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'Ryle suggested that different therapies addressed different aspects of the sequence – whether appraisal as in cognitive therapy, action as in behavioural therapy, or aim as in psychodynamic therapy. With such a broad theoretical underpinning Ryle to some extent future-proofed CAT as its theoretical base was wide enough to accept many fellow travellers. It may have been possible in the past to say this person has a psychodynamic-flavour of CAT, or this one is a CBT-style CAT therapist but these tribes are much less in evidence as CAT becomes mature as a model in its own right.'

A REVIEW BY FRANK MARGISON OF THE SECOND EDITION OF *INTRODUCING CAT* BY RYLE AND KERR

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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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Editorial
Looking back and Looking forward

THIS volume arrives in the post COVID climate and on the eve of the 9th International CAT conference when we are returning to Finland where the first international CAT conference took place twenty years ago in Valamo in 2003. The theme of the conference is looking back and looking forward and this volume has echoes of this especially with the contribution from Frank Margison in reviewing the first and second edition of the Ryle and Kerr Introducing CAT books. We may also be looking back and looking forward to the strange warp of time during the pandemic. The COVID struggles list by Mayer and Jefferis touches on this.

Interest in CAT has grown in the past twenty years. From its first development in the UK and then Finland, Ireland, Greece and Spain it has a growing following in Australia and New Zealand, Italy, Netherlands, India, Malta, Chile, and interest in France and Switzerland.

It is six years since the first issue of this journal. Thirty-six peer reviewed articles and nineteen book reviews later we are pleased to have a rich and diverse body of work on CAT, freely available online to readers around the world. For future issues, we hope to produce one issue annually and we look forward to a variety of contributions – whether reports on additions to the evidence base for CAT; case studies that either illustrate the range of CAT practice or introduce innovations to the approach; or articles that explore the applications of a CAT understanding the wider relational context to psychotherapy and mental health. A great variety of approaches to psychotherapy have been established along parallel or divergent tracks to CAT and we have partly seen the cognitive analytic understanding used as a framework for engaging different techniques and ways of working.

Having carried the journal on a voluntary basis for these years the two founding editors Ian Kerr and Steve Potter are now extending a warm welcome to a bigger team and a collective approach to sharing the editorial load. Welcome to Anna Laws from the northeast of England, Claire Regan from Ireland and Rita Toli from Greece. We are delighted to have their contribution and equally delighted to welcome Elaine Martin the new chairperson of ICATA to join our editorial group. It is a healthy step to handing over the journal to the next generation.

We continue to appreciate the support from ICATA and hope the

journal plays an active part in its work as a federation of countries where CAT is practised and developing. We now have Psych Info registration approval which is a step for referencing and are seeking to consolidate this aspect of the journal as a source for referencing and research by getting the journal indexed more effectively on search engines and optimised for being listed on academic indexing search engines. We are committed to keeping the journal freely available online. Some print copies are available for library use or reference.

Turning to this issue, we are pleased to have a thoughtful outsider contribution from our invited guest, Giancarlo DiMaggio who has written of the common factors across integrative and relational therapies with his article Hope Perspective Action.

Rowan Tinlin shows the versatility of CAT in her enquiry into Mapping sexual diversity using Cognitive Analytic Therapy: a qualitative, cooperative enquiry with the LGBTQ+ community. Rowan's contribution opens a space for thinking along CAT lines about dominant and pluralistic narratives of gender, sexuality and diversity.

Lee Crothers and colleagues offer a relational model of consultation for relational trauma using a Cognitive Analytic Therapy approach to secondary consultation to services that help young people in Out of Home Care. Mark Dawson and colleagues report on the challenges and results of a study of measuring the effectiveness of Cognitive Analytic Therapy (CAT) in a Personality Disorder Service. Irene Elia has done a CAT outcome study of private practice which offers food for thought about the distinctiveness of CAT in that sector. Future articles might look comparatively at how private practice is positioned in relation to public sector provision where and if it is available.

Several papers report on work related to or affected by the pandemic. Claire Mayer and Steve Jefferis describe their work in developing and evaluating the Covid Struggles List which is a checklist that has echoes of the psychotherapy file but for different times and contexts. Two short papers are very welcome more as research notes to highlight the value of small-scale routine evaluation and research built into practice. Siobain Bonfield writes about space to think and reflect during the pandemic and Eirini Vasiliki writes up a study interrupted by Covid but still bringing some helpful insight into the use of self in evaluating a one-day relational skills training with a Community Mental Health Team.

