Working Together Towards Overcoming Transgenerational Trauma

Using Cognitive Analytic Therapy With Child-Caregiver Dyads

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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.

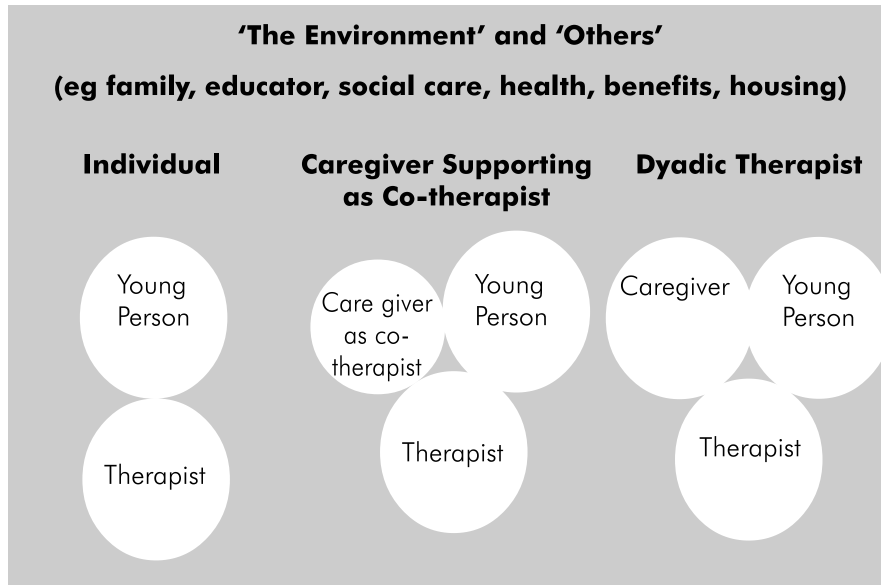

Figure 1: A diagram depicting the microenvironment within therapy of individual therapy, individual therapy with caregiver as co-therapist, and dyadic therapy.

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.

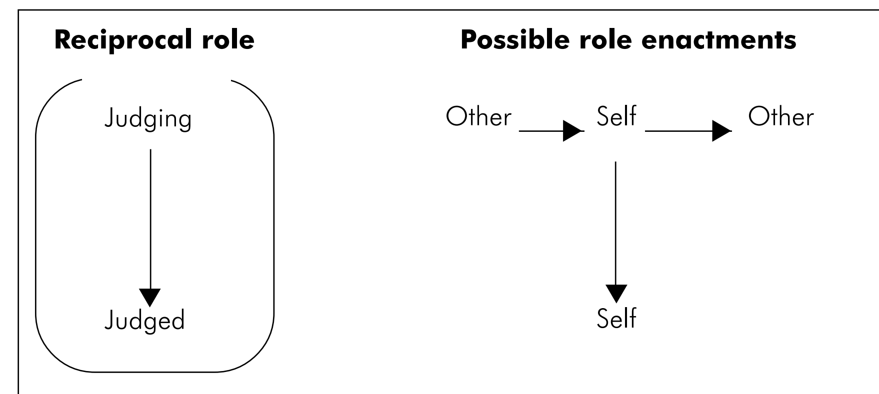

Figure 2: *Left* is a diagrammatic representation of a reciprocal role. *Right* is a diagram outlining the possible enactments that can occur within a reciprocal role.

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 reversable 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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