughout the evaluation period, explore attendees' experiences of CARP sessions throughout the period, and explore the overall perspectives and experiences of attendees after sessions were complete.

Methods

Ethics

Prior to commencement of the project, it was registered with the relevant clinical effectiveness team (audit and service evaluation department) who approved the registration.

Service Context & Participants

Participants were practitioners in a Learning Disability IST. The IST were a multi-disciplinary team of health practitioners based within a Community Learning Disability Service. The team comprised 1x team leader (LD/mental health nurse background), 6x LD Nurses, 1x Speech and Language Therapist, and 3x Support Workers. Facilitators of the CARP group were a Highly Specialist Clinical Psychologist working in the same service in a different team, and a second-year Trainee Clinical Psychologist on placement in the service. Prior to CARP group sessions being offered, the IST had no Practitioner Psychologist in post for over six months. The time-limited group sessions were therefore offered in part, to offer some psychological provision for the team in the absence of formal psychological staffing.

Cognitive analytic reflective practice (CARP)

Although there is no prescribed protocol for CARP, introductory texts, principles and techniques have been published to guide clinicians in facilitating CARP sessions (e.g., Marshall & Kirkland, 2021). The CARP sessions in the current evaluation were informed by the training and clinical experience of facilitators in applying CAT to various clinical problems and contexts. This included mental health services, learning disability services, individual psychological therapy, and team formulations, published guidance on applying CAT to reflective practice (RP) and in LD settings (e.g., Marshall & Kirkland, 2021; Lloyd & Clayton, 2014), and the Grounded Theory model of CARP developed by Priddy (2021).

All CARP sessions were 60 minutes in duration and took place in an appropriate room outside of the team's usual office (same room each session except one occasion where it was double-booked). The typical format of sessions included starting with a reminder of the main contracted agreements (e.g., confidentiality, difference between RP and personal therapy, no prior agenda, number of sessions remaining), followed by a check-in from each group member, choosing a session topic, discussion and 'reformulation' of the topic informed by CAT theory and tools, followed by a brief 'ending' exercise (e.g., reminder of how long is left and inviting final comments/thoughts). At each session, group members were reminded of appropriate potential content to be brought to the session (e.g., organisational issues, relational patterns within the team, or with specific service users or carers, self to self patterns associated with coping with an emotionally demanding job role, etc.). Facilitators used flipchart paper to diagram or 'map' content of discussions during sessions. Flipchart paper was always destroyed after sessions as per the CARP contract made during session 1. No other records or summary notes were made during or after sessions, in accordance with the contract, of which group members were reminded at each session.

Measures

Adherence to CAT model

Adherence to the CAT model was assessed through using an amended version of the original Competence in CAT tool (CCAT; Bennett & Parry, 2006) used in a previous study (Priddy, 2021). The amended CCAT assessed for adherence (presence/absence) of 10 specific domains. Percentage of adherence was calculated based on the number of domains present/observed across all domains.

Maslach Burnout Inventory (MBI)

The MBI (Maslach, Jackson & Leiter, 1996) is the most commonly used self-report tool to assess burnout severity (Schutte et al., 2000). The MBI is made up of 22 items that explore three components: exhaustion (7 items), depersonalisation (7 items) and personal achievement (8 items). The items are rated using a 7-point response scale ranging from 'never experienced such a feeling' (0) to 'experience such feelings every day' (6). The scores for each component are computed separately and can be coded as low, moderate, or high using cut-off scores. The range of burnout experienced is broken down as follows: exhaustion (low, ≤ 16 ; moderate,

17–26; high ≥ 27); depersonalisation (low, ≤ 6 ; moderate, 7-12; high, ≥ 13); and personal achievement (low, ≤ 31 , moderate, 32-38, high, ≥ 39 ; Maslach, Jackson & Leiter 1997). Burnout is associated with higher scores on the exhaustion and depersonalisation subscales and a lower score on the personal achievement subscale. There is evidence that the MBI has acceptable properties of reliability (Rupert & Morgan, 2005) and validity (Maslach, Jackson & Leiter, 1996). The MBI was selected to assess change in burnout severity over time. Respondents completed the inventory at 3 time points over the CARP groups (session 1, session 3 and session 6).

Clinical Supervision Evaluation Questionnaire (CSEQ)

The CSEQ (Horton et al., 2008) measures overall staff perception of clinical supervision in group supervision models which emphasise reflective processes. The CSEQ consists of 14 items related to three factors: the Purpose, Process and Impact of clinical supervision. Respondents are asked to rate their agreement with 14 statements using a five-point Likert scale that ranges from 'strongly agree' (+ 2), to 'strongly disagree' (- 2). Gabrielsson, Engström and Gustafsson (2019) used the CSEQ to assess perceptions of RP groups and found it to be a valid and reliable tool in this context when translated to Swedish. The CSEQ was selected to assess changes in purpose, process and impact over the course of CARP sessions. The CSEQ was completed at three time points over the course of the CARP groups (session 2, session 4 and session 5). The CSEQ was anonymised.

CARP Feedback Questionnaire

An idiosyncratic questionnaire was developed to understand CARP group attendees' experiences of the sessions overall. The questionnaire was divided into three sections: background information, closed questions, and open questions. The content of the questionnaire was based on Priddy's (2021) CARP Grounded Theory themes of facilitator processes, group processes and outcomes. This was done to elicit information on each of these areas as they have been shown to be relevant to the positive impact of CARP in previous research (Priddy, 2021). These questionnaires were given to participants after the final (session 6) CARP group and were kept anonymous.

Procedure

The procedure of the current evaluation project involved facilitating brief introductory training on RPGs and CAT concepts to IST, an initial contracting session with participants, four CARP sessions, then a final CARP/ending session. This procedure was over four months – with the six CARP sessions contracted being over three months (two per month).

Analysis

For quantitative data (MBI and CSEQ), descriptive statistics and inferential tests were carried out. Cohen's *d* corrected for unequal sample sizes (Lenhard & Lenhard, 2016) was calculated as a measure of effect size for each MBI sub-scale (exhaustion, depersonalisation and personal achievement) from baseline (session 1) to final session (session 6), which was interpreted using the cut-offs 0.2, 0.5, and 0.8 for small, medium and large effects, respectively (Cohen, 1992). For both MBI and CSEQ, repeated measures Multivariate Analyses of Variance (MANOVA) were conducted with time (session number) as the independent variable and the three sub-scales of each measure (MBI and CSEQ) as the dependent variables in each MANOVA. A MANOVA was conducted as neither MBI nor CSEQ were designed to calculate a single, total score and thus sub-scales should be considered separately. Assumptions for MANOVA were tested and met (see supplemental information). Questionnaire responses from group members were summarised using a descriptive approach, grouping qualitative data by the question asked (e.g., facilitator factors, impact on relationships with team, etc.).

Results

Adherence to CAT model

Adherence to the CAT model was assessed through choosing a specific CARP session and discussing it in-depth in CARP group supervision. The amended CCAT (Priddy, 2021) was used to assess adherence to the CAT model in session 4. Session 4 was used due to this being most pragmatic (a group supervision session was arranged for the day after session 4 thus the process and content of the session could be recalled most clearly by facilitators). The total CAT adherence score for session 4 was 57%. Though there are no established cut-offs regarding levels of adherence (e.g., high, moderate, low) for the amended CCAT, a score of 20/40 (50%) is the competency cut-off used for the original CCAT (Bennett & Parry, 2006).

Burnout and evaluation of RP sessions

Both the MBI and CSEQ were analysed by their separate domains as they do not yield overall scores. Two repeated-measures Multivariate Analyses of Variance (MANOVA) were conducted, the first one (MBI) investigated the difference in areas associated with burnout – exhaustion, depersonalisation and personal achievement – over the time participants engaged in the CARP group. The second (CSEQ) investigated the difference in participants' understanding of the purpose, process and impact over the time participants engaged in the CARP group. Table 1 shows the mean (SD) scores of the MBI and the CSEQ from each time point of the group. Figure 1 (MBI) and Figure 2 (CSEQ) display the mean scores over time.

Scores on the MBI all improved pre to post CARP. These results suggest that group participants showed reduced exhaustion, reduced depersonalisation and improved personal achievement by the end of the CARP group. Scores on the CSEQ were more mixed and by the end of the CARP group, participants appeared to perceive the purpose of the group as less clear, had a more positive view of the process and felt an improved impact on their clinical work. Effect sizes indicated that from the first to final CARP session, exhaustion and depersonalisation improved with a small effect size, and personal achievement improved with a large effect size.

Although differences between means can be observed, there was no statistically significant difference in burnout over time, $F(6,16) = 0.61$, $p = 0.72$; Wilk's $\Lambda = 0.662$. There was also no statistically significant difference in evaluation of the CARP sessions over time – purpose, process and impact, $F(6,8) = 0.50$, $p = 0.79$, Wilk's $\Lambda = 0.53$. Given that there were no statistically significant differences on MBI nor CSEQ scores over the course of the group, no further analyses on the data were indicated.

Table 1. Descriptive statistics of group member burnout (MBI) and self-reported purpose, process and impact (CSEQ) scores from beginning to end of the CARP sessions

Measure	Session 1 Mean (SD) n=8	Session 3 Mean (SD) n=8	Session 6 Mean (SD) n=6	Cohen's D pre to post (95% CI)
MBI				
Exhaustion	17.25 (10.46) [moderate]	15.75 (12.23) [low]	15.17 (9.99) [low]	-0.2 (-1.26-0.86)
Depersonalisation	11.25 (11.35) [moderate]	11.13 (10.53) [moderate]	8.67 (13.22) [moderate]	-0.21 (-1.27-0.85)
Personal Achievement	31.63 (8.69) [low]	35.88 (8.77) [moderate]	39.83 (3.76) [high]	1.16 (0.02-2.3)
CSEQ				
	Session 2 Mean (SD) n=9	Session 4 Mean (SD) n=6	Session 5 Mean (SD) n=4	-
Purpose	2.11 (2.32)	2.67 (1.75)	1.75 (2.97)	-
Process	8.22 (1.72)	7 (1.90)	9.25 (1.5)	-
Impact	3.22 (4.41)	5.67 (5.16)	6.75 (3.78)	-

Notes: MBI = Maslach Burnout Inventory, CSEQ = Clinical Supervision Evaluation Questionnaire. CI = confidence intervals, SD = standard deviation. MBI cut-offs: exhaustion (low, ≤ 16 ; moderate, 17–26; high ≥ 27); depersonalisation (low, ≤ 6 ; moderate, 7-12; high, ≥ 13); personal achievement (low, ≤ 31 , moderate, 32-38, high, ≥ 39 ; Maslach et al., 1997).

Figure 1. Mean scores on the MBI over the CARP evaluation period

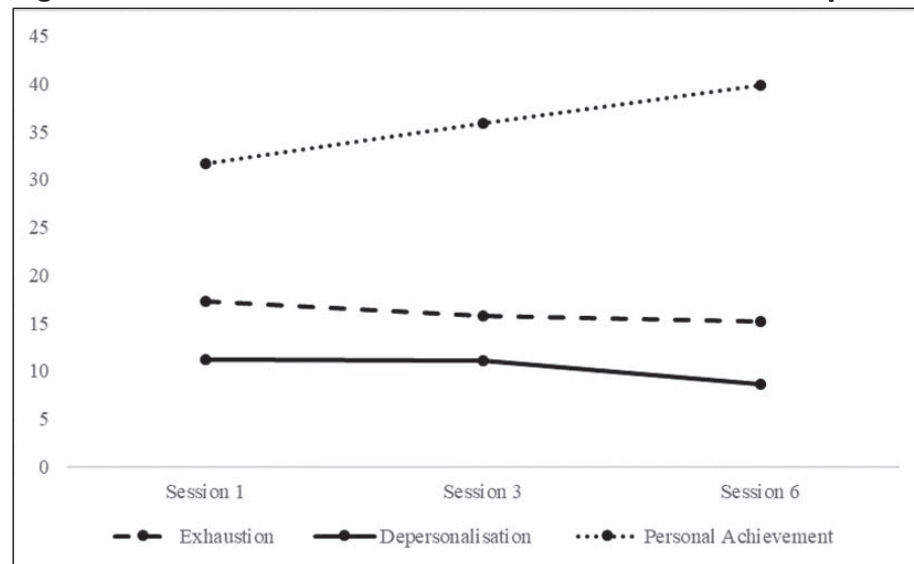
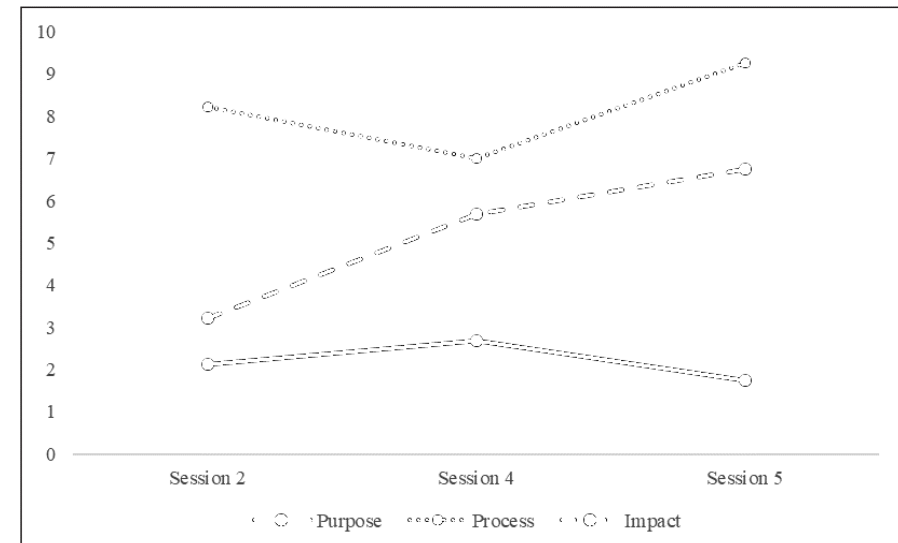


Figure 2. Mean Scores on the CSEQ over the CARP evaluation period



Experience of CARP after the contracted sessions were complete. Feedback questionnaires were distributed to n=10 individuals who attended at least one CARP session. N=5 (50%) were returned (n=3 female). Roles of respondents were: LD nurses (n=2), clinical lead (n=1), and care support workers (n=2). Years of experience among respondents was a mean of 24.75 years (min. 9 years, max. 35 years).

