A Relational Model of Consultation for Relational Trauma

a Cognitive Analytic Therapy (CAT) informed model of secondary consultation to services that help young people in Out of Home Care

LEE CROTHERS, CLAUDIA EDWARDS & LYN RADFORD

Abstract: Secondary consultation provides an opportunity for professionals to seek support and guidance from another professional with specific expertise in the relevant area. Young people in the out of home care (OOHC) system require specialised care and understanding from several perspectives including trauma, attachment and mental health and the professionals that support them require consultation that encompasses these. In the Australian state of Victoria there were over 12,000 children in OOHC in 2021 costing the government more than $850 million. Relational experiences early in life establish neural pathways around seeking care (relational templates) and consultation models that recognise this are valuable to those who are working with children and young people in OOHC. The early relational experiences of this cohort often include abuse and/or neglect and disrupted attachment relationships. Understanding the behaviours exhibited by these young people requires an understanding of the underlying attachment need that they are trying to meet and the relational template through which they understand themselves and the people that they have relationships with. Cognitive Analytic Therapy (CAT) provides a framework for understanding relational templates and the patterns that arise. Secondary consultation which utilises a CAT framework not only identifies the underlying need and the relational pattern, it also helps professionals to consider their own relational patterns and how they may be unwittingly perpetuating the patterns of the young person rather than finding a way to meet

1. Lee Crothers, Occupational Therapist, CAT practitioner/supervisor and Director of In Dialogue, Victoria, Australia. www.indialogue.com.au
2. Claudia Edwards, Clinical Psychologist, CAT practitioner and Senior Clinician at Berry Street, Take Two program. Victoria, Australia
3. Dr Lyn Radford, Clinical Psychologist, Clinical Manager at Berry Street Take Two. 677 The Boulevard, Eaglemont, Victoria 3084, Australia. Email: lradford@berrystreet.org.au Telephone: +61 3 9450 4700

the underlying need. This paper describes the use of a relational consultation model informed by CAT within a therapeutic service for children and young people in OOHC. A case study is provided to illustrate.

Keywords: consultation; developmental trauma; Cognitive Analytic Therapy; reflective practice; relational; out of home care

Introduction

Secondary consultation in youth mental health is often used to support staff around planning services for young people who are seemingly complex or hard to help within the system. Mental health consultation involves a consultant, consultee/s, a client and a work-related issue (Caplan, 1970; Lambert, 2004). Secondary consultation assists the system/team or individual to consider the skills they have within their context and how they may use their skills and resources to provide and plan for better care. Experienced secondary consultants are 'inherently validating of the consultee's skills' (Southall 2005, p. 5) prompting them to be more creative as well as help address the gaps in their thinking, gaining skills they will hopefully apply again. Mental health consultants foster a wider or multidimensional reflection on the problem, which allows space to consider more helpful or therapeutic care, however they are not usually clear on how the consultee can become their own expert or consultant in future complex client presentations.

Whilst the value of consultation is widely accepted (Caplan et al, 1994; Mendoza, 1993; Carradice, 2017; Ghag et al, 2021; Kellett et al, 2020) the specific challenges and demands of providing consultation have been largely overlooked in the supervision literature. This contrasts with the literature regarding the importance of supervision for psychotherapy or clinical work (Carradice, 2017). In their review of consultation outcomes Ghag et al (2021) highlight the necessity of adequate training in (and supervision of) consultation competencies.

CAT consultation uses a relational reflective model that helps the professional caregivers notice how they may replay (unwittingly) unhelpful relationship patterns that confirm to children/adolescents that they are not worthy of consistent care. 'It has been said that relationship-based trauma can only be healed through a nurturing relationship and the capacity for connecting is the core ingredient for cultivating that type of relationship' (Purvis et al 2013, p.371).

The CAT informed model of consultation, or what we will call relational consultation, outlined in this paper, provides a model of consulting or reflecting on complexity with a relational mapping tool that the consultant uses with consultees in order to address the work-related issue or 'stuckness' but also to teach a relational framework mapping tool that consultees learn to apply to consider future complexity. The relational consultation model with Berry Street Take Two was aimed at not just providing consultation around complexity but teaching a reflective practice tool that the consultees could take to use as their own supervision or consultation approach. Mendoza (1993, p.629) points out that the goal of consultation is to help consultees 'deal with their work' as well as 'preventing dependency on the consultant' and this is a particular skill.