In the selection of book reviews, we are grateful for Frank Margison's extensive comparative review of the first and second edition of the Ryle and Kerr book. As an invited review it does something more than review the book but also take stock of the CAT model. In the same vein we are pleased to have reviews of the Introduction to CAT in Greece by Iannis Vlachos who has done so much to develop CAT in that country to the point of strength it now has and of the distinctive book by Marie-Anne Bernardy of the use of CAT in France with rich case studies and examples reviewed by Annie Nehmad.

Book reviews are concluded with a compelling account of Nick Trotton's book on Wild Therapy. Nick Barnes in reviewing the book introduces a CAT perspective on its application to therapeutic work in the Scottish Highlands.

We as an editorial group learn from our contributors and our own efforts with writing. Finding words that bring clarity in complex times means we meet words that are troublesome in good and bad ways. One of the editors Steve Potter offers an opening contribution to some troublesome words in the CAT lexicon. It is invitation for further contributions in future issues.

Looking back and looking forward may be a false division. It might be something nautical like steady as she goes and holding to the pragmatic, relational and integrative fabric of what might be called a socio-bio-psycho-but with-humanity approach.

Steve Potter, Ian B Kerr, Anna Laws, Claire Regan, Rita Toli
June 2023

Hope, perspective, action: a pantheoretical perspective on three common ingredients for effective psychotherapy for people with serious interpersonal problems

GIANCARLO DIMAGGIO

TREATING people with serious interpersonal problems is both possible and challenging. Evidence testifies that these persons gain benefit from different psychotherapies but many still suffer from residual, at times serious, levels of symptoms and interpersonal problems by treatment termination. There exists therefore the need for common ground knowledge in order to better understand what is needed to treat them with more effectiveness, no matter what one's preferred orientation might be.

In this paper I will consider three ingredients of change that clinicians need to focus on in order to increase the likelihood that patients stay in treatment and derive benefit from it. I am not assuming these ingredients do the job on their own, there are many others I am not discussing mostly for reasons of space, but I will offer the position that any clinician needs to consider them. The idea is that psychotherapy with these persons, commonly diagnosed as having personality disorders, can be effective if clinicians are able to help patients: a) change their perspective; b) have some hope that they can improve and live a less painful and more fulfilling life; c) commit to action aimed at changing maladaptive patterns and strive towards goals they feel are deeply owned.

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Suffering and problems in personality type disorders stem from predictions

Interpersonal problems stem mostly from predictions arising from earlier formative relational experience. For example, neglect during childhood leads us to predict that others will neglect us when we have emotional needs. Patients expect that some of their innermost wishes will remain unmet by the others. This is an idea at the core of the large majority of psychotherapeutic orientations. Just as an example, Cognitive Analytic Therapy (CAT, Ryle & Kerr, 2020), Schema Therapy (Young et al., 2003), Transference Focused Therapy (Clarkin et al., 1999) and my own model, Metacognitive Interpersonal Therapy (MIT, Dimaggio et al., 2015; 2020) share this view.

Such wishes are relevant as they have been evolutionarily selected, and failing to meet them meant to our ancestors risking starvation, physical integrity, failing to mate and, ultimately death (Liotti & Gilbert, 2011). Examples of those wishes are: the need to be cared for when in pain, i.e. attachment (Bowlby, 1969/1982); social rank, which grants order of access to limited resources (Gilbert & Irons, 2005); exploration and autonomy, which are activated when the individuals need to find new resources such as food, lands, and refuges when necessary; caregiving, aimed at protecting the breed; sexuality, in its more complex form which is more than mere mating, and refers to forming stable bonds filled with intimacy; and group belonging, which increases the odds of being protected from predators and outgroups and to reach shared goals the individual would be unable to meet if left alone.

Due to a mixture of temperament, developmental history and cultural influences, individuals develop predictions of how others will react when they try to fulfil their wishes. A couple of examples may help. In the domain of attachment the individual can predict that 'If I ask for care the other will be unavailable'. As a consequence, she forms a core self-concept such as 'I am unlovable'. In the domain of social rank the prediction can sound like: 'If I seek appreciation the other will scorn me and ridicule me', which leads the individual to harbour the idea that 'I am inferior and unworthy'. In the domain of exploration a typical negative prediction sounds like: 'If I try to learn something, I will need resources that the other will not provide me with', which leaves the individual with a core concept of 'I am powerless and stuck'.