In terms of respondents' overall experience of the CARP sessions, all felt the sessions provided them with space that felt safe enough to reflect on the emotional aspects of their work (5/5 strongly agreed). All respondents also thought that CARP sessions increased their awareness of themselves, others and the wider system (3/5 strongly agreed, 2/5 agreed). Similarly, all respondents thought that CARP sessions gave them space to think differently about how they relate to clients, others and the wider system (3/5 strongly agreed, 2/5 agreed). All respondents (5/5) expressed that they would want to engage in further CARP sessions if they were offered.

Facilitator factors

Facilitator factors that respondents felt were helpful included having a safe and non-judgemental space to reflect on how their clinical and general work was impacting them. Having a space and time outside of their office helped limit distractions and protect the time for reflective practice. In terms of facilitator style, facilitators allowing conversations

to flow naturally (without frequent interruptions) if topics were relevant was found to be helpful in addition to a gentle and inclusive interpersonal style from facilitators. Respondents also fed back that facilitators sharing knowledge of relevant psychological theories and models helped structure and make sense of the experiences being discussed.

Respondents also shared some aspects they felt may have hindered the quality/helpfulness of the CARP sessions. Difficult topics not being adequately 'closed' before sessions came to an end resulted in attendees carrying unacknowledged feelings/anxiety back into their working day or evening. A number of respondents also highlighted that often the one-hour session duration did not feel long enough to meet the intended aims of the sessions at times. Additionally, more sessions overall were suggested as an area of improvement to the CARP groups generally.

Relationships with team

Having a planned and protected space to discuss dynamics within the team was said to have a particularly helpful impact on relationships within the team. More specifically, the experience of hearing how other members of the team felt about situations helped to reduce misunderstandings and enhance intra-team support and cohesion.

It was also noted that some attendees appeared to find the process of CARP sessions difficult (e.g., no planned agenda, or 'problem-solving' objective). This appeared to have an impact on how other attendees received and/or responded to the contributions and discussions in sessions, which affected the sense of group safety at times.

Relationships with patients/carers

Respondents felt that CARP sessions helped them to reflect on and understand relational boundary difficulties and challenges with service users and carers. The process of sharing, naming and acknowledging relational difficulties with clients appeared to help attendees enhance awareness of relationship patterns and consider alternative ways of relating to service users and carers. There were no aspects of the sessions that respondents thought hindered relationships with service users/carers.

CAT model in RP sessions

Respondents commented that they found using the principles and language of the CAT model (e.g., reciprocal roles, mapping on flipcharts) helpful in CARP sessions. Additionally, respondents highlighted that it was a useful way to recognise and understand the patterns that were occurring in relationships with service users, carers, within the team and with the wider system (e.g., other teams and agencies).

In terms of hindering factors, the respondents felt that six, one-hour sessions was not enough to fully explore difficult relational patterns occurring in the past and present in the team, adequately.

Discussion

The aim of the current small-scale study was to evaluate a time-limited cognitive analytic reflective practice group for practitioners in an LD Intensive Support Team. In order to meet this aim, we collected and analysed the following data: [1] burnout severity of attendees from first to final CARP session, [2] attendees' perceived quality of specific CARP sessions, and [3] attendees' overall perspectives of CARP sessions.

Average burnout severity among attendees improved across the course of the reflective practice groups. Although none of the scores on MBI subscales changed to a statistically significant degree over time, all three subscales showed a slight trend towards less burnout. Between the first and final CARP sessions, exhaustion reduced from moderate to low severity, depersonalisation remained moderate, and personal achievement increased from low to high (suggesting less severe burnout at the end of the sessions). It is worth pointing out that there was a high variance around the mean in participant MBI scores which may have reduced the likelihood of a statistically significant trend in MBI scores across time. Results from the CSEQ (measuring quality/experience of specific sessions) were less linear. Although none of the scores on CSEQ subscales changed to a statistically significant degree over time, average scores indicate that the perceived impact of sessions on attendees' day-to-day work increased over time, whereas purpose and process factors fluctuated across sessions, on average. Results also indicate that facilitators were generally adherent to the CAT model during the sessions.

Qualitative assessment of the CARP sessions, highlighted helpful facilitator factors, including a reliable time and place being set, and conditions of psychological safety. Some attendees felt that both the

session durations and number of sessions were not long enough and would have preferred longer/more. Generally, attendees found that CARP sessions had a beneficial impact on relationships within other team members and service users, though some members appeared to find the format of the sessions (e.g., no set agenda) challenging. All respondents expressed a desire to engage in more CARP sessions if they were offered.

Although remarkably few studies have investigated the impact of reflective practice groups (RPGs) on healthcare/LD practitioners, findings from the current study are generally consistent with previous research. Attendees of the CARP sessions, for instance, commented on the value of the safe and structured conditions of the sessions – aspects that have also been highlighted in other studies on RP with healthcare practitioners (O'Neill et al., 2019; McAvoy, 2012). Previous studies have reported on the positive impact on team cohesion and affiliation after attending RP sessions (Dickey et al., 2011), which was noted in this study. In addition to the overall feedback of attendees, severity of burnout showed a trend towards less severe burnout as sessions progressed in the current study, which is consistent with previous evaluations suggesting that RPGs can improve the capacity to manage the emotional impact of health and social care roles (Lees, 2017).

In one of the few studies that has been conducted on cognitive analytic reflective practice groups, Priddy (2021) developed a theory of how CARP sessions may influence relational awareness for practitioners working in a secure children's home. The theory consisted of three overarching factors: [1] establishing a reflective space (facilitator processes), [2] widening awareness of self/other/system, and [3] changing relational dynamics. By exploring LD clinicians' experiences of CARP sessions in the current study, support was found for each factor. Facilitator factors (e.g., a non-judgemental, structured and inclusive approach) were seen as foundational, in addition to widening awareness of self/other/system (e.g., through listening to and exploring the impact of work on self and other team members) and changing relational dynamics (e.g., by exploring and naming relational patterns with colleagues, service users and carers in a structured way).

Strengths of the current study included a clear and planned structure to providing CARP to the IST (e.g., including introductory training, explicit contracting and facilitating sessions at an agreed frequency). This hopefully enhances the replicability of this CARP evaluation model to other LD teams and other types of health and social care settings. Other strengths of the project include facilitators engaging in cognitive analytic

informed group supervision through the evaluation period, and CAT model adherence being considered explicitly (which is less common in small-scale service evaluation projects).

There were limitations to the project. The authors evaluating the CARP sessions were also the facilitators of the sessions. Although this makes for a very rich experience of both engaging in indirect clinical practice and small-scale research, this may have naturally led to some bias when collecting and analysing data for the evaluation. Additionally, attendees may have been eager to report positive experiences from the group due to the facilitators collecting this data. Questionnaires were all anonymous in an attempt to minimise this risk. Another limitation related to the number of sessions and length of the evaluation as it only occurred over 3 months. Although this was consistent with the time-limited nature of CAT (Ryle & Kerr, 2020), this design did not allow for exploration of the longer-term impact of CARP on practitioners. Similarly, there was no follow-up data collected after CARP was complete – and thus long-term burnout data was not available.

In future, longer-term CARP groups and/or follow-up measures could help to understand the impact of CARP on teams vulnerable to burnout. Additionally, CAT model adherence was measured using an adapted tool to guide facilitators' reflections on model adherence in a group supervision context. This adherence-checking could have been improved by audio recording sessions, and an independent (ideally an accredited CAT therapist) scoring CAT adherence shown during the session(s). Future CARP evaluations should audio record at least one session in order to provide a more valid and reliable measure of CAT model adherence. Comparing outcomes between CARP and other forms of RPGs would also be enlightening in future studies in order to explore whether different types of RPGs have different impacts on participants or their clinical practice.

Finally, although facilitators had both been clinically supervised by CAT practitioners previously, neither were accredited CAT practitioners themselves. Ensuring facilitators achieved a minimum standard of CAT knowledge and expertise may have helped ensure the adherence and quality of CAT practice in sessions was to a high standard.

Given the infancy of CARP research, future studies should continue to develop, investigate and explore the impact, outcomes and theory of how CARP can help healthcare practitioners as individuals and teams in various health and social care settings. Particular factors that would build

on the current study might include longer evaluation periods, inclusion of a comparison RPG condition, collection of follow-up quantitative and qualitative data from attendees, audio-recorded adherence checking, interviews with attendees and collection/comparisons of service user data to assess the impact on direct clinical practice.

In conclusion, reflective practice groups explicitly informed by the CAT model are in an early stage of research and development. The current project set out to evaluate a brief, time-limited cognitive analytic reflective practice group offered to a Learning Disability Service Intensive Support Team. Findings suggest that burnout severity in the team may have reduced on average and attendees felt sessions had an increasing impact on their work as sessions progressed. Attendees fed back on the helpful and hindering aspects of the sessions from their experiences and all respondents expressed an interest in attending further CARP sessions if offered. □

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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

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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

Paired Samplest-test – comparison with baseline ^								
Descriptivestatistics								
	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 ^								
Descriptivestatistics								
	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

Figure 1: RAM Part A Mean outcomes for each session with 95% Confidence levels

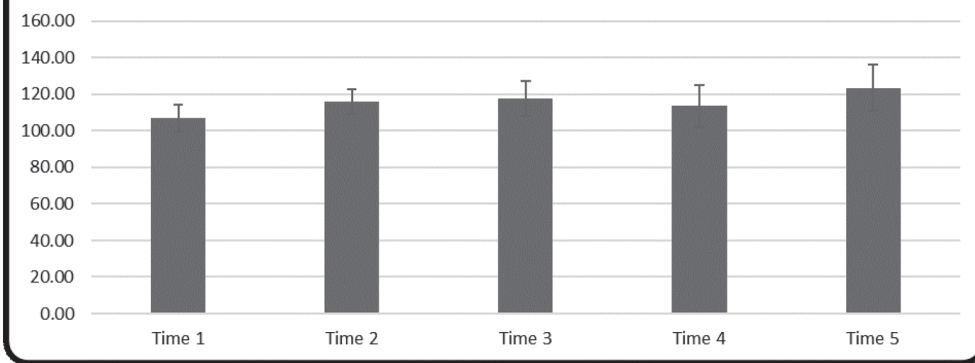
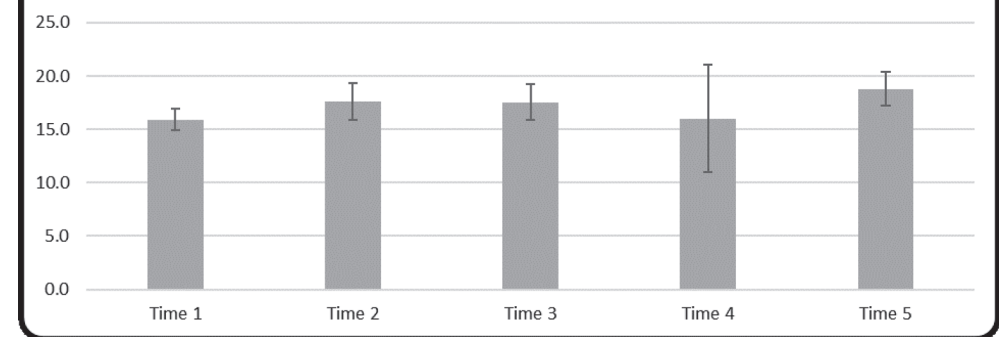


Figure 2: RAM Part B Mean outcomes for each session with 95% Confidence levels



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

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	-

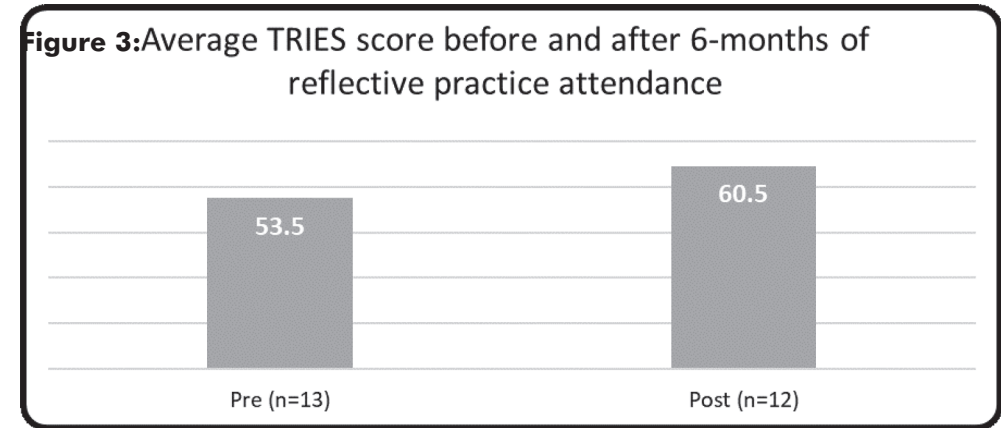
rated was 8.9 (SD=2.9, $n=11$, Scale 0 not at all to 13 Very much on a VAS). Table 3 sets out ratings for the 7 individual items and qualitative responses to each question.