The relational consultation approach is twofold. The consultees have an experience of being consulted with over a regular period whilst learning a relational reflective mapping tool that can be used as a way for the consultees to become future consultants and consider complexity for OOHC clients and services independently. The Take Two clinicians, having an experience of group relational consultations, have then been able to apply this consultation model aided by a mapping tool to consult to services that see highly complex children and young people in OOHC. The consultees become the consultants and can provide a relational consultation model that helps all in the system consider how they relate to the young person.

The aim of this paper is to provide an overview of the CAT informed relational consultation project used at Berry Street, Take Two and explore the usefulness of a relational consultation model for secondary and tertiary consultation in responding to complex client presentations alongside understanding the consultees' role in unhelpful relational patterns. A case study is used to illustrate the model and the outcomes of its use.

Mental Health consultation

Mental health consultation was pioneered by psychiatrist Gerald Caplan in the 1950s who developed this initially as a means of providing indirect mental health services to a larger number of clients. Caplan went on to develop and refine mental health consultation as both a primary prevention tool and means of improving the quality of mental health care (Caplan, Caplan, & Erchul, 1994). The dual focus of Caplan's style

of consultation was to help the consultee with a current client problem and to increase their effectiveness in addressing similar difficulties in the future by providing information or teaching skills (Mendoza, 1993). The relationship between the consultant and consultee was recognised as central to effective consultation (Mendoza, 1993).

Caplan (Mendoza, 1993) identified four distinct types of consultation: client-centred case consultation; consultee-centred case consultation; program-centred administrative consultation and consultee-centred administrative consultation. Broadly speaking, these are now often encompassed by the terms - primary, secondary and tertiary consultation. Primary consultation involves direct work (with a client) whereas secondary and tertiary consultation are both considered indirect work (Carradice, 2017). Tertiary consultation is not concerned with a specific client but focuses at the program or organisational level. Consultation is distinct from supervision. Consultants provide guidance or advice which the consultees can then choose whether to adopt or implement (Ghag et al, 2021).

Caplan et al (1994) identify central elements of mental health consultation which they refer to as enduring principles. These include: understanding the context; formalising consultation agreements; non-coercive consultant-consultee relationship; fostering of orderly reflection; a focus on client-related elements, rather than the unconscious displacement of the consultees; avoidance of interpretation; and, wide frames of reference and support for consultees to become consultants.

CAT consultation

Cognitive Analytic Therapy (CAT) is an evidence-based relational model of therapy and is growing in its application to consultations and understanding of work context (Carradice, 2017; Ghag, Kellett & Ackroyd, 2021; Kellett et al, 2020). CAT was developed by Dr Anthony Ryle (Ryle and Kerr, 2020) whose initial aim was to bring together cognitive and object relations theories. Its primary focus is around the notion of reciprocal roles. Reciprocal roles explain that we learn how to relate to ourselves and others through how we have been related to in the past, usually by early attachment figures. The idea that we learn by being in relationship, which becomes reciprocated or replayed and internalised, is a key understanding and leads to a formulation that is compassionate and humane. CAT, as a time limited therapy, has been further developed by Finnish psychologist Mikael Leiman (Ryle & Kerr, 2020). Leiman bought the ideas of social formation of mind, dialogism and activity theory, further developing the CAT model of the relational self as individuality is shaped and maintained through relationships with others (Ryle & Kerr, 2020). CAT has become established internationally with various applications and an emerging evidence base (Calvert and Kellett, 2014).