Due to those predictions, individuals tend to experience suffering and act in order to protect themselves from the psychological pain arising from both the negative view of themselves they endorse and the reactions from the others they fear. A person with a core self-concept such as 'I am unworthy' will be more prone to experience shame and sadness and as a consequence to become perfectionistic, to avoid social exposure and will be keen to adopt maladaptive coping strategies such as alcohol or drug abuse in order to soothe a pain he is unable to soothe in other ways.

What is the target of psychotherapy in the light of such ideas? I maintain here that three ingredients are necessary:

1) *changing perspective*. If individuals suffer from their predictions, they need to try and view themselves and the world from a different angle. Psychotherapy therefore is about helping individuals to form or bring to light alternative predictions about the fate of their own wishes.

2) in order to change perspective *hope* is needed. It does not mean thinking unrealistically that others will be always there for us, praise us and sustain our efforts. It is about having an underlying, albeit minimal, idea that we are not doomed to fail and that others will respond as we wish.

3) in order to change perspective and sustain hope, *committed action* is necessary. There is no point thinking that personality disorder-type problems will change only because we have developed a new and more adaptive set of ideas. They will not truly change the way they see themselves, the others and the world only by talking with their therapist if, once home, they sit on the sofa, ruminate about past relational problems, worry about the future or dwell on their anger about having been mistreated. Change comes to life out of sustained behavioural efforts to alter one's set of ideas held for a lifetime, and discover how alternative views are possible.

I will now describe how clinicians can implement these elements with a (fictionalised) case history, so to give a sense of their pragmatic application.

Changing perspective

In order to see the world from a different angle and discover different landscapes, clinicians need first to help patients realise that their interpersonal problems have two components. The first is reality based,

but that is not the focus of psychotherapy. Human relationships hurt – that is life and we are equipped to cope with problems. The second is that suffering stems from their predictions that their wishes will remain unmet by others. Put it simply: patients enter therapy saying 'I suffer because he neglects me'. The goal is to help them pass to this kind of understanding: 'He neglects me and that hurts. But I am aware now that I think that I am unlovable so when he neglects me, I agree with him, that makes me so clinging and depressed'. Clinicians validate the first aspect of suffering as human, reality based, but then try and agree with the patients that the work will be focused on the second element.

Charlotte is a 41 year old architect. She has been married for three years to a yoga teacher whom now she describes as bizarre. 'I loved him because he sounded original, kind of a mystic. But I realise now that he is more of a freak. He has 5 clients overall and he pretends he works and he doesn't realise I pay the bills. He is also a conspiracy theorist and, well, it's so annoying. How can I talk him into assuming more responsibilities?" Charlotte was unable to confront him out of fear of being insulted and attacked. Consequently, she was submissive and pleasing, which then reinforced her dissatisfaction. In this stage she portrayed her interpersonal condition as reality based and that made her feel stuck and powerless. I asked her where these ideas of being insulted and attacked came from and episodes of violence at home emerged. She was often belittled and at times beaten by her mother. Her father was aware of the physical punishments but agreed with her mother that that was okay and neglected Charlotte. She learnt to be the 'good girl' to avoid punishment. She also developed the idea that she was inferior and could only match with people she did not value. 'If I meet a clever man, how would he ever like me?'

At this point we realise that her suffering in her marriage mostly comes from her prediction that if she were able to express her wishes and opinions, she would have been both humiliated and in danger. This was the first step toward healing. But in order to change perspective she needed to have hope that a different view is possible. That was the second therapy step I had to help her to take.

Restoring hope

Where does hope come from? It is about giving room to more benevolent ideas of self and others such as 'worthy' in face of a 'praising and supporting' other. With such a concept of self and other, individuals can be motivated to act differently and have more chances to fulfil their own wishes in the real world. Of note, well-being is not strictly connected to real life fulfilment of the wishes. Put simply, healing does not mean finding the persons who love us forever or the job we dreamt of. If this happens, that is better, by the way. Well-being stems from the idea that we have a chance to be loved, to find the work we love, to explore the environment as far as it is possible. Against this background, when persons face setbacks, their core concept remains mostly unaffected: 'Okay, I failed, I was not cared for, not appreciated or not supported, but that's life, it's not necessarily on me, it makes sense trying again'.