Team cohesion

Inferential testing 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	-0.27	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 through 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

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Reflective Practice Groups for Leaders

Helping NHS leaders to 'feel well and able to do my job':
an interpretive phenomenological analysis of participating in
a cognitive analytic reflective practice group

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Abstract:

Objectives

Healthcare leaders are required to manage a complex and emotionally demanding role, which impacts staff and patient care. Reflective practice is understood to aid healthcare workers in managing such roles. In addition, given the highly relational nature of healthcare, it has been suggested that ideas from cognitive analytic therapy have much to offer healthcare staff in terms of making sense of the relational dynamics that affect the experience and ability of healthcare workers to enjoy a positive experience of work and provide high quality patient care.

Design

This study was conducted as a service evaluation to gain understanding of the experience of leaders participating in an existing cognitive analytic reflective practice group.

Methods

Semi-structured video-interviews were conducted with 3 participants of long-term 1-2 monthly reflective group for a leadership team. Transcripts were then analysed using interpretive phenomenological analysis.

Findings

Findings generated four group experiential

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themes: 'bearing the pressures of leadership'; 'appreciating a nurturing and developmental space'; 'needing to feel safe to use the group well'; and 'accepting the limits of the group's work in practice'. The study found that this intervention was highly valued by these participants. This included general effects of reflective space, as well as specific benefits of applying the cognitive analytic relational model.

Conclusions

These findings suggest that leadership reflection is an important and valued intervention for leaders. It also supports the growing evidence for the benefit of applying cognitive analytic therapy organisationally to help improve healthcare staff support, in line with NHS workforce commitments.

Key words

interpretative phenomenological analysis, leadership, reflective practice, staff support, cognitive analytic

Public Significance Statement

Healthcare staff, including leaders, have complex, emotionally demanding roles, upon which depend the quality of patient care. This study highlights the benefits and challenges of using a specifically relational model of reflection that allows leaders to better understand and manage the interpersonal demands of their role. It supports research evidence for cognitive analytic therapy to be used beyond direct patient care, to support and develop those who lead healthcare services.

Introduction

Healthcare leaders are instrumental in creating and maintaining high quality, safe, compassionate patient care (West et al., 2015). The act of care involves both kind, supportive help (e.g. 'caring for') and also thoughtful, mindful attention (e.g. 'taking care'). Indeed, values of compassion and responsibility are embedded in the UK's National Health Service (NHS) constitution (Department of Health & Social Care, 2024). However, the ability to provide such care is challenged by the current NHS system pressures, with insufficient resources to meet increasing needs, operational difficulties and disruptions and challenges to staff and teams trying to maintain workload, relationships and wellbeing (Page et al., 2024). Staff also face particular emotional costs of managing complex and challenging clinical presentations and risks (Anandaciva et al., 2018). Under pressure, care can fail, with serious consequences

(Francis, 2013). A common thread in reviews of care failures is problematic organisational culture, which leaders have a key role in understanding and shaping (Mannion & Davies, 2018). And yet, while leaders are increasingly expected to understand and shape compassionate culture, leaders are subject to the same pressures as other staff that inhibit the capacities to be reflective, compassionate and emotionally aware (Marshall, 2021). Failures to provide compassionate, collaborative, thoughtful care can be understood as a response to such overwhelming emotional demands or pressures (Menzi-Lyth, 1960). Akin to a trauma response in individuals, organisations too can respond to interpersonal threats, such as exclusion, exposure or criticism, demonstrated by an impaired capacity to think, fragmentation and withdrawal from others and a lack of flexibility and empathy (Harvey, 2021, 2024). In fact, leaders may be particularly subject to such response, due to their increased responsibility, accountability, often, isolated position, and common cultural belief that failure is shameful (Anandaciva et al., 2018; Harvey, 2024). Therefore, a key question is how to support leaders to gain and/or maintain compassionate, collaborative, reflective care.

One suggestion has been to borrow tools and techniques from cognitive analytic therapy. Cognitive analytic therapy began as a 1:1 therapy, focused on understanding and improving both wellbeing and interpersonal relationships through identifying, understanding and adjusting repeated patterns in how individuals think, feel and behave both towards others and towards themselves (Ryle & Kerr, 2020). Such efforts are known as 'reformulation', i.e. a new way of making sense of complex relationships and patterns of emotion and behaviour. Authors such as Walsh and Freshwater (2024) have highlighted that such reformulation may be usefully applied to systems, organisations, and leadership dynamics, as well as individuals. CAT concepts have already been used in clinical teams to aid team formulation and care planning as a way of making sense of relational dynamics between services and service users. Such studies have reported improvements to teams themselves, in terms of increased communication, care for each other and clinical confidence, alongside greater insights into their patients and relationships with patients (Kellet et al., 2014; Kellet et al., 2020; Caruso et al., 2013). In some instances, CAT ideas have been applied to teams themselves. It has been used as a way of understanding common relational patterns, such as between colleagues or between managers and staff (Shannon et al., 2016; Craven-Staines, 2019).

One of the earliest applications of CAT in an organisational context

was Walsh, who usefully explored the relational dynamics and ‘exits’ (i.e. alternatives) with a hospital surgical team and managers (1996). More recently, the same author has written about the use of CAT as a ‘thinking framework’ to understand how individuals and systems fit together, with specific utility in clinical supervision to help staff hold on to their capacity for thinking systematically when overwhelmed or challenged by organisational pressures (Walsh, 2019). Much of the existing evidence is practice-based, reported in grey literature. One paper examined the use of a tool outlining common reciprocal roles experiences by those in a ‘helper’ role. Questionnaires and focus group of NHS staff working in learning disability teams found the reflective experience predominantly valuable (Staunton, 2015). An additional reflective paper by one psychologist working in an occupational health service highlights parallels between personal and organisational psychology in the common reciprocal roles and coping procedures described by her staff clients, noting that the organisation itself can be both participating in the creation and maintenance of problems, and a partner in changing or resolving them (Appleby, 2003). A more recent published paper similar reports on improvements for staff clients accessing CAT in an employee psychology service, noting that CAT allows the helpful recognition that both staff and managers are drawn into interacting systems and will both experience both ‘pain inducing’ and ‘pain receiving’ ends of reciprocal roles (Craven-Staines et al., 2019). In additional work with teams, Craven-Staines (2019) described teams valuing a CAT ‘mapping’ exercise (also known as ‘sequential diagrammatic reformulation’), which visualised the team’s maladaptive reciprocal roles and procedures, and likewise allowed recognition of the reciprocity between staff and managers both experiencing pressures. An article and book chapter by Marshall (2014, 2021) describes the experience and challenge of facilitating a CAT-informed reflective practice group for a team following a crisis. It highlighted the value of giving staff a voice and having an opportunity to ‘stand back’.

Several authors have suggested that CAT could have similar utility for leaders to look at wider organisational as well as team relational dynamics. This is argued to be that CAT can provide a shared language and framework for understanding relational issues. It is particularly useful given the power of leaders to influence the wider use of such a framework (Marshall, 2021; Harvey, 2024). However, the peer-reviewed evidence base for organisational applications of CAT is scarce, with leadership applications even more so. Thus, in this paper, we present the case for application of CAT ideas to leadership reflective practice and report on

the experiences of NHS leaders who participated in a CAT-informed leadership reflective practice group (‘Group’).

Materials and Methods

Design

The study was conducted as a service evaluation, in collaboration between an English National Health Service (NHS) mental health Trust and a University partner. The project used a qualitative IPA design. IPA was selected as the goal of the project was to understand complex, emotionally-laden experiences of individual participants (Smith et al., 2021). Understanding the experiences of individual participants would then order to inform future development of leadership reflective practice groups within the organisation.

Participants and intervention

Purposive sampling was used. All participants of a leadership reflective practice group (‘Group’) which ran from 2022 to 2024 were invited to take part. The Group was started in response to a request from a leadership team to have reflective space to explore team relational dynamics, including those that had been problematic. Participants attended a 1-day introduction to CAT concepts prior to the Group sessions. The Group met 1-2 monthly in a mix of face-to-face and online meeting. On average, 3 individuals attended per session. When new members joined a review of ‘map’ and brief intro to CAT concepts was offered. The Group ended following a changeover in staff and difficulty for the leadership team and facilitator to attend a recap / teaching session. Taking into account leadership staff turnover and periods of leave, 7 individuals attended the Group over time, representing clinical and operational leaders from psychiatry, psychology and nursing professional backgrounds. Participant characteristics (e.g. professional background, length of time in the role, length of time in the Group) are not detailed to preserve anonymity of participants.

Procedure

Six out of seven attendees were contactable at the time of the service evaluation and were invited to participate via an email communication

from the lead researcher, using contact details gathered from the Group's facilitator. Three agreed and were given written information and consent forms to complete. Participants took part in individual 50-60 minute online interviews, using Microsoft Teams software. Semi-structured interview guide questions were developed through discussion within the research team and in consultation with a senior CAT practitioner. Questions were designed to elicit participants' retrospective views on their experiences of the Group, helpful and unhelpful aspects, and any perceived changes in understanding and/or other impacts of the Group on individuals or teams.

Analysis

Interview data was video-recorded and a draft transcription automatically generated within videoconferencing software. The transcription was reviewed and revised to ensure accuracy and completeness, and identifying details of individuals and teams were redacted. Video recordings were then deleted, with the final anonymised transcripts analysed. Analysis was via interpretative phenomenological analysis. This qualitative approach focuses on both phenomenology, i.e. individuals' lived experiences of the subject in question, and interpretation, i.e. how both participant(s) and then the researcher(s) make sense of the experiences described. Analysis followed the steps outlined by Smith et al. (2021), acknowledging that the steps involved repetition, revision and back and forth between steps and between single and whole perspectives, as themes were tested and revised.

- Step 1 – Familiarisation – data was repeatedly listened to and read in the process of transcription.
- Step 2 – Noting – concurrent with and continuing beyond Step 1, items of interest were noted on beside the transcript, focusing on described feelings, attitudes, and perceived impacts.
- Step 3 – Experiential statements – in turn, each noted transcript was systemically read through and units of data summarised, aiming to concisely capture participant specific experiences and attitudes.
- Step 4 – Making connections – considering each participant's transcript one at a time, statements were collated into related clusters, which were then triangulated in discussion with the research colleague external to the organisation.

- Step 5 – Naming and tabling individual themes – for each participant, these were then revised, charted in a table.

- Step 6 – Developing group experiential themes – individuals' themes were then considered as a group, to generate overarching themes, retaining divergent experiences. Themes were then reported in writing.

Findings

This analysis generated four group experiential themes regarding the experience of being in a CAT-informed leadership reflective practice group: 'bearing the pressures of leadership', 'appreciating a nurturing, developmental space'; 'needing to feel safe'; and 'accepting the limits of the Group in practice'.

Bearing the pressures of leadership

This theme represented the participants' awareness of the challenges involved in their leadership roles, formed the context of their attendance of the Group.

Feeling responsible but not empowered

Participants were mindful of the multiple, sometimes conflicting, roles and responsibilities they held as 'mini leaders'. This included caring for team members, patients and the service itself while holding responsibility for decision-making and ensuring good quality, safe service provision. At the same time, participants described working under operational pressures and near-continual upheaval, often without the autonomy or resources to effect desired change. Power was seen as residing in the organisation's more senior leaders who were variably seen as judgemental, supportive, or absent, leaving participants to 'get on with it'.

'It's almost like we have all this pressure and responsibility placed on us but actually we're quite powerless to do much about some of the challenges that arise.' (P1)

'It was demands and expectations from below and from above, which altered during the time we, had altered the whole time we existed, are still altering. You just, you just get used to being built on, I don't know, tidal sands.' (P2)

‘It wasn’t like we could just do something, and it would make it all better, and so people. . . people felt like we didn’t care.’ (P3)

Feeling the emotional fallout of managing trauma and risk

Participants all spoke about the enduring emotional impact of working with trauma and risk, which held specific challenges. Firstly, participants felt leadership responsibility and blame, particularly in instances where service users had experienced harm. Secondly, their position as authority figures made it difficult to express their own emotional needs and access the same support resources available to non-leadership staff members. Thirdly, there was a recognition that the leadership team themselves and their wider staff team were disconnected and fractured, so not able to ‘come together for support’.

‘Our team dynamics in the leadership set were really problematic and dysfunctional... the communication within the leadership team broke down quite significantlyand it caused real friction between individual leadership members.’ (P1)

‘I didn’t want to unsettle people, I also didn’t want to cause ripples, because how does it look if I’m starting crying or if I start saying ‘I hate this’, you know, ‘I can’t cope anymore’, you know, you feel like you’ve got to keep it together for people.’ (P3)

‘At the point the pandemic hit, we were [a relatively new service], we didn’t yet have a business as usual, we haven’t settled into that, then we all get, we’re dispersed anyway, so team spirit, closeness, connection, all those things were a challenge.’ (P2)

Appreciating a nurturing, developmental space

This theme represented the ways in which the Group was valued by the participants. Participants each focused in on different aspects, though these were echoed in others’ accounts.