CAT, as a model for consultation, works from the premise that teams can experience clients as challenging and then the team or team members can unwittingly repeat unhelpful relationship patterns that can contribute to or exacerbate the clients fear or hopelessness about getting care and about being too challenging (Ryle & Kerr, 2020). CAT consultancy helps teams consider these relational pulls and pushes and a shared and accessible way of reflecting as a team on their own relational stance or approach that aids their psychological thinking and thus planning client care (Thompson et al, 2008). Contextual reformulation is often the term used in the CAT literature to describe a way of looking at the system that helps the consultee consider ways of relationally addressing a stuck or complex client situation. In CAT consultation what is often 'stuck' or complex is the relationships that are being enacted between systems, services, professionals and individuals and is not just focusing on the client holding all the complexity. This can be a confronting model at times as it does provide a framework to consider how professionals and services can unknowingly contribute to an unhelpful relationship dynamic. This unconscious re-enactment can confirm to clients that they are hard to help or are 'difficult' but in doing so can also loosen these feelings of 'stuckness' as it acknowledges there are other factors at play, not just those within the client. It fits with the old saying that we often talk about with families and systems, that if we admit we are part of the problem we give ourselves some room to be part of the solution.

The Usefulness of a Relational Framework for Consultation

When working with complexity a relational framework for consultation addresses each of the nine enduring principles of consultation outlined by Caplan et al (1994). It enables the 'ecological field' or systemic context to be thought about and addressed. It also lends itself to widen the frames of reference by analysing the work problem within overlapping contexts of intrapersonal, interpersonal and institutional systems of client, consultee and consultant.

Relational consultation supports consultation that is both client-centred and consultee-centred as it allows reflection on the clients'

relational patterns and relationships with the consultee (practitioner or team). Instead of solely focussing on the problems of the clients there is also attention on specific difficulties for the consultee. Very much informed by the collaborative stance of CAT, the consultant relationship is explicitly 'non-coercive and non-hierarchical', with consultees free to accept or reject the consultant's input. This is a cornerstone principle of 'Caplanian' mental health consultation (Caplan et al, 1994). Consistent with Caplan's original intention of providing mental health services to more clients, CAT consultation enables the concepts and tools of CAT to be available more broadly than individual psychotherapy.

A relational model of consultation is also viewed as particularly helpful as relational and alliance ruptures are often brought to consultation sessions (Onyett, 2007 cited in Ghag et al, 2021). Given the increasing emphasis on the value of consultation and recognition of the skills required to provide consultations, having a theoretical model underpinning consultation is important (Ghag et al, 2021). Ghag, Kellett and Ackroyd (2021) conducted a review of psychological consultancy (both primary and secondary consultation) and found that cognitive behavioural and cognitive analytic (CAT) were most frequently adopted as theoretical models. They commented on the lack of research into outcomes of consultation and Kellett et al (2020) describe the challenges of evaluating outcomes. The four broad themes regarding outcomes studied included: client outcomes; staff outcomes; consultant factors; and the organisational impact of consultancy. Psychological consultation was found to mainly improve staff understanding of clients. Staff understanding of clients has previously been found as a crucial aspect of caregiving and improves interpersonal processes (Finch, 2004 cited in Ghag et al, 2021). Kellett et al (2014) found that Cognitive Analytic Consultation (CAC, secondary consultation) showed no impact on client outcomes but significantly improved team practices and relationships at the organisational level.

More recently Kellett et al (2020) used a primary or direct consultation model to look at outcomes of CAC across several mental health teams. The study found that staff felt more competent and clients felt less fragmented after CAC with these benefits maintained at follow up. The authors discuss the usefulness of the mapping tool and highlight the bi-directional or reciprocal nature of change relationally and systemically.

Implementation of a relational consultation model in the Berry Street Take Two Program

Berry Street Take Two is an accredited state-wide mental health service in Victoria, Australia, which provides therapeutic services to infants, children and young people who have experienced neglect, family violence and/or abuse. The services including assessment, intervention and consultation, are delivered within the context of several different programs within Take Two. One of these programs is supporting carer staff to provide therapeutic care to young people in therapeutic residential care (TRC) (Cox et al, 2021a).

TRC homes provide residential care to young people in the Child Protection service and have additional funding to support the provision of 'therapeutic' care within the homes. This funding allows for a part-time therapeutic specialist role for four children as well as other resources designed to support the provision of therapeutic care. One of the primary tasks of the therapeutic specialist is to facilitate fortnightly reflective practice to the care staff. The Berry Street Take Two program provides this role with Berry Street's residential care services as well as for other organisations.