When Charlotte realised her current marital struggles were so painful both because she did not like her husband any more and because of her learned experiences, she had moments of deep sadness and anxiety. She did not see any alternatives. How to restore hope when it is absent? The clinician needs to be aware that, with the exception of the most severe cases, patients do have some positive views of self and others. It is just that they seldom ever retrieve them – when they access them they do not take them as true, and they do not let them guide their actions. Mostly these ideas appear but they quickly vanish from their stream of consciousness (Dimaggio et al., 2020).

At this point, I asked Charlotte to focus on moments where she felt self-confident. In the first moment she cried and said she never was. I helped her recall many moments in which she described herself as competent at work and others in which she had evidence she is attractive. I also remembered a moment where she confronted me about something I said, and let her note she was quite clear in expressing disagreement and in having faith that she was right. She recognised that in all these moments she felt better and had good self-esteem.

Hope needs to last and guide action in order to ignite change. To do so, I used a combination of role-play and body-oriented work. We agreed to role-play a moment when her mother had insulted her. I played the mother. During the first rehearsals she surrendered, cried and could not retort. We repeated the scene many times and I invited her to talk back. She came to answer: 'You humiliate me and I don't deserve it'. She felt scared when saying so. I then invited her to repeat the same sentence while changing her posture and voice. I invited her to open her arms, raise her chin and speak louder. Then I monitored how she felt, and she realised that with this new stance she felt more self-confident. I then

spoke with a harsher voice and said she was disrespecting me. Again she felt bad and tended to surrender. We noted how she was again the prey of her mechanisms and I invited her to retort again, even yell if she felt like it. After repeated attempts she could tell her mother she did not want to be treated that way anymore.

At the end of this intense experience she realised that she felt more confident, she knew now that she could react even under stressful conditions. 'I don't feel powerless anymore, it's hard, but maybe I can try'. At this point of the therapy Charlotte has regained hope. Is that enough for a sustained change? No, change in the interpersonal domain needs to be supported by new behaviours, it is pointless changing ideas if old actions are repeated over and over again.

Committed action

There are some orientations, e.g. relational psychoanalysis (Aaron, 2013) and humanistic orientations inspired by Carl Rogers, who think that change mostly come from a safe and supportive relationship. Actually relational factors only explain a very tiny part of therapy outcome (Flückiger et al., 2018). Treating serious interpersonal problems requires that the client decide to act differently in their everyday life. They need to break old habits where they were driven by tendencies to surrender, attack, avoid, be perfectionistic and stern and so on. Only with the intentional enactment of new behaviours can new aspects of the self be consolidated and increase the chances of one's innermost wishes being fulfilled. This is a core tenet of many orientations, mostly cognitive-behavioural and third wave, such as for example Dialectical Behaviour Therapy, Acceptance and Commitment Therapy and MIT.

At this stage a core ingredient of change is anchoring the client to her wishes, focussing on the now re-instilled hope, and planning behavioural experiments. This is what I aimed to do with Charlotte. We planned to express disagreement with her husband on many occasions. We planned to face her fear of being alone so as not to cling desperately to him even when she was seriously unhappy with him. That was not easy at the beginning because she feared both humiliation and violence, even if she knew the last fear was completely unwarranted. Repeated attempts made her feel more and more safe and self-confident. She eventually realised she did not love him anymore and she deserved a man she appreciated. After a few months of therapy, she asked for divorce. She had to face conflicts but those were manageable.

Conclusions

Treating people with serious interpersonal problems, often diagnosed with personality disorders, requires many therapeutic activities. I have suggested here that at least three elements should be taken into account by clinicians, no matter their preferred orientation. First, they have to help the patients be aware that reality matters but only to a certain extent, and that their suffering is chronic because of their predictions that their goals in the relational domain will remain unmet. When patients reach this awareness clinicians need to monitor if patients have hope that they can change. This cannot be taken for granted and, if hope is missing, work must not be focused on behavioural change. Clinicians need to help patients contact their healthy aspects, made of self-confidence, a sense of safety, being lovable and having power over their mind.

Once clients have hope that a different destiny is possible, psychotherapy is about committed action. Therapist and patients need to agree goals and draft a new contract where it is clear that changes can be achieved by doing something different under a volitional effort. Change is built in the therapy room, but it is made solid and sustained thanks to something patients purposefully do between sessions for a prolonged period, until new habits become part of a new sense of self. □

References

Aron, L. (2013). *A meeting of minds: Mutuality in psychoanalysis.* Routledge.

Bowlby, J. (1969/1982). *Attachment and loss. Vol I.* , Hogarth Press, London.

Clarkin J.F., Yeomans F.E. & Kernberg O.F. (1999). *Psychotherapy for Borderline Personality.* New York: Wiley.