Relief at being heard, validated, supported

Participants all spoke about the vital nature of the Group during an emotionally and operationally difficult work period. Participants described the Group as supporting them to stay in work and keep on

engaging in trying to support and improve things for others.

‘I’m not sure I could have stayed, actually, without this.’ (P2)

‘When I look back now, I think it was just a really positive experience and certainly helped me at work feel well and sort of able to do my job. Otherwise, it would have made me just withdraw. . . because there was just so much chaos. . . I think I would’ve just thought, it’s just too overwhelming.’ (P3)

One participant spoke in particular about the importance of having their views and experiences seen, heard and validated by the facilitator and, literally, put ‘on the map’.

‘I think it was a sort of a safer way to have difficult conversations and sort of depersonalised it as well, but also, for me personally, allowed me to acknowledge some difficult emotions that I had in response to what was happening.’ (P3)

Another participant focused on the relief of being able to discuss and understand each others’ experiences with compassion and not blame.

‘I had some level of awareness then that I had, that I’m not always easy, and, yeah, so what if people say things and it doesn’t work and the team is completely broken. . . you know, I wasn’t personally in the best place at that point, but overall, it just, it, it just, it was such a relief, the map made so much sense [and] didn’t feel personal because the dynamic has several parts.’ (P2)

Another participant particularly valued the opportunity to step out of the emotional pushes and pulls of the work, to be able to think, reflect and so be bolstered to withstand these dynamics when they arose.

‘There was a real sense of all of these problems coming to me and me not being, actively not being in a position to be able to do anything about them other than just contain and then kind of hold. . . It gave me that kind of reflective space to think about, actually, ‘What’s mine? What’s the system’s? How’s the system pulling me into this? How can I step out of that for a second?’ So that was really helpful, particularly at that point.’ (P1) Participants noted the value in having a specific leadership Group, where their needs could be met, rather than being on duty as leadership figures in other meeting spaces.

Participants noted the value in having a specific leadership Group where their needs could be met, rather than being on duty as leadership figures in other meeting spaces.

'[In other reflective spaces] I was always conflicted about whether I should be there, 'cause it felt like a space where people needed to be able to say anything, but equally, you're sometimes sat there and thinking, well, as a member of the leadership, I can't ignore you've just said that.' (P2)

'We met weekly [in leadership meetings but] it was like, 'oh, there's this crisis happening, what are we going to practically do about this' or, you know, 'there's this staffing issue'. It wasn't like, 'how do you feel, and also how do you frame how you feel, and how you move forward from it', you know, it wasn't therapeutic, it was like task-focused fire-fighting every week.' (P3)

Appreciating the opportunity to learn, understand, connect

Participants spoke positively about what they had learned about relational dynamics, demonstrating use of CAT terminology and sharing examples of using some CAT techniques in and out of sessions. Participants spoke about the value of being able to see (literally, through mapping) and being able to make sense of difficulties in a way that recognised the interplay of personal, interpersonal and systematic responsibilities and vulnerabilities and strengths that influenced the team's patterns of relating.

'It answered, really quite quickly, it answered a whole heap of different, like 'what the hell's gone wrong there', you know. . . we're all, we're all just falling into these same dynamic patterns, and it just made so much sense. And that was a massive relief.' (P2)

Participants felt they had built better communication and stronger connections with the other team leaders. This was due to developing shared understanding, shared language, shared practice in safely talking about issues when they arose 'live' in the room, and simply sharing face-to-face time with colleagues, getting to know them personally.

'Many times it's been the only space that we've had to come together without a task, so just being with my colleagues and in a space where the expectation is different has real value.' (P1)

The experiential nature of the Group was highlighted by one participant as building empathy and compassion, which had improved their professional relationships.

'I'm a better practitioner because of it, in what I do in my day job. There's some, something really powerful in that experiential

learning and having it all drawn out for you and thinking actually it's not just, it's not just the sort of people who get mental health, but because we all have some bias somewhere. . . I could have gone to a lecture about CAT therapy and it would have made sense, but it wouldn't, would not have been the same as realising that I could be 'CAT-ed onto a map.' (P2)

Needing to feel safe

Throughout participant accounts there was a strong theme relating to feeling safe/unsafe, comprising two sub-themes.

Dealing with anxieties and fears stirred up by the Group

Participants all spoke about anxieties and fears they experienced and/or perceived in others, particularly at the start of the Group. None of the participants were very familiar with using the CAT model beforehand, so that the Group required a 'leap of faith' that engaging in the process would be safe and worthwhile – especially, as noted by one participant, given that the exploratory, unstructured nature of the reflective practice was in sharp contrast to the leadership set's usual highly structured, task-oriented management meetings.

'I was like, oh, great, we're gonna do something exciting, it's gonna be great, learn a little bit of CAT. . . that's right up my street, but I, I was really aware of the feelings of my other colleagues that were very, very anxious about being vulnerable.' (P1)

One participant evocatively described the prospect of opening up talk about the team's problems as dangerous, exposing, perhaps even lethal. Another participant described their concern about the 'fragility' of individuals and of the service.

'I knew it was necessary, but I was scared of what it would show and that the cure might kill the patient. . . I stopped feeling anxious fairly quickly [that] it would destroy us completely quite quickly [but] I was still quite nervous when we came to do the actual CAT mapping because I knew there was some difficult, yeah, I knew I'd have to think about my part in the dynamic.' (P2)

Participants described tolerating their anxieties by recognising the necessity of the intervention – one compared it to alcoholism, with the hardest bit being 'admitting you have a problem'. All noted that some

attendees struggled in the Group and generally at that difficult time, noting that numerous leadership members took sick leave or left the service. Participants felt capacity to deal with anxieties varied depending on personal history, current state, and professional background.

‘To reflect openly on, on a dynamic that’s live in the room [is less common in some professions than others] and that then intersects with how you are in that moment and your personal well-being and how much you feel like you can tolerate.’ (P1)

Needing the Group to be made safe enough

Participants highlighted the role of the facilitator as key in creating enough psychological safety to participate in reflective exploration. Participants’ descriptions of the facilitator highlighted their skill/expertise, as well as their important position as an external authority. They were described as kind and non-judgemental, facilitating issues to be raised without individuals ‘being scapegoated for raising them’.

‘I don’t think we could have done this ourselves, ‘cause I don’t think any of us, erm, were brave enough to open the conversation ourselves. . . if [any one of us] tried to open those conversations, I think it would have been excruciating, and sometimes you need a neutral, you need a neutral person so you can say what you need to say without it feeling, yeah, you need somebody else to hold the safety in the space for you.’ (P2)

‘We’re all like living and breathing work together and there’s a lot of intense emotions, so we all, we can all get caught up in things and not realise, and so it’s just helpful to have a different viewpoint or person there that can help us think, ‘what does it look like somebody else here?’ (P3)

‘Whenever I see a CAT practitioner working in that way, it feels like magic because it feels like there’s all these words coming at them, and they find the perfect word, just the key. . . that can just strip away all of this, all of the kerfuffle of team stuff. . . but you have to have an ear to that and also be feeling it.’ (P1)

Participants described aspects of the CAT model that facilitated safety, such as its emphasis on patterns and reciprocal behaviours rather than single individuals or events. This made the Group less judgemental – even if not completely free of judgement.

‘It was a function of team pattern as opposed to it being ‘that

person’s being difficult’ . . . so it really brought us together and created a sense of this is what’s happening and we’re part of it, but it’s not us.’ (P1)

Perceptions of how safe the Group was varied between participants. For one participant, it was initially scary to open up oneself to difficult personal conversations, such as hearing about own’s own difficult behaviour, but this became really powerful and worthwhile learning experience, beyond what could be gained from ‘listening to a lecture’. On the other hand, such conversations reflecting on past behaviour represented for one participant some avoidance of the Group’s primary task of exploring live dynamics as they happened between participants within sessions. They felt this happened because the Group did not (yet) feel safe enough for the latter, noting the nuance required by the facilitator to attune to the needs and capacity of the Group.

‘Some things that are on the map. . . I understand how they may have impacted people in the past, but in terms of what was happening in the here and now, they just didn’t connect with me. . . like talking to something that happened in the past that created some context, but almost as like in a way to avoid some of the more difficult stuff from the here and now.’ (P1)

Accepting the limits of the Group in practice

This theme captured both disappointments and realistic understanding about the limitations of what had been achieved in the Group.

Frustrations at the impact of staff turnover

Participants all described widespread staff absence and turnover as a key factor in the story of the Group. Participants agreed that a lot of positive changes had taken place in the team’s work and relationships, but the staffing changes made it difficult to parse what effect the Group itself had. Buy-in was weaker for newer members who missed the starting orientation and mapping days and were not so closely connected to the dynamics on the map, such that eventually there became no point in ‘limping on’ and the Group came to an end.

‘it’s hard to do that when you’ve got, like, rolling team members all the time.’ (P1)

There was a sense across participants of a divide between ‘older’

and ‘newer’ leaders, with the sense either that older members were guarding against the reappearance of dangerous dynamics to which newer members couldn’t or wouldn’t see, or that older members were stuck talking over past problems without their map evolving sufficiently to represent and engage newer members.

‘They didn’t really know some of the history as to why it was important, they didn’t feel it like we did.’ (P3)

‘We feel like we really need to guard against [historic patterns recurring but] they don’t see it as a problem, and we’ve never managed to find a way of, erm, helping them see the full value.’ (P2)

Participants noted disappointments that wishes to share their learning (the map) and/or the experience of CAT-informed reflective practice had not come to pass, e.g. with their non-leadership colleagues, senior leaders, or other leadership teams. There was an overall sense of seeking to share and be understood by others, but feeling ‘left to get on with it ourselves’.

‘I think [having the wider team do CAT mapping too] would have helped them understand us as well as us understand them. . . (pause) and that sense that we were, trying to make a difference.’ (P2)

‘You were kind of left to sort it out and nobody really wants to know what’s happened and if it, if it’s actually changed what’s happening in the team.’ (P3)

Accepting the limits of individual and service capacity and impact

All participants recognised that there had been logistical difficulties in maintaining the Group due to the nature of the clinical service (e.g. needing to respond to risk), as well as leaders’ and the facilitator’s limited availability, and practical challenges in securing a suitable space to gather together for a team that was spread out geographically (and for some of the time operating with COVID restrictions). These constraints were all accepted as part and parcel of NHS working. However, the end of the group was still viewed as a loss.

‘When we when we get together, it’s helpful, but we’ve had limited times that are workable, always at the jeopardy of clinical urgency . . . when you’re under pressure, the first thing that goes is your supervision, it’s the thing you most need.’ (P2)

Participants also linked the Group end with underlying ambivalence towards the process, acknowledging that reflective practice could be effortful and challenging, especially as some people were more ‘psychologically minded’ and others were more ‘doers, just getting on’.

‘I think the busyness of working with people’s priorities and also the capacity to commit [got in the way]. . . but, in a way, maybe [also] people not quite understanding what it was about, I think sometimes people wanted to pretend everything’s OK.’ (P3)

‘[To feel] safe enough to discuss it with people, with each other when we’re in those moments, say for example, ‘I’m feeling like you’re being a bit critical’ or ‘I’m feeling like I’m being criticised’ . . . that takes a lot of like practice and confidence and safety and insight and all of those different things to do, and when that’s, when your running around like a crazy person trying to manage people and manage risk and write clinical notes and all that stuff, so yeah, I just don’t know that we had the space psychologically and practically to kind of really embed that.’ (P1)

All participants reflected on the importance of individual mental health, both as a prerequisite for engaging in self-reflective practice and as a factor in the improvements seen in the team.

‘Change occurred because of the change in team members and a change in team members’ personal wellbeing. . . individually, people had their own resources restored and were able to not be pulled into some of the more difficult roles that they would have been before, because they were operating from a more ‘healthy island’.’ (P1)

‘One of the things that has come out of it is that we’ve had a real focus on sort of well-being development and conversations about well-being and connectedness and how important these things are.’ (P2)

Participants noted too that change processes take time and effort, and that even though finding ‘exits’ (alternatives) had been harder than identifying the problems, even just being able to see and understand issues had been really important.

‘We could name it, but we weren’t very good at working out how to do it differently, that’s taken a long time, and I’m not sure we’d have ever done that if we hadn’t had the ongoing [reflective practice group], so those of us who were there at the time massively valued it and would ideally still like it to be going on.’ (P2)

While the wider benefits to the team were uncertain, participants themselves all found the experience of the CAT reflective practice group to have benefited them personally, in terms of self-understanding and mental wellbeing, and professionally, in terms of their ability to communicate and repair/build relationships, empathise and view issues with a systematic, relational perspective.

‘We changed in how we understood what the problems were and how we related to each other. . . whether that changed the wider team, I don’t know, it certainly changed how I felt.’ (P3)

Discussion

The aim of this evaluation was to learn about the phenomenological experiences of taking part in a CAT-informed reflective practice group, in order to inform the development of future similar activities. Key questions were if, and in what way, participants experienced and valued the group and whether the group helped participants feel better able to understand and manage the relational and emotional experiences of work. Participants did report valuing that Group as a supportive and learning space, which helped them to bear the pressures of leadership. Participants were mindful of the need to feel safe in order to use the Group well and were accepting of the limitations involved in running the Group in a changing NHS service context.