Children and adolescents in OOHC have typically experienced complex developmental trauma. This differs from an acute 'one-off' trauma such as a car accident or natural disaster as it is multiple traumatic experiences of sexual, physical and/or emotional abuse over a prolonged period (Purvis et al, 2013; van der Kolk & Courtois, 2005). The context of this abuse is almost always relational, and the perpetrator is often the primary carer or attachment figure. It also happens during crucial developmental periods and thus disrupts development and affects developing neuro systems (Cox, Perry & Frederico, 2021b). The impact of complex developmental trauma is global, affecting attachment systems, dissociation, cognition, affect regulation and self-concept (Cox et al, 2021b & Purvis et al, 2013). These early experiences, and the subsequent impact on the child's neurodevelopment, influences their perception of relational interactions and relationships, often resulting in misinterpretations that perpetuate maladaptive strategies.

In order to keep children safe, they are removed from the care of parents/carers who have abused them or been unable to keep them safe and placed into OOHC. This disruption in the child's attachment further impacts the attachment system or relational templates. It is not uncommon for the child to move from placement to placement as the

system attempts to find a stable home for them. Not surprisingly, children in the OOHC system find it hard to trust adults and can develop coping strategies that jeopardise their relationships with carers (Cox et al, 2021b). Interventions that support carers to provide stable and nurturing care are most effective (Purvis et al, 2013). Understanding the pushes and pulls experienced by the people in the child's care network is the first step. The second step is finding a way to explain it to carers and others in a non-blaming or shaming way.

In the Australian state of Victoria there were 12,669 children in OOHC or on permanent care orders in 2021 (Australian Institute of Health and Welfare, 2022). Out of home care and other supported placements for example kinship placements (not including permanent care) in Victoria has been costed at $850 million for 2020-2021 according to government figures (Australian Productivity Commission, 2022). The number of children in OOHC and the financial costs highlight the need to develop appropriate and effective response to these vulnerable and complex children and young people.

A small number of Take Two staff have been trained in CAT and were utilising it in supervision and case presentations. Those that were exposed to this relational framework recognised its value in understanding the young person's relational templates as well as the role of the people in the young person's life inadvertently perpetuating. This was communicated to senior leadership and in 2019 Berry Street Take Two committed to a phased project to introduce relational consultation within the program.

The primary aim of this project was to support the development of skills and experience in relational formulation and consultation using the mapping tools of CAT. This practical and accessible reflective tool is particularly useful where professionals or the care system are challenged by the complex presentations of young people. Initially, an external CAT consultant and trainer was engaged to provide a series of consultations within the program as well as a training day for the whole program. In the second phase, in 2020, a CAT informed consultation group (subsequently referred to as relational consultation group) of 10-15 participants was established.

The relational consultation group comprised of senior management, team leaders and clinicians across the program who were interested in further developing skills in using a relational consultation model within the program. The external CAT consultant was engaged to facilitate monthly two-hour consultations with a focus on using mapping and relational formulation as a reflective tool. Due to COVID-19 restrictions associated with the 2020-21 pandemic these sessions took place online. A mentoring approach to enable those within the group to continue the consultation group in the next phase was an additional aim.

The relational consultation group continued in 2021 without the external consultant and was led by a senior manager, a CAT practitioner (who was also a senior clinician), and a team leader undertaking CAT training. Group membership was also opened to team leaders who had not been part of the group in 2020 as their role afforded opportunities to use the model within their teams. The group continued to meet monthly for two hours utilising the relational consultation model provided in 2020 by the external consultant. At each session one group member presented a case to be mapped together and the group members also practiced mapping with a partner. Once again, due to COVID restrictions, most of the sessions took place online.

Case study

The following case study has been de-identified to protect the identity of the young person in OOHC. Judy, a Berry Street Take Two clinician, presented a complex situation at one of the relational consultation groups where she was supporting TRC staff in their work with a 14-year-old young person, Andy (not his real name). Andy had a long history of parental neglect and was living in a TRC home, with trauma-informed and therapeutically trained carers who were supported by Judy. The carers felt frustrated and useless in their role with Andy because he would often run away and not return to the home when asked. Andy would return occasionally for meals and a bed to sleep in but did not engage much with the carers and the support they offered. The carers expressed their frustration to Judy stating that Andy was taking up a bed that another young person needed.