Dimaggio, G., Montano, A., Popolo, R. & Salvatore, G. (2015). *Metacognitive Interpersonal Therapy for Personality Disorders: A treatment manual.* London: Routledge

Dimaggio. G., Ottavi, P., Popolo, R. & Salvatore, G. (2020). *Metacognitive Interpersonal Therapy Body, imagery and change.* London: Routledge.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). 'The alliance in adult psychotherapy: A meta-analytic synthesis.' *Psychotherapy, 55* (4), 316–340. https://doi.org/10.1037/pst0000172

Gilbert, P., & Irons, C. (2005). 'Focused therapies and compassionate mind training for shame and self attacking' in P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London, UK: Routledge.

Liotti, G., & Gilbert, P. (2011). 'Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy'. *Psychology and Psychotherapy: Theory, research and practice, 84*(1), 9-25. https://doi.org/10.1348/147608310X520094

Ryle, A., & Kerr, I. B. (2020). *Introducing cognitive analytic therapy: Principles and practice of a relational approach to mental health*. (2nd Ed) Chichester, UK: Wiley.

Young, J.E., Klosko, J.S., Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

Mapping sexual diversity using Cognitive Analytic Therapy: a qualitative, cooperative enquiry with the LGBTQ+ community

ROWAN TINLIN

Abstract: Cognitive Analytic Therapy (CAT) is concerned with intrapersonal and interpersonal patterns and procedures, formed through early interactions with others and the world around us. CAT does not pathologise distress and does not lean on a diagnostic framework, instead it lends itself to understanding the complex subjectivity within identity formation, and how sexuality may interact with our Self, others and society. This paper utilises CAT theory and practice research to understand sexuality and introduce a CAT map of sexuality. This map was developed with members of the LGBTQ+ community (n=8) and encompasses commonalities observed in relational patterns and procedures, despite intersectionality and unique context. The CAT map of sexuality is not an attempt to generalise and suggest that all LGBTQ+ individuals will internalise these unhelpful patterns and procedures due to negative external influences, it is instead an attempt to understand sexuality and the complexity of self-other and self-society relationships as an LGBTQ individual. Clinical recommendations include affirmative practices, acknowledging societal snags and influences, and creating a safe and accepting space which invites individuals to bring their connected self into the room.

Keywords: cognitive analytic therapy; sexuality; LGBTQ; authentic Self; internalised homophobia

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1. Introduction

1.1 Cognitive Analytic Therapy and the development of the Self

A core feature of Cognitive Analytic Therapy (CAT) defines the 'Self' as both a relational and social concept, built on an internalised framework of patterns and reciprocal roles (RRs) that one is exposed to during childhood (Ryle & Kerr, 2020). This framework, comprised of observed patterns, becomes a shorthand map for how an individual makes sense of the world, and thus mediates how we interact with the Self and others in future (Ryle, 1975). This developmental process does not occur in a vacuum; both internal factors such as epigenetics and predispositions, and external factors such as existential and cultural influences, shape these internalised patterns and procedures (Laws, 2019). Emphasis is also placed on inherited cultural dialogue; either abstract dialogue with culture through our ancestors of which the imagined is as important as the concrete, and external dialogue occurring in everyday life with others (Bakhtin, 1986). Therefore, the Self is a dynamically constructed state, shaped by cultural norms and beliefs, social and societal meanings, and political context and becomes crystallised in early adulthood following a period of exploration and expression (Laws, 2019). This has been referred to as achieving the 'mature, individual, phenotypic Self' in CAT, comprising of an integrated and dynamic structure (Ryle and Kerr, 2020). Conversely, if negative or harmful RRs are internalised during our early experiences, maladaptive or restrictive reciprocal role procedures (RRPs) will emerge, creating a trauma-induced or dissociated Self structure (Ryle and Kerr, 2020).

1.2 Sexuality & the Self in CAT

Historically, LGBTQ+ people have been positioned on the outside of 'normal', as criminals, perverts or mentally ill. These societal assumptions were accepted by the majority throughout history and enforced by those in power, for example, Margaret Thatcher introduced 'Section 28' in the late 1980s which made discussing same-sex relationships in schools illegal, until it was later repealed in 2003. Moreover, medical professionals pathologised homosexuality through the invention of diagnostic criteria for 'homosexuality' and 'sexual orientation disturbance' which gave rise to the prescription of conversion therapies going on to harm to thousands of LGBTQ+ individuals for decades (Przeworski, Peterson, & Piedra, 2021). The UK government is currently debating the legality and ethics around conversion therapy 30+ years later, with evidence suggesting it is still practised today (Talbot & Finlay, 2022).