There is little existing literature in this area. However, the broadly positive experience of participants reflects a recent grounded theory analysis of CAT-informed staff reflective practice groups (Priddy et al., 2024). It aligns more broadly with the value for leaders of peer reflective practice groups (Daniëls et al., 2020) and relational leadership development interventions (Park et al., 2023). Findings also support CAT literature recommending CAT’s utility for leadership (Marshall et al., 2021; Harvey et al., 2024).

The first theme captured the context in which leaders were accessing the Group. Participants’ experiences of high responsibility, low power and multiple demands reflects the critical operational and financial pressures that NHS currently faces (Darzi et al., 2024). This includes the specific pressures on healthcare leaders as responsible for ‘delivering the impossible’ (Anandaciva et al., 2018). NHS leaders often juggle multiple roles, including managerial and clinical duties, as well as competing responsibilities to take care of staff wellbeing while also ensuring that staff performance is up to standard (Marshall, 2021; Kline,

2019). In CAT terms, this requires balancing between pacifying/care-giving and controlling, reflecting an interpretation of leaders’ experiences as parental, perhaps unsurprising in a care-giving organisation (Marshall, 2021). Furthermore, participants’ experiences of lacking power and perceiving senior leadership as absent or neglectful, reflects a sense that the NHS not being a ‘good enough’ mother and that staff are ‘not being taken care of’. In addition, mental healthcare work is understood to risk negative secondary effects on staff from working with people who have significant trauma (Collins & Long, 2003). Leaders may also feel less able to seek emotional support due to their need to maintain an appearance of authority and capability (Appleby, 2003). Moreover, if and when things go wrong, leaders are more likely to face, or fear facing, being blamed (Marshall, 2021). Participants’ accounts of their team being disconnected and isolated in part reflects the realities of service provision during the COVID pandemic but also reflects Ryle’s (1997) multiple self states model of trauma response, applied to organisations (Harvey 2021, 2024). In this, an organisation may respond similarly to an individual following trauma, for example through avoiding emotion, responding rigidly, relating to others with mistrust, blame, control and neglect.

The second theme captured the two-fold nurturing and development value that participants had for the CAT reflective practice group, enabling them to better deal with work pressures. This aligns with the idea of a reflective practice groups as an emotionally containing space (Thorndy-craft & McCabe, 2008). In analytic terms, the Group may provide a ‘corrective emotional experience’ (Hartman & Zimberoff, 2004). In this, experiences were validated and re-formulated, self-understanding, self-compassion and self-reflection developed, and thus ego strengthened to better withstand work pressures. In CAT terms, the participants take in their experience of being compassionately cared for and the experience of compassionately caring, giving them practice in offering this to others. In addition, McVey & Jones’s (2012) study of reflective practice groups for staff in cancer services highlights the value of being able to talk about stressful and emotional subjects with peers, as does a national evaluation of reflective ‘Schwartz Rounds’ spaces for healthcare staff (Flanagan et al., 2019). Yiu et al. (2025) similarly assess staff reflective practice groups in inpatient mental health services, finding multiple benefits among which is being able to reflect with some distance from their emotions. In addition, the sense of leaders learning and developing their understanding of relationships, ability to communicate and thus ability to build better relationships is reflective of much of the literature on using CAT thinking with teams, with studies reporting better team

cohesion, shared language and better communication (Thompson et al., 2008; Kellet et al., 2014; Caruso, 2013).

The third theme focuses on participants need for safety. Menzies-Lyth's (1960) classic studies explore the unseen ways in which organisations manage the anxieties stirred up by working with people who are sick, suffering or in pain, by avoiding emotional engagement, such as through focusing on tasks. This is echoed in participants' accounts of the team, other spaces being structured, task orientated, and the unstructured reflective Group thus generating a lot of anxiety for people at the start. Psychological safety is a prerequisite for reflective spaces, requiring a shared belief that taking risks and trying something new and unknown is safe, that potential failures and mistakes will not expose individuals to shame or ostracisation (Daniëls et al., 2020). Facilitation is key. Craven-Staines & Finch (2024) theorise about the importance of facilitator competence and confidence. They discuss the value of CAT in bringing unspoken ways of relating and behaving into the open in a way that does not blame individuals because it allows visibility of all the intersecting factors that contribute to problematic patterns. This capability of the CAT model to create safety echoes the accounts of participants. A significant factor in these participants' experience was the degree of staff absence and turnover during the course of the Group. This aligns with the experiences of healthcare leaders in the NHS (Anandaciva et al., 2018). A thematic analysis of nurse reflective groups in inpatient mental health settings noted that turnover of attendees in an open group likely limited the depth of reflective exploration that could take place and that it was vital to secure protected space for reflection (Thomas & Isobel, 2019). Similarly, it is likely that the Group's progress was slowed because of the continual changes in membership.

Finally, participants also noted the importance of personal mental health and self-reflective capacity in order to engage with the Group, recognising that this varied between and within participants over time. It is not clear if these constitute prerequisites or outcomes of the Group, or both. It is notable that previous studies have highlighted the accessibility of CAT to staff across professional backgrounds (Jones & Annesley, 2019). Yet, for these participants there was a sense that newer members didn't have the same level of engagement and buy-in.

Limitations

IPA is idiographic by nature, providing an in-depth analysis of the phenomenological experiences of a small homogenous sample (Smith et al., 2021). Still, the sample of 3 represents participants that were

relatively engaged in the Group and were motivated and able to be interviewed. Their accounts refer to perceptions of differing experiences across the leadership team, which may or may not have been fully captured.

IPA's qualitative approach is not concerned with issues of reliability and bias, instead recognising that the orientation and interpretation of the researcher(s) will influence the themes that they generate. However, to support rigorous analysis, the project design included regular research supervision and triangulation of findings with the third author who was an experienced qualitative researcher and external to the organisation. Still, the positionality of the lead researcher as relatively new to IPA and a relatively junior employee of the same organisation as the participants may have affected what participants shared as well as the interpretive depth of the analysis.

The data collection and analysis were designed to maximise participant safety and avoid identification of participants by those within the organisation. However, this required not reporting demographic and biographical characteristics of the participants, which removes an otherwise useful contextual layer of these individual's accounts.

Given that the leadership-focused applications of CAT and reflective practice literature in general are relatively scarce, and that the experiences of the participants reported here are largely very positive, further implementation and assessment of this kind of intervention is warranted. Furthermore, given the ubiquity but lack of clear definition about what constitutes reflective practice, future studies may benefit from more detailed investigation the nature and benefits of a CAT model reflective practice group beyond other theoretical approaches (Kurtz, 2020). A longitudinal design with a larger sample may also be useful. Further implementation of such reflective practice groups should: advocate for the importance of protecting reflective space; create and review psychological safety at the start and with each/any change in membership; raise and explore how ruptures (e.g. absence) may reflect dynamics being played out; and be mindful of the position and power of the facilitator as a skilled, informed but external model of 'good enough' authority and care.

Conclusions

CAT reflective practice groups may offer a valuable resource that is particularly needed and beneficial for leaders. Firstly, as an emotional support for a cohort who may be less likely or able to access other existing

resources, bolstering leaders' ability to withstand the pressures and meet the requirements of their role. Secondly, as a professional development opportunity to build interpersonal and reflective skills that are vital for contemporary leadership, helping leaders to create and spread compassionate, reflective culture that is vital for the long-term health and success of the NHS workforce. □

Data availability Statement

Data available on request due to privacy/ethical restrictions.

Funding, Data & Ethics Statements

We have no known conflicts of interest to disclose with respect to the research, authorship and/or publication of this article. The project was completed as part of the authors' work and study roles and the authors received no financial support for the research, authorship, and/or publication of this article. The project was registered as a service evaluation and received ethical approval through the NHS Trust's quality governance team, Project Number: 7496AMH24. A Data Protection Impact Assessment was similarly completed and approved. Participants were verbally instructed as to the purpose of the study, including its future use in publication, and consented to participate in data collection voluntarily and anonymously.

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Development of cognitive analytic therapy guided self-help for depression (CAT-GSH-D) in NHS Talking Therapies

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Abstract:

There is a lack of patient choice of intervention for those that attend at NHS Talking Therapies (TT) services with a presenting problem of depression. Previous work has seen the development and thorough evaluation of cognitive analytic therapy guided self-help for anxiety (CAT-GSH-A). This paper sets out development process for a sister version for depression called cognitive analytic therapy guided self-help for depression (CAT-GSH-D). The project employed the Medical Research Council (2008) guidelines for developing and evaluating complex interventions. The CAT-GSH-D workbook was developed through a matrix model that included a) identifying the evidence-base; b) identifying appropriate theory; and c) creating a model of the intervention. Three TT staff then rated the CAT-GSH-D workbook using the Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression and their feedback was incorporated into the final version. The CAT-GSH-D workbook has good fidelity to GSH principles and is theoretically grounded in the three-phase (reformulation, recognition and revision) CAT approach.

Keywords:

Cognitive analytic therapy; guided self-help; IAPT

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Introduction

The aim of the NHS Talking Therapies (TT) services (formerly known as The Improving Access to Psychological Therapies) for anxiety and depression is to improve the access to, and delivery of, evidence-based psychological therapies for people experiencing anxiety and depression. The TT programme uses a stepped-care approach with the aim of providing the least restrictive recommended psychological treatment first and then increasing treatment intensity appropriately (Bower and Gilbody, 2005) according to treatment response and risk. Within step-two of these services, low-intensity (LI) interventions for depression, typically underpinned by principles drawn from cognitive behavioural therapy (CBT; National Collaborating Centre for Mental Health, 2019) are recommended and are delivered by psychological wellbeing practitioners (PWPs). LI-CBT is offered to people with mild-to-moderate depression (National Institute for Health and Care Excellence; NICE, 2022) as the intervention fits the remit of being brief and least restrictive.

LI-CBT is, to some extent, an effective and durable intervention for those experiencing mild-to-moderate depression in primary care services. LI-CBT is significantly more effective than control conditions (Santoft et al., 2019) with the clinical impact being maintained at least a year after ending (Cuijpers et al., 2010). However, these results found in research may not translate easily into TT services. According to the NHS England (2024) review of their Talking Therapies services, only 47.9% of patient entering LI treatment 'reliably recovered'. Furthermore, the same report showed that approximately 45% of people who began a LI intervention dropped out. As such, whilst CBT-informed LI interventions can be beneficial for some, there are still problems regarding lack of choice, effectiveness, durability, and attrition.

One of the ways suggested to improve outcomes in routine services is to improve better choice of treatments for patients (Windle et al., 2020). To improve the range of possible interventions at step 2 of TT services, Meadows and Kellett (2017) adapted cognitive analytic therapy (CAT)

into a guided-self-help (GSH) format for anxiety. CAT-GSH for anxiety has six, 35-minute, PWP-facilitated sessions which follow the three 'R' CAT approach (reformulation, recognition and revision) embedded in a patient workbook. Reciprocal roles are termed relationship roles in the workbook for ease of understanding and the sequential diagrammatic reformulation is termed the 'roadmap'. In the initial pilot (Meadows & Kellett, 2017) CAT-GSH was acceptable to patients and PWPs, was clinically effective and gains were maintained at follow-up. Wray et al., (2022) investigated treatment acceptability of CAT-GSH with PWPs and found increased treatment choice, collaborative therapeutic relationships, increased insight and the intervention enabling concrete change. Kellett et al., (2023) conducted a large (N=271) patient preference trial of CAT-GSH versus CBT-GSH. Whilst both formats were competently delivered and were clinically efficacious, CAT-GSH was chosen more often (72% v 28%) and CAT-GSH participants differentially attended more sessions and completed more full treatments. CAT-GSH produces both common and distinct change processes when compared to CBT-GSH (Headley et al., 2024).

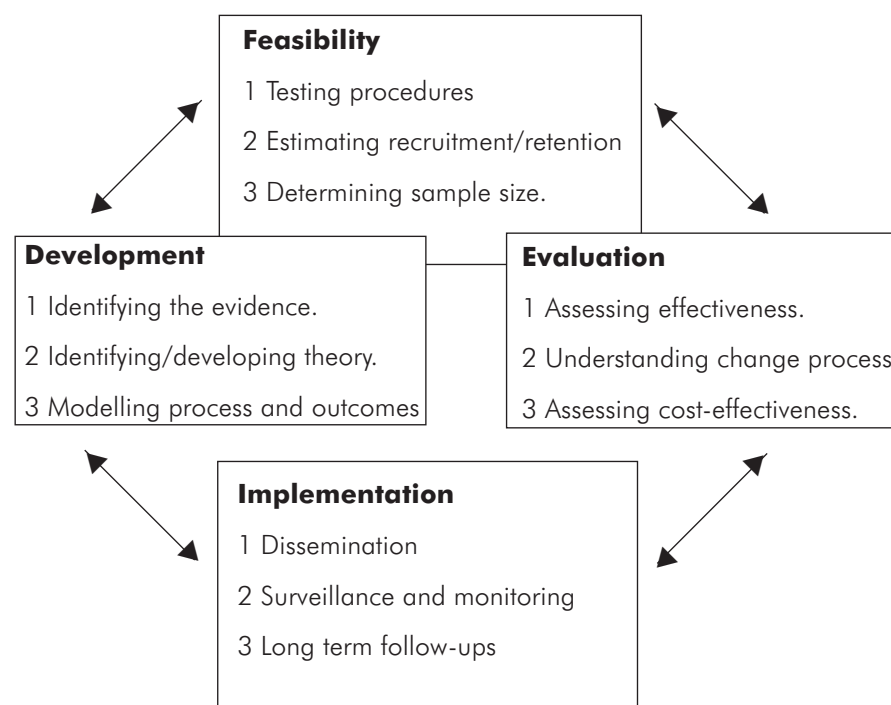
Therefore, whilst the development and evaluation of CAT-GSH for anxiety has been achieved, the development of CAT-GSH for depression has not occurred. Developing a sister CAT-GSH specifically for depression holds the potential for expanding patient choice at step 2 for people attending with depression. This is important because, accommodating patient preference regarding treatment is associated to lower drop-out rates and higher therapeutic alliance compared to patients who either did not get a choice or were allocated to their nonpreferable treatment (Windle et al., 2020).