Judy's role was to help the carers understand the underlying needs that were driving Andy's behaviours and support them to respond therapeutically. Judy told the consultation group that she, in turn, felt frustrated by the carers. She believed they didn't understand the mistrust and fear of abandonment that ensues from neglect and that transferring Andy to another care option would exacerbate existing attachment issues further reinforcing his relational template. Adding to Judy's struggles was that the level of frustration and annoyance that the carers were

expressing to her was very different to their usual responses to young people in their care. Judy brought this to the relational consultation group and wondered if the carers were getting caught up in the relational dynamic that had historically shaped Andy's behaviour of not getting close to others as a form of self-protection.

The relational consultation group mapped (see Figure 1, below) the relationship dynamics of feeling overlooked or dismissed/used and with it the expectation that others are dismissive or can give up, abandon. The consultation group wondered together, helped by this map, if the carers may have tried very hard to provide care to Andy but as it was not 'perfect' care, their attempts to engage him fell short and were dismissed. Then the carers, having tried so hard and feeling dismissed themselves, were feeling pulled to reject Andy voicing their desire to have him placed somewhere else. In doing this they were unknowingly enacting this cycle of neglect and abandonment that Andy was accustomed to and which had helped shape his relational template.

Mapping these dynamics allowed Judy to notice that she too could play out some of these dynamics by seeming dismissive of the carers' efforts and their hurt in trying to engage Andy and their feelings of helplessness. This was a shift for Judy as she recognised that at times she contributed to these unhelpful dynamics, but it also provided her with an opportunity to consider how she could 'step out' of these by being more acknowledging of the carers' efforts. By putting the dilemma to them, that everyone seemed to want to care for Andy and if they couldn't they gave up, enacting a cycle of abandonment that Andy had already experienced often. Looking back at the map helped Judy formulate relationally what was occurring within the system of care involved with Andy and then talked with the carers in 'a relational formulation language'. For example: that a relational pattern of wanting to care but giving up if it didn't seem good enough was occurring often. Judy provided the opportunity to process the staff reactions to the formulation and brainstormed how they could use this formulation in how they responded to and cared for Andy.

This helped carers to be less likely to enact these relational positions, or they were able to talk about this amongst themselves often noticing their frustration and acknowledging that they were trying hard to care for Andy. The carers were able to step back from their frustration that their efforts didn't seem to be acknowledged by Andy and that their wanting to give the bed to another young person could look like abandonment to Andy. The staff continued to care for Andy, putting in