Method

The Medical Research Council (MRC, 2008) guidelines for developing and evaluating complex interventions directed the process of cognitive analytic therapy guided self-help for depression (CAT-GSH-D) development. Figure 1 set out the four-stage process. This was the process has been previously used to develop both CAT-GSH for anxiety (Meadows & Kellett, 2017) and CBT-GSH (Lovell et al, 2008).

An adapted version of Lovell et al., (2008) and Hardeman et al., (2005) matrix modelling approach was used to develop CAT-GSH-D. This included a) identifying the evidence-base; b) identifying appropriate theory; and c) creating a model of the intervention. Identifying the

Figure 1 Key Elements of the Development and Evaluation Process



Note: Adapted from the Complex Intervention Guide (MRC, 2008)

evidence-base and appropriate theory was completed by defining depression, identifying key components of GSH, identifying key components of CAT, and identifying our target population and related needs. Table 1 outlines the aims, and the exploration methods used. An interview guide developed during the process of reviewing the literature, guided consultations.

Table 1: Methods Used to Develop CAT-GSH Workbook

Exploration Aim	Specific Methods Used
Define depression and its importance	Review qualitative and quantitative evidence which defines depression, people’s experiences and its impact.
Identify key components of GSH	Review evidence about the key components of GSH. Hold consultation meeting with qualified and trainee CAT practitioners, alongside NHS Talking Therapies PWP’s.
Identify key components of CAT	Review evidence regarding the key components of change within CAT. Consultation meeting with qualified and trainee CAT practitioners, alongside NHS Talking Therapies PWP’s.
Identify target population	Review demographics of NHS Talking Therapies services and refer to evidence base.

Note: Adapted table from Lovell et al. (2008) and techniques from Hardeman et al. (2005).

The Matrix Model

Table 2 presents the populated matrix model.

The CAT-GSH-D workbook was adapted based on the feedback to produce a final version. Regarding transparency, an author section at the end of the manual was included. Furthermore, the written content and number of examples was reduced. Table 4 provides an overview of the manual session content and homework.

Development of the CAT-GSH-D workbook

The matrix therefore guided and underpinned the development of the psychoeducational GSH workbook that is the cornerstone of CAT-GSH-D. A trainee CAT practitioner, a PWP, and a team manager of an NHS Talking Therapies service reviewed the workbook. They provided qualitative feedback alongside rating the manual over five criteria using the *Scale for Evaluation of Self-Help Guidance for Anxiety Disorder and*

Table 2: Matrix Guiding the Development of CAT-GSH-D

	Experiences of depression	Barriers to receiving help	Core components of CAT
Systematic Reviews and Research	Depression experienced as emotional, physical, and interpersonal problems stemming from childhood experiences.(Haroz et al., Issakainen & Hanninen, 2014)	Common barriers include stigma, scepticism about treatment, misfitting treatment and unavailable service. Depression-specific barriers include poor motivation, or fearfulness.(Andrade et al., 2013; Mohr et al., 2010; Salaheddin and Mason, 2016)	Three core stages of CAT useful: reformulation, recognition, and revision. Patients valued reformulation tools and associated them to change. Idiosyncratic exits strategies useful.(Sandhu et al., 2017; Tyler and Masterson’s, 2011; Westacott, 2010)
Consultation	Not explored	Potential narrative in society is ‘just keep going’, which could influence a person’s opinion about seeking help.Resources within services are limited and patients can feel that pressure (long waiting lists, inconsistent appointments).	Recognition research is underdeveloped yet a useful aspect of CAT. Psychotherapy file may be inaccessible and difficult to translate into GSH. Reformulation letters are difficult to translate into GSH. Considered useful to some clients.
Other Resources	NICE guidelines outlining low mood, loss of interest, and impact on daily functioning.	No relevant findings	Development of ‘self’ through repeated life experiences. Develops RR and RRP with the aim of coping. Typically, core emotions related to patterns. Understanding procedures as snags, traps, dilemmas. Three stages: reformulation, recognition, and revision. (Ryle and Kerr, 2020)
Included in manual	Emphasis on social functioning and relational expectations alongside low mood and other culturally diverse symptoms. Use of lay language and relevant examples beneficial. Useful to also include in training.	Warm and validating opening to manual, with page dedicated to clear goal setting. It’s importance to outline the predicted research effectiveness. Validating people’s experience of difficulty accessing services.	Follow three core stages of CAT: reformulation, recognition, and revision. Include tools including target problems; traps, dilemmas, and snags; family tree; timeline; mapping; recognition homework tasks; developing and practice exits; identify new roles (strengths and resilience). Exclude letters and psychotherapy file.

	Client Experience of CAT	Mechanism for Change	CAT and depression
Systematic Reviews and Research	Mixed opinions. Some appreciated the journey, reformulation tools, and developing exits. But could experience difficult emotions. Positive experiences of CAT-GSH for anxiety.(Meadows and Kellett; 2017; Rayner et al., 2010; Tyler and Masterson’s, 2011)	Suggested mechanisms of change include development of insight, recognition of processes, understanding proximal development.(Tyler and Mastersons, 2011)	CAT is transdiagnostic and little exploration specifically for Depression
Consultation	Mapping tools important for clients. Important to promote client language.	Recognition of both conscious and unconscious beliefs.	People with a core emotion linked to depression tend to have patterns relating to withdrawing and disconnecting socially. Common snags are dismissing own achievements. Transdiagnostic model with idiosyncratic aims.
Other Resources	No relevant findings	No relevant findings	No relevant findings
Included in manual	Promote own language using relatable examples. Included mapping of patterns and roles.	Promoting development of insight within core stages of CAT.	Input relatable examples for people who experience depression.
	Number of sessions of GSH	Delivery experience	Client and PWPs GSH
Systematic Reviews and Research	Eight and six sessions of CAT have promising results. Number of sessions not related to GSH outcome.(Gellatly, et al., 2007; Meadows and Kellett, 2017; Wakefield et al., 2021)	GSH have outcome improvements, even with a broad range of delivery (including semi-face-to-face, computer delivered, telephone delivery, internet/emails(Cuijpers et al, 2010; Gellatly et al., 2007)	GSH should include lay language; promote an appropriate and safe space; clearly outline expectations; acknowledge the stigma; individual is central to change. Positive experience of CAT-GSH for anxiety with patients engaged and motivated. CAT-GSH can invite discussion of past trauma during sessions which can

			be difficult for clients and PWPs. Past-present discussion, and therapeutic relations, help develop 'insight' in the client, and this promoted positive change (Khan et al., 2018; Meadows and Kellett; 2017)
Consultation	Typically, fortnightly, and 35-minute sessions in some NHS Talking Therapies services	Typically, face-to-face but could be via tel/video call depending on COVID related restrictions within Talking Therapies services	Not explored
Other Resources	Needs to be feasible for step two NHS Talking Therapies (NICE, 2009)	NHS Talking Therapies uses PWPs to provide their GSH.	No relevant findings
Included in manual	Six sessions	PWPs delivered sessions. Ideally face-to-face but can be delivered via video link depending on COVID restrictions/service user need.	Readability to be identified with consultations. Some of the information identified here standard part of PWPs training and can be discussed in supervision.
	Considerations for people with Learning Disabilities	Consideration for working with people from different ethnicities	
Systematic Reviews and Research	Helpful techniques include repeating information, checking in with person, using reasonable adjustments. Other suggestions include creating easy-read material, addressing service issues, changing the pace of therapy.(Dodd et al., 2011)		
Other Resources		Consideration about values and spirituality as part of intervention.(BABCP, 2019)	
Included in Manual	Some of the strategies can be included but it is outside the scope of this research to create an easy-read manual or change the time/formatting of CAT-GSH.	Whilst not directly incorporated into manual, this is included in supervision and training to discuss application to all areas of person's life impacted by depression	

Table 3: Scores ranges on the Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression

	Scope	Evidence	Engagement	Implementation	Transparency
Range of scores	20, 24, 25	17*, 19, 23	23, 24, 25	18, 20, 18	2, omitted, 3
Note. * one question was omitted					

Table 4 Within and between session CAT-GSH-D workbook content and link to the three-phase CAT approach

Session	In-session content	Between-session task
1	Reformulation – Identification of key depression pattern (i.e., a depression dilemma, snag, or depression trap).	Noticing the depression snag, trap or dilemma, complete a family tree, and complete a timeline.
2	Reformulation – identification of origins of depression from past. Introduction to key relational role.	Noticing key depression relational role.
3	Linking past to present. Recognition – writing a depression specific problem statement that makes links from past to present.	Noticing survival patterns developed as a child or adolescent.
4	Revision – creating roadmap and considering exits.	Recognising survival patterns and developing potential depression exits.
5	Revision – developing healthy identity. Identify personal strengths and resilience. New positive relationship role.	Identifying and practicing exits from depression roadmap and developing new positive relationship role.
6	Revision – acknowledging endings. Relapse prevention.	Continuing the work into the rest of life.

Depression (University College London, n.d.). This scale was appropriate because it builds upon practice guidelines (Baguley et al., 2010) and uses broad areas to evaluate GSH. The maximum score was 25 for scope, 25 for evidence, 25 for engagement, 20 for implementation, and 5 for transparency. There are no published psychometric norms for this scale. Table 3 outlines the range and mean rating for scope, evidence, engagement, implementation, and transparency criteria. Readability, clarity, and the compassionate approach of the manual was highly rated. However, reviewers were concerned about the manual's transparency and the large amount of content.

Discussion

This paper has outlined the development of CAT-GSH-D using the MRC treatment development guidelines. This has shown fidelity to that process and the responsiveness to the feedback that was provided. This enabled the creation of a CAT-GSH-D patient workbook that was less cluttered, had examples that depression-specific and retained the three-phase transdiagnostic CAT approach. This is the second CAT-informed brief intervention which has been developed to use in NHS Talking Therapies services, alongside Meadows and Kellett's (2017) CAT-GSH for anxiety. The development of CAT-GSH-A and CAT-GSH-D demonstrates the versatility of CAT as an approach, the workbooks still retain the relational focus of CAT and their availability does expand choice in TT services.

However, this has project not been without dilemmas and compromises. Firstly, the MRC (2008) guidelines were used because they were available at the time of development. However, the guidelines have since been updated (Skivington et al., 2021) and other recommendations developed (O'Cathain et al. 2019). One difference between the 2008 guidelines and more recent editions is how the MRC recommendation (2008) places less emphasis on including stakeholders through the development stages. As Racine et al. (2022) demonstrates, including stakeholders (for example, professionals from NHS TT services alongside patient and public involvement; PPI) within in development stages provided key insights which contributed to the final intervention of the workbook. A decision was also taken by the development team to increase the social inclusivity of the CAT-GSH-D workbook through changing some of the images from the CAT-GSH-A workbook. As such, professionals from NHS TT services and CAT trainees were consulted to ensure treatment faithfulness to CAT and GSH and potentially mitigate risks from

developing a novel intervention. However, more could have been done such as consulting PPI groups and stakeholders within developing the proposal of the intervention. It is recommended that in future developments of novel interventions stakeholders are involved.

CAT-GSH-D demonstrates the adaptability of CAT as a theoretical model which can be utilised across stepped-care TT services. There is evidence that CAT delivered at step 3 of TT services enabled a recovery rate of 46.4% at end of treatment that increased to 50% at follow-up (Owen et al. 2023). One example of how CAT concepts have been translated into a step-two GSH intervention is the use of reciprocal roles (RR; called relationship roles within the manual). According to Ryle and Kerr (2020), RR are internalised relationship positions that people develop from early life experiences, which can then be internally or externally enacted. Within CAT-GSH for depression, session two introduces RR and builds on the information about historic relationships that the patient and PWP have discussed in session one. The aim is for the patient and PWP to discuss in session and consider what key RR exist in the patients' current close relationships. This 'past-present' focus of CAT-GSH-D makes it distinct from CBT-GSH which works purely in the here and now. Again, differently from CBT-GSH, the CAT-GSH-D workbook also asks the PWP and patient to consider if and when the RR (and RR procedures) occur within the therapeutic relationship during GSH sessions (i.e., an 'enactment' has occurred). This is another example of how CAT's theoretical underpinnings can be incorporated into a step-two GSH intervention and demonstrates CAT's versatility in supporting people with mental health difficulties.

However, there were some key dilemmas when developing CAT-GSH-D and translating key tools within CAT to GSH format. For example, the reformulation letter is a tool used within CAT which helps the patient and therapist achieve a preliminary joint understanding (Ryle & Kerr, 2020) and can contribute to improve insight and change to patients (Tyrer & Masterson, 2019). However, this aspect of CAT does not translate well into GSH, due to the increased need for supervision, time and resources. Meadows and Kellett (2017) found that the lack of a reformulation letter did not seem to significantly impact on outcomes within their pilot and both patients and PWPs felt a joint understanding was achieved regardless (Wray et al., 2022). There is deconstruction trial evidence with depression that narrative reformulation does not enhance the effectiveness of CAT (Kellett et al., 2018). Clearly, whilst not all CAT tools are fit-for-purpose in a GSH context, the most important aspect is the workbook being

theoretically grounded and also based upon the three-phase approach to enabling change.