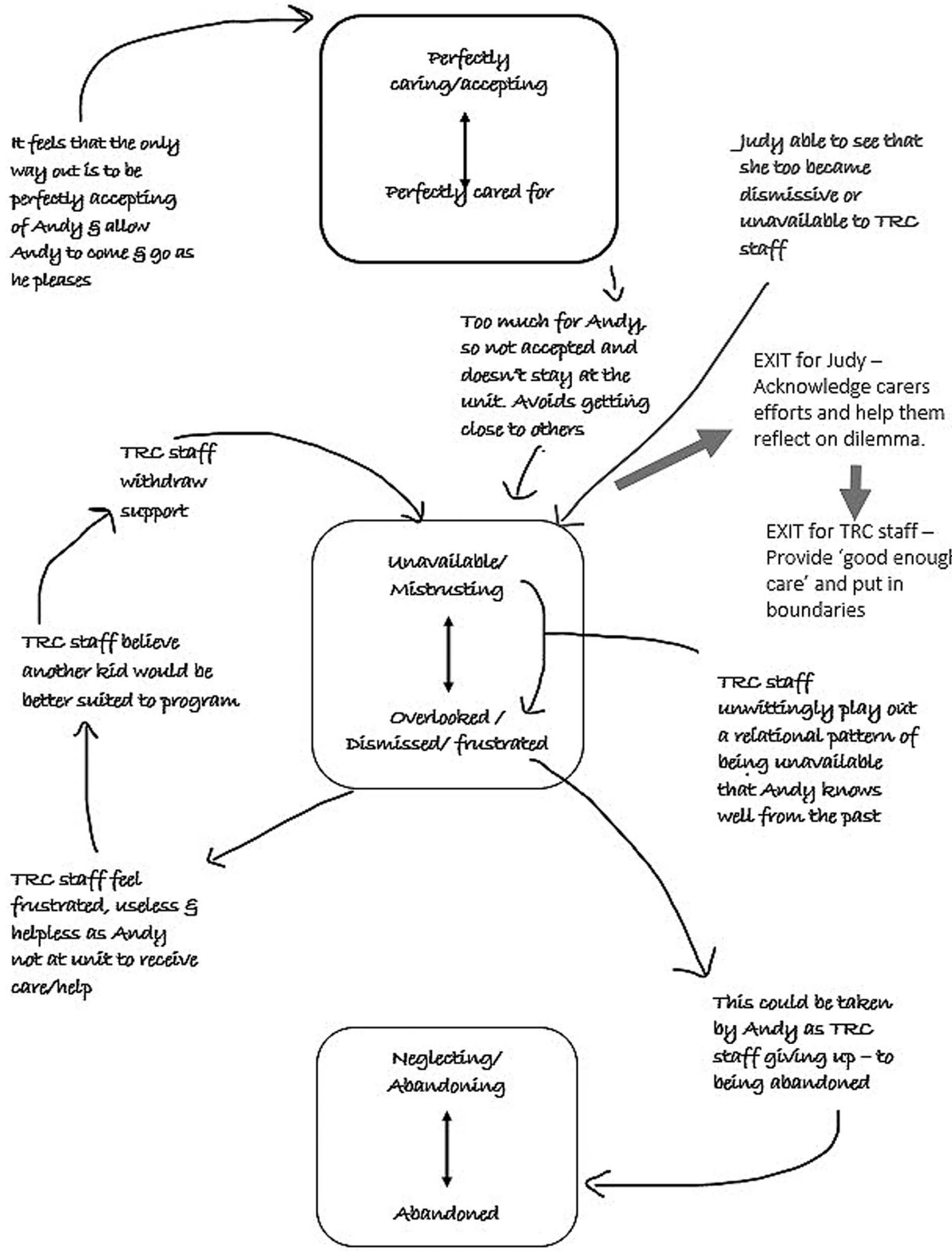

Figure 1: Map completed with Judy

boundaries and not being as frustrated by his seemingly dismissive way as they understood it differently, through a more empathic and relational lens aided by the relational formulation. This helped them relate to Andy in a 'good enough' way, and over time Andy showed increased independence letting the carers know what he was doing, he stopped running away and was more open to the carers' concerns about him.

Conclusions and future directions

This article describes a relational consultation model that would be useful for people working with complex client presentations within complex systems. A small project using this model with a group of clinical staff working with young people who have experienced relational/developmental trauma and are often living in OOHC is also described. The project highlighted the ongoing importance and relevance of a relational model of secondary consultation when working with developmental trauma and associated relational complexity within care systems.

Participating clinicians found the mapping tool valuable as a consultation model and reflective tool. Some have taken this further using it as a model to help structure ongoing consultations as a team and as a framework for their own consultation to residential care staff or other professionals involved in supporting young people in out of home care.

The relational model described here addresses Caplan et al (1994) enduring principles. It incorporates the teaching of consultation skills to consultees by providing a mapping tool that can be used to support consultation and reflective practice. Consultation skills need to be taught, being a competent clinician is not considered enough (Caplan et al, 1994). The mapping tool and process of mapping also addresses the principle of 'fostering orderly reflection' offering systemic reflection to support consultees re-establish or maintain their sense of equilibrium. Furthermore, relational consultation avoids any direct psychotherapeutic techniques with consultees such as interpretation and continuing to focus on client-related elements rather than 'confronting' a consultee who may be expressing 'inner conflicts' or their own relational templates. A relationally attuned consultant, remaining positive and supportive towards the consultee enables the consultee to safely consider their own relational templates and patterns through the reflective process of relational mapping. It should also be acknowledged that this group had the support of senior leadership who led through using relational language, one being a CAT practitioner. Finally, the formal agreement within Berry Street, Take Two as host organisation and the project being sanctioned by senior leadership ensure that the consultations were useful.