There are several strengths and limitations of this current project. In terms of strengths, diligent steps were taken to ensure that CAT-GSH-D was faithful to both CAT and GSH theoretical underpinnings and also the evidence base for depression. As well as one of the lead researchers being a trained CAT psychotherapist, supervisor and trainer with prior experience of developing CAT-GSH-A, consultations with CAT and GSH experts were completed during and after workbook development. From this advice, alongside critically reviewing the evidence base, CAT-GSH-D was then designed and developed. In terms of limitations, more could have been done to involve experts by experiences and stakeholders. The Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression is currently psychometrically unvalidated and therefore its reliability and validity are open to question. Another limitation was not completing an initial clinical pilot of the CAT-GSH-D workbook. Meadows and Kellett (2017) piloted the CAT-GSH-A workbook with the patients seen by N=3 clinical psychologists with CAT experience.

Conclusion

CAT can be adapted to produce a 6-session GSH intervention for people experiencing mild-to-moderate symptoms of depression for delivery by PWP in routine TT services. This conclusion was achieved by using the MRC (2008) guidelines for developing and evaluating complex interventions to create CAT-GSH-D, receiving appropriate corrective feedback and also making the workbook more inclusive. Informed decisions were made to continue to include and adapt key concepts of CAT to balance faithfulness of the CAT model with the needs and demands of NHS TT services. The CAT-GSH-D workbook was therefore shortened on this advice to enable better acceptability and usability. What does not differ between CAT-GSH-A and CAT-GSH-D is the 'past-present' focus and the three-phase approach. CAT-GSH-D needs now to be tested for effectiveness and acceptability in a clinical pilot study. □

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Delivering brief 8-session cognitive analytic therapy (CAT): the therapist experience

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Abstract:

Whilst cognitive analytic therapy (CAT) can be offered in a brief 8-session format, the therapist experience of this type of focal clinical work has not previously been explored. This study therefore investigates experiences and perspectives of five therapists who delivered brief CAT during the 'Relational Approach to Treating Self-Harm' (*ReLATe*) randomised control trial. Semi-structured interviews lasting 45-60 minutes were conducted online and a thematic analysis then identified themes. The five key themes were: *Positive Experience; Pressure and Responsibility; Focused but Flexible; Accessible and Engaging; and Future Utility*. The fast pace and focussed-approach helped create momentum for patients to stay engaged, whilst the brevity and the option to choose the mode of delivery (i.e., online or face-to-face) helped to make brief CAT accessible. Results suggest that therapists had a positive overall experience and could see the future utility of the 8-session approach in routine services, although they did feel pressure of the brief time limit in the context of the increased risk and complexity of the patients. Brief CAT emerges as an acceptable approach to be considered alongside the medium (16-session) and long (24-session) versions of CAT. Recommendations to support the delivery of the briefest version of the CAT model are made.

Keywords:

Self-harm; cognitive analytic therapy; brief therapy; qualitative

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The data and the analysis are available from the corresponding author on request.

Conflict of interests:

None.

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Introduction

Self-harm can be defined as any deliberate act of self-injury or self-poisoning as a means of expressing emotional distress, regardless of the intended outcome (National Institute for Health and Care Excellence [NICE], 2024). Whilst prevalence is difficult to determine as many people do not seek help, it is estimated that around 7.3% of adults and 22.1% of young people in the UK engage in self-harm, with trends suggesting that these numbers are increasing (Lim et al., 2019; NHS, 2016). Self-harm is considered an externalising symptom of often widely differing mental health difficulties and has an adverse ongoing negative impact on wellbeing (Bryson et al., 2021). As well as the physical implications, such as the risk of infections and scarring, self-harm is also a strong predictor of eventual suicide (Duarte et al., 2020). Treatment is therefore important, but a recent meta-analysis demonstrated that, at present, interventions for self-harm have limited treatment effects (Fox et al., 2020). This has led to calls for rapid access to brief and evidenced-based interventions (Saini et al., 2020).

Cognitive analytic therapy (CAT) is a transdiagnostic and relational psychotherapy delivered in 8, 16 or 24 session contacts (Ryle et al., 1990) and the model has a growing evidence base. Recent meta-analyses have demonstrated that CAT generates large treatment effects across a range

of symptoms (Hallam et al., 2021) and is differentially acceptable (Simmonds-Buckley et al., 2022). Both meta-analyses noted that the 16 and 24-session versions of the model had been more thoroughly researched in comparison to the 8-session version. Two versions of the brief 8-session forms of CAT have recently been defined and termed the Somerset and the Sheffield models (Kellett et al., 2024). The key difference between these models is that the Sheffield approach reformulates at session 3 and places more emphasis on earlier identification and tracking of target problems/procedures and the Somerset model has a combined reformulation and goodbye letter. The Somerset model has been demonstrated to have equivalent effectiveness to cognitive behavioural therapy (CBT; Beck, 2011), but with lower dropout rates (Wakefield et al., 2021). A service evaluation has demonstrated the feasibility of a brief CAT-based intervention for self-harm, again highlighting the high engagement rates within a relatively complex population (Taylor et al., 2021).

Based on such evidence, a feasibility randomised control trial has since been funded and conducted examining 8-session CAT for self-harm: *Relational Approach to Treating Self-Harm* (RelATe; Taylor et al., 2024). Whilst the results of the RelATe trial are yet to be published, the trial has been being conducted with a view to conducting a future fully powered randomised controlled trial, should the results be positive. As part of the development of an evidence-base, however, it is important to understand the acceptability of any intervention with therapists delivering the intervention and this needs to be considered in equipoise with issues of efficacy/effectiveness. In short, if therapists do not find the brief CAT approach acceptable, then they will not deliver it. Whilst patients' experiences of CAT have been explored (Rayner et al., 2011), therapist experiences have been somewhat overlooked. The aim of the study is therefore to explore therapist perspectives of delivering 8-session CAT (Sheffield model) and additionally experiences of delivering CAT during RelATe trial. This study sought therefore to understand what it felt like to deliver 8-session CAT, what made this work or got in the way, to explore the focus of the approach, and to name the themes within the therapists' experiences. Gaining this insight will help to identify strengths and weaknesses of the 8-session model and the way it is delivered, to help refine relevant aspects of the approach. This will enable a set of recommendations to be made to ensure 8-session CAT is fit for routine service delivery.

Methods

Design, Approval and Consent

A qualitative design was employed, using structured interviews conducted with therapists who had delivered 8-session CAT for self-harm as part of the RelATe trial (Taylor et al., 2024). Purposive sampling was used, whereby all therapists from the trial were approached via email and asked if they wished to participate. The RelATe trial was ethically approved (Greater Manchester West REC; ID: 318068) and this nested qualitative study was approved as a service evaluation (RDaSH Ref: SE15). To be a patient participant in the RelATe trial, then a person had to have three or more active episodes of self-harm in the previous past year (Taylor et al., 2024). When approaching prospective therapist participants, it was made clear that taking part was optional. Information about the purpose and nature of the service evaluation was given, as well as the opportunity to ask questions. Written consent was sought prior to interviews taking place.

Participants

Demographic characteristics are outlined in Table 1. Two of the therapists were undertaking the CAT practitioner training at the time of the trial, two were qualified as CAT practitioners, and one was qualified as a CAT psychotherapist.

Table 1: Demographic Characteristics of Therapists (N=5)

Characteristic	Mean	SD
Age (years)	45.4	7.27
Years qualified	6.5	11.70
Patients prior to trial	55.8	65.61
Patients in trial	5.4	4.16

Note. Four of the participants were female and one male. 'Years qualified' refers to years since completing CAT practitioner training. 'Patients prior to trial' refers to the approximate numbers of clients the therapist had worked with using CAT prior to taking part in the RELATE trial. 'Patients in trial' refers to the number of clients the therapist worked with as part of the RELATE trial.

Data collection

Interviews were conducted, recorded, and transcribed using Microsoft Teams and were approximately 45-60 minutes long. A semi-structured interview schedule was used to ensure consistency between interviews. The aim of the interviews was to gather information on experiences and perspectives of delivering eight-session CAT for self-harm, including expectations, challenges, barriers, what worked well, and what could be improved.

Interview questions

1. What were your thoughts and feelings about the 8-session approach before you started on the trial?
 - Prompts: What were your thoughts on how effective it would be?
 - Did you have any concerns, and if so, what were they?
 - How did it compare with your expectations?
2. Could you tell me about your experience of delivering 8 session CAT in the trial?
 - Prompts: How did it feel?
 - How comfortable and confident were you in delivering it?
3. What were the similarities and differences with the 16 and 24 session approach?
 - Prompts: What were your thoughts on the shorter timeframe?
 - Which techniques, if any, might you have like to use from longer forms of CAT which were missing from this approach?
4. What is the most difficult aspect of delivering 8 session CAT?
5. What is the best aspect of this approach?
6. What did you learn over time about delivering 8 session CAT?
 - Prompts: Could you tell me about anything that might have surprised you?
 - Is there anything you learnt from this approach that you will carry into your everyday practice, and if so, why?
7. What do you think helped clients to engage and do well with this approach, or to not do well and drop out?

- Prompts: What sorts of things did clients report to be helpful/unhelpful?

8. Is there anything about 8 session CAT you would change or add?

9. What factors most helped you to deliver the 8-session approach competently?

- Prompts: Were there any particular resources you found useful, and if so, why?

- How did you use supervision in the trial compared to how you would usually?

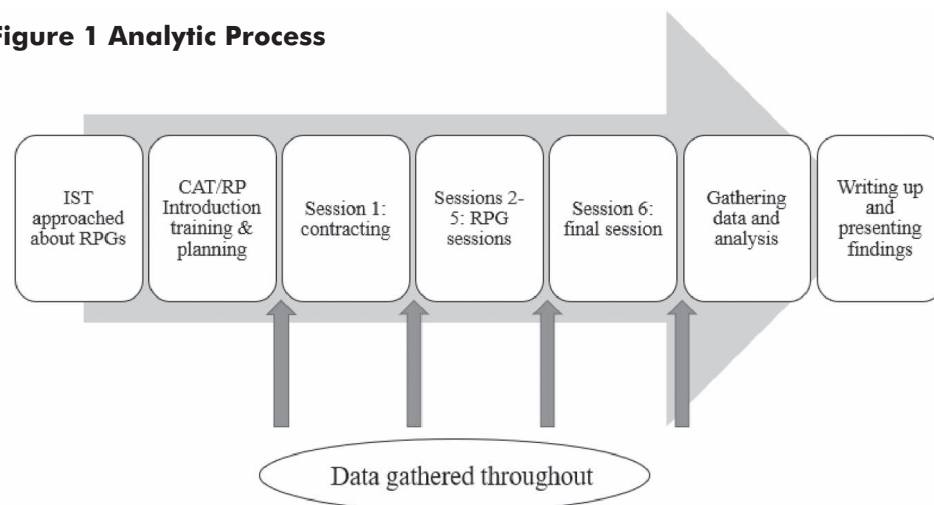
10. Were there any challenges or barriers to delivering the intervention?

- Prompts: For you as the therapist? For the client?

Data analysis

Inductive thematic analysis was used to analyse interview transcripts using Braun and Clark’s (2006) guidelines, the steps of which are displayed in Figure 1. A realist, data-driven approach to analysis was taken, identifying semantic themes to explore broad views and experiences, and to give a rich descriptive account of the dataset. Key themes were identified where there appeared to be high prevalence of discussion about a topic and the topic was of relevance to the research aims. There was no specific number of codes needed to form a theme, however, the topic must have been coded a number of times across the dataset as a whole and mentioned by multiple participants in order to be considered a theme.

Figure 1 Analytic Process

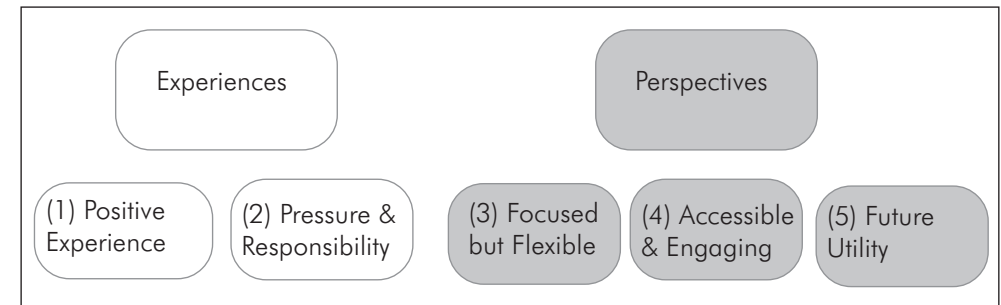


Note. The six phases of thematic analysis, as defined by Braun & Clarke (2006).

Results

Five key themes were identified: (1) Positive Experience, (2) Pressure and Responsibility, (3) Focused but Flexible, (4) Accessible and Engaging, and (5) Future Utility. These were grouped into therapists’ own experiences of delivering the approach (1 & 2) and therapists’ perspectives of the model (3, 4 & 5) for ease of interpretation. These are presented in a thematic map in Figure 2 and examined in detail beneath.

Figure 2: Thematic Map



Note. A thematic map of the five themes identified, grouped into ‘experiences’ and ‘perspectives’ to aid interpretation.

(1) Positive Experience

All therapists spoke positively of their experience of delivering the approach. This related to positive feelings about helping people who really needed it, seeing what clients achieved, and hearing positive client feedback:

‘It felt like a good thing to be spending my time doing.’