An important factor in facilitating the acceptance of this consultation model was the systemic thinking and reflective capacity of the Take Two practitioners. These skills may need to be developed in some instances before teaching a relational consultation model. A staged approach might benefit some groups. For example, the CAT consultant and senior staff might initially introduce this way of thinking through individual supervision, supporting the development of reflective group space and/or providing smaller group consultations using the model. There might not be expectations that staff use it for outside reflection or if they do it is after they have developed the essential reflective skills.

A challenge for this project was embedding the relational consultation model within a large state-wide program when only a small group of clinicians and team leaders participated. It was agreed that targeting senior staff (supervisors and team leaders) to participate in the group would enable greater reach across the program by virtue of them being able to use and teach the model within their own teams. The utilisation of an online meeting platform had the advantage of including people who worked in rural settings but was limiting in its opportunities for open discussion. There was only limited success meeting this aim, with competing priorities for the program making it hard to emphasise this model.

The development of a brief training package in the relational consultation model has also been identified as an important next step. This could be provided and then supported by regular consultation groups. Evaluating this approach to teaching and embedding the relational consultation model is also an area for future consideration. Given the challenges previously described of evaluating secondary consultation an evaluation framework beginning with staff outcomes (perceived competence, confidence and understanding of clients) would be helpful. In summary the development of a relational consultation training package and evaluation of small-scale models of embedding relational consultation models are future priorities as highlighted by this project.

CAT informed consultation with its relational framework of understanding that relationship dynamics often add to complexity, alongside its practical tool of mapping these, is well suited as a consultation model for staff who work with young people who have

relational trauma and are living in OOHC. Relational consultation uses the relational framework of CAT with the foundational understanding that people behave expecting to be related to in ways that are often replications of their childhood relationships. This fits with the attachment system difficulties many young people with relational trauma hold in OOHC. This understanding allows the consultant to help the consultee consider how they may be invited into unhelpful relationship styles with young people who do not know what it is like to be in caring and responsive relationships and offers a framework of mapping this. Importantly, this then enables consultees to reflect on future complexity outside the group.

This reflective model, helped by mapping the relational dynamics can be used as a way to consult with a wide range of people. This includes mental health workers with specific work-related language and psychological theories, residential care workers with different perspectives and less clinical knowledge or a family member who has little formal education and their own trauma background. □

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Measuring the Effectiveness of Cognitive Analytic Therapy

An Evaluation of Using Psychological Outcome Measures in a Personality Disorder Service

MARK DAWSON, KATHERINE ROWELL, LAURA JOHNSTONE, PHILIP PAMPOULOV & SOPHIE RUSHBROOK

Abstract: The present study aimed to evaluate the impact of Cognitive Analytic Therapy (CAT) on a range of psychological outcomes for adults with personality disorder. CAT is a time-limited psychotherapy with a focus on relational patterns and a collaborative alliance between the client and therapist. The data was analysed from a non-randomised sample of twenty-one clients open to a tertiary Personality Disorder Service in a mental health trust in Dorset. These clients were seen for CAT between November 2017 and November 2019. Outcome measures were collected at three time points; prior to starting therapy, at the mid-point of therapy and at the end of therapy. Data from the following outcome measures was collated; The Structured Clinical Interview for DSM-5 (SCID-5), The Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5), The Dissociative Experiences Scale (DES), The Inventory of Interpersonal Problems (IIP-32), Clinical Outcomes in Routine Evaluation (CORE-34), The Acceptance and Action Questionnaire (AAQ-2), The Brief Over control Scale (BOS) and The Symptom Checklist (SCL-90). Paired samples t-tests found that there were significant effects for all outcome measures, suggesting that CAT can be effective in reducing measures of psychological distress and improving psychological wellbeing in clients with personality disorder. Clinical implications and recommendations for future research are discussed.

Key words: Cognitive Analytic Therapy, Outcome, Measurement, Evaluation

Affiliation: Intensive Psychological Therapies Service, Branksome Clinic, 51A Layton Road, Poole, Dorset BH12 2BJ England