‘I think it was overall. . . a good experience of actually doing the work. I enjoyed doing the work with people.’

‘I think service users kind of found it helpful and gave some really positive feedback.’

Therapists also spoke of surprise at how quickly clients progressed and how much change could be made and maintained in the brief timeframe:

‘. . . how easily people were able to change and to kind of embrace the kind of exits to the patterns, I think that surprised me how quickly people did that really.’

‘. . . people I think were quite surprised at the gains they managed to make in the sessions.’

‘. . . taking a lot of pleasure in hearing that people were still doing well.’

This theme was evident across all five interviews, demonstrating acceptability of the intervention from a therapist perspective.

(2) Pressure and Responsibility

Although overall experiences were positive, the shorter timeframe in this form of CAT was a key topic of discussion. This brought pressure to add value in every session and to work quickly in pinning down target problems and writing reformulation letters. Therapists spoke of this in the below examples:

‘I found it quite packed, quite pressured.’

‘To be able to be able to rate the [target problem] procedure, you’ve got to have it pinned down enough in session one. I think that. . . is quite challenging.’

‘I suppose that reflects some of that pressure I felt in having to write that letter, in having to invest in that relationship quite quickly from a time perspective.’

Risk and complexity being high due to the nature of the client population added to this pressure, as therapists were trying to hold space for risk issues whilst still adhering to the protocol:

‘I think there’s a time pressure to eight sessions with a complex client group, that doesn’t leave you the same space to work with what comes up, while also trying to work with everything you need to get done.’

It did seem, however, that the pressure related to degree of experience of the therapist. This was evident as newly qualified therapists reported more pressure and anxiety, but how their confidence grew over time, whilst more experienced therapists did not emphasise the pressure as much:

‘I think probably all those things become easier the more experienced you are, because you have your own style and you know the model and you can use the model and flex it to who you are and how you work.’

‘. . . you maybe needed to be a bit more skilled to do an effective eight session cat.’

‘I think at the end my confidence grew. . .’

It should be noted that the pressure of delivering the approach was sometimes hard to disentangle from the pressure that came with being part of a research trial. Therapists described feeling a sense of responsibility to get it ‘right’ and were aware of feeling watched due to recording sessions for adherence ratings.

‘I suppose, and maybe this is a trial thing. . . I felt really responsible. So I was a bit like ‘I’m not just seeing. . . Joe Blogs. . . I’m seeing Joe Blogs but like, oh my God, I’ve gotta get this right because. . . there’s a lot resting on this’.’

Overall, this theme shows that therapists delivering the approach felt a definite sense of pressure and responsibility to work quickly and work well. This primarily related to time and the added risk and complexity in the target population, but this sense of responsibility was hard to differentiate from the trial conditions. Whilst pressure and responsibility were reported by most therapists, it appeared to reduce as experience increased.

(3) Focused but Flexible

Therapists reported the approach to be highly focused on self-harm as the problem, rather than as a symptom of another problem, which helped to enhance understanding:

‘I’d probably sort of superficially worked on [self-harm] with people before and felt like we’d sort of understood it as almost like a symptom linked with another problem. But actually, when people were bringing that as the problem, there was. . . the depth at which we understood it. . .’

‘All the participants in the trial have the same dilemma of either ‘I’m cut off from my feelings and at risk of self-harming’ or ‘I’m overwhelmed with my feelings and at risk of self-harming’.’

The focus was guided by the protocol, which appeared to provide structure and help therapists to stay on track. Therapists described the containing nature of the protocol in maintaining the focus:

‘And the protocol. . . actually it provided a really containing

framework to think about. It gave you a real sense of how to pace it and how to structure it.'

'... what I've discovered really early on was that actually having the protocol was really, really containing and so you weren't having to do a huge amount of the thinking of 'how do we fit this into eight sessions', because the protocol became a guide of how to structure it.'

Despite being highly focused, therapists still described a flexibility within the protocol to deliver it in their own style and to adapt the content to their clients' individual needs:

'It's got what I've called... having a 'loose/tight' focus.'

'There's a lot of conversation about holding [the protocol] lightly, so it's about achieving the things that need to be done, but doing it in your own style and doing it flexibly and in response to the client's needs.'

Supervision also appeared to be focused on the approach, helping therapists to bring the protocol to life but with the flexibility to think about what the therapists were bringing and their own confidence too:

'Normally... my supervision would be a bit broader and it would be including things about... organisational and systemic issues as well, whereas this was purely kind of a therapy focus and thinking about CAT so it was more focused.'

'[Supervision] gave me that reassurance that I was doing it right, but it also helped me to boil it down to eight session size.'

Overall, the focus of the approach, guided by the protocol and by supervision, seemed to help counteract some of the difficulties with the time pressure as there were guidelines of what to cover and when. Whilst the approach was highly focused, it also had enough flexibility to avoid rigidity and to ensure it could be tailored to suit both the clients' needs and the therapists' style.

(4) Accessible and Engaging

Therapists described the accessible nature of a brief piece of work that clients could commit to, even when they may have a lot going on in their lives (as was common in the target population). Offering sessions online increased this accessibility, and whilst it posed some challenges for

therapists (in building rapport, managing risk, and mapping collaboratively) it did not appear to disadvantage clients:

'I suppose committing to a shorter piece of work is less onerous than committing to a longer piece of work... I don't think my client would have done a longer piece of work. And also the flexibility that it could be online.'

'[client] said to me it was the only piece of therapy that they had been able to successfully take part in and complete, because we'd been able to work with them quite quickly, but also because eight weeks was a really realistic time frame for them to be able to commit...'

It also appeared to help clients to engage in further support post-intervention:

'They felt quite empowered... and a lot of them, where they maybe had struggled a little bit to engage with some of the support available and services, afterwards had then been a lot more open to it, and had gone on to do other interventions in the service.'

Therapists reported that the fast pace of the approach, with early feedback in terms of reformulation letters, helped provide momentum. This supported clients to be more engaged and involved in the process:

'I think [the brevity] really helps focus attention and the... sense of momentum, that 'this is the time we've got and we're not trying to look at everything, we're just focusing here on what can we do that's more useful than the patterns that we're stuck in already'. That's potentially very useful.'

'I think having a map and having a reformulation letter so quickly means people instantly feel like something is happening. So I think that's really important.'

'... at the end of that two sessions you've then got a letter... of somebody reflecting your life back at you. I think you're kind of 'in' by then.'

This increased engagement also appeared to come from clients writing their own reformulation letters, which helped to redress the power imbalance:

Actually, clients are really, really good at being able to reflect and to do that. And I think it's a really important way to set up how you share power in the sessions...'

It was clear to see that the approach was accessible and engaging. This appeared to be due to the brevity and pace creating momentum, as well as the option to work online. The collaborative nature of the approach also helped with engagement by sharing the power.

(5) Future Utility

A number of the therapists talked about how the approach could be utilised in services moving forward. This included bridging the gap between primary and secondary care and supporting clients who may not fit the criteria of one service or another:

‘ . . . at the moment people have to wait to go to another team for therapy. But it doesn’t have to be like that and I could easily be working, doing eight session work with some of the people that we see in our team.’

‘It just felt like I was working constantly with that group of people that fell through the cracks and it felt really good.’

There were suggestions for future development. These included extending the time frame of the intervention (without adding more sessions) and the follow-up period, to give time for letter writing and to allow clients more time to implement changes:

‘I think maybe if . . . the window had been a bit longer. So we could have missed a week [to write] either letter. I think that might have been helpful.’

‘ . . . one of the things I’ve wondered about is doing eight sessions but not in eight weeks and what difference that would make. You know, so that you were only offering eight hours, but building within that more time for people to be practising exits’

‘ . . . that slightly extended time frame to consolidate, to practise the recognition and revision, had been really useful.’

It was evident that the therapists were able to see where the approach could fit in a real-world context, and how this could help to improve the offer that services can provide to ensure wrap-around care for vulnerable clients. This also helped therapists to feel like their work was worthwhile. Therapists did feel, however, that increasing the treatment and follow-up windows may be beneficial to reduce time pressure on both clients and therapists.

Discussion

When self-harm is an aspect of a patient’s problems, then CAT therapists would normally consider the 24-session approach. The RelATe trial (Taylor et al., 2024) is testing the feasibility and acceptability of offering 8-session CAT. This nested project was concerned with the experience of delivering the briefest version of CAT to patient group that self-harm, because acceptability is important in terms of both patient and therapist perspectives. In summary, five key themes arose from the interviews conducted with therapists involved in the RelATe trial: Positive Experience; Pressure and Responsibility; Focused but Flexible; Accessible and Engaging; and Future Utility. These themes aligned with the aims of the project, naming themes of the experience of delivering eight-session CAT in the trial, to understand what it felt like to deliver this version of CAT, what made the 8-sessions work, and what got in the way, and to explore the focus of the approach. The findings suggest that therapists had a positive overall experience, though they did have feelings of pressure and responsibility, mainly due to time pressure. Therapists could see where the 8-session model could be utilised in routine service delivery and felt it was highly accessible and engaging, even for patients that may have struggled to engage previously. Whilst the approach places demand on therapists to work quickly, the focus, protocol and support from clinical supervision help to mitigate some of this. The approach differed from therapists’ previous experiences by placing self-harm as the core focus, rather than as an expression of another difficulty. However, therapists described the approach as flexible enough to be tailored to the needs of individual patients, meaning the focus did not create rigidity. The 8-session CAT therefore needs to not get caught up in a dilemma of being either overly focussed or overly loose.

The time-limited nature of the approach largely underpinned most themes. The focus this brings has been suggested to be a factor in clients engaging in brief interventions (Lyons & Low, 2009), perhaps by increasing the motivation and accountability for change (Markussen et al., 2021). The present findings support this hypothesis as therapists described a sense of momentum and ‘buy in’ due to the fast pace, as well as increased accessibility due to the relatively short-term time commitment and the choice regarding mode of delivery. This could help to explain the low attrition rates found in 8-session CAT previously (Taylor et al., 2021; Wakefield et al., 2021). The protocol used in the trial aided the focus, whilst allowing therapists to practise with authenticity and tailor the approach as needed, aligning with the notion of *flexibility*

within fidelity', outlined by Kendall and Frank (2018). This is significant, as therapist flexibility has been associated with better outcomes for clients (Owen & Hilsenroth, 2014).

An interesting paradox occurs in that often less experienced or less qualified therapists offer briefer interventions (for example in the stepped care approach seen in NHS Talking Therapies services), and yet, it appears that more experienced therapists are better equipped to cope with the demands of a faster pace. The findings in this project suggest that this is due to efficiency and confidence in using the Sheffield 8-session CAT model of identifying target problems early, early narrative reformulation, active mapping, and goodbye letter writing (Kellett et al., 2024). This aligns with research suggesting number of years' experience is related to reduced anxiety and improved decision making in therapists during brief work (Dawson, 2017). More experienced therapists also showed a clearer understanding of the boundaries and limits of the work, and so were not trying to fit 16- or 24-session CAT into 8-sessions. This highlights the importance of ensuring therapists are trained and confident not just in the theoretical model, but in leveraging time effectively (Reynolds Welfel, 2003). Therapists in brief interventions may need to take more initiative (Fosha; 2004), which requires a sound working knowledge of the CAT model and this needs to not be an enactment in the CAT model. Whilst focus and initiative taking is arguably important in all therapies, it is amplified during brief therapies, where time really is of the essence. Whilst the protocol gave therapists a sense of security in relation to adherence, it is important that supervisors of 8-session CAT are mindful of therapists' confidence with the brief CAT format, as feelings of incompetence can impact the working alliance and, ultimately, treatment outcomes (Bernstein, 2021).

Limitations of the present study should be noted. Only five therapists were interviewed as this was the available sample, and one therapist only worked with one patient in the trial. No cross-coding took place to check reliability. The sample size was small, limited to the trial and a larger sample size may have brought up alternative perspectives. As the model was only delivered under trial conditions and not in routine service delivery, it was challenging to disentangle how much of the pressure was attributable to the trial conditions versus the 8-session model itself. In a routine-service context therefore, the pressure noted in the analysis may become less pertinent (and other pressures possibly emerge). It should be noted that the present study is qualitative and so does not provide evidence of the efficacy of the 8-session approach. Further

research in the form of efficacy and effectiveness trials are needed to more clearly define the clinical outcomes of 8-session CAT for self-harm (and other clinical presentations).

Practice Recommendations

The following six practice recommendations are made based on the study findings: (1) ensure that therapists using the model are trained in the focal 8-session approach and have access to the treatment protocol, (2) adapt clinical supervision to the demands of the brief approach, (3) consider offering 8-session CAT to patients who may be struggling to engage in longer forms of CAT, (4) offer patients the choice to have CAT online to improve accessibility, (5) for therapists to consider leaving an additional weeks' gap between sessions two and three to write narrative reformulations, and (6) to offer an extended follow-up period where indicated (by client preference and clinical judgement).

Conclusions

The 8-session CAT approach in the RelATe trial has emerged as an acceptable therapy to deliver for therapists with the right support. The evidence base for any therapy needs to balance indices of effectiveness, efficacy and acceptability. Further research is needed regarding the 8-session CAT approach as it is underrepresented in the CAT evidence base. As services often want to commission brief interventions, then the 8-session CAT approach is emerging as an important contribution to any service offer as it combines brevity with theoretical adherence, but in a manner that does not sacrifice the individuality of each patient. □

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