The UK has made considerable progress in recent years regarding the law. However, around the world anti-gay laws thrive. Hungary recently banned LGBTQ+ couples from adopting children and Russia extended its 'gay propaganda' law in 2022 making it illegal for any person or media outlet to spread positive messages about homosexuality. The lack of equality for LGBTQ+ individuals worldwide perpetuates the narrative about being worth less than their heterosexual counterparts regarding freedom, respect and rights. The minority stress model of sexuality highlights how distal and proximal stressors faced by the LGBTQ+ community, such as microagressions, discrimination, concealment of one's sexuality, internalised homophobia, or a lack of emotional support, leads to poorer mental health outcomes than their heterosexual peers (Alessi, 2014). Indeed, Stonewall, in their nationwide 2018 survey of LGBTQ+ mental health, found that 52% of LGBTQ+ adults have experienced symptoms of depression at some time in their lives, and one in eight LGBTQ+ young adults had attempted suicide in the year the survey was undertaken, significantly higher than for their age matched heterosexual peers (Stonewall, 2018). Moreover, discrimination based on sexual orientation can extend into the therapy room, with research showing that this understandably correlates with a poorer therapeutic relationship and outcomes (Macdonald, 2014; Nadal et al., 2011).

Homophobic and transphobic attitudes and beliefs have been created through a sociocultural lens over time, as sexuality and gender are understood and constructed socially and culturally (Denman & de Vries, 1998). CAT establishes a middle ground in the biological versus psychological debate, as it understands that every part of the Self is created in interaction with others, influenced by the political, cultural and social lens of the time. Therefore, CAT is well suited to understand the sociocultural and political context relevant to the experiences, and therefore distress and wellbeing of the LGBTQ+ community (Lloyd & Pollard, 2018).

2. Method: entering dialogue with LGBTQ+ others

2.1 Aim

The author aimed to hold the social justice principles and theoretical good fit of CAT in mind and co-create a CAT map for sexuality in the form of a sequential diagrammatic reformulation, alongside the LGBTQ+ community. Taplin et al. (2018) explored the helpfulness of mapping patterns and procedures within CAT and 'understanding the self' was a superordinate theme endorsed by all participants. Participants felt that visually mapping patterns and procedures allowed them to find clarity, promoted self-reflection, prompted changes in self-perception, and normalised distress through externalising procedures on paper. Mapping can therefore be a powerful tool when exploring sexuality, as it has the potential for exploring 'the Self' as Taplin's (2018) participants described.

2.2 Design

Given the exploratory aims and objectives, an inductive qualitative approach informed data collection and analysis. A social constructivist epistemological position was adopted, allowing the author to position oneself as a peer researcher and active ingredient in the design and data, constructing meaning in a collaborative way. Social constructivists understand research as a creative and transformative activity, as well as a cognitive and embodied activity (Kim, 2014). These principles speak to the foundations of CAT, and moreover are appropriate for facilitating a creative research design involving physical mapping and playing with language during dialogue.

2.3 Participants

Eight individuals responded to a call out for participants through opportunistic social media adverts and snowball sampling within LGBTQ+ networks known to the researcher. Participants were interviewed using an online video calling platform. Inclusion criteria ensured that all participants had a sexual orientation other than heterosexual, were over 18, and spoke English enabling meaningful dialogue. All participants consented to their experiences and quotes being used in the development and dissemination of this CAT map, with anonymity prioritised throughout.

Four participants identified as female, three as male, and one as non-binary. Three identified their sexuality as lesbian, three as gay, one as pansexual and one as queer. Six participants self-identified being White Caucasian, one as Black, and one as Asian. The age range of the sample was 28-63.

2.4 Procedure

Semi-structured interviews were conducted with participants, enabling an iterative process of learning, mapping and checking understanding regarding the participant's experiences. The researcher set an *a priori* target problem (TP) for the purpose of mapping, which can be understood in traditional research frameworks as the research question, to enable focus and specificity; *exploring how individuals understand their LGBTQ+ self and how this influences, and is influenced, by others and society.*

The researcher mapped *in vivo* with the first participant whilst using a semi-structured interview guide to prompt the sharing of experiences, thoughts, feelings and memories. This early version of the map, which was co-created with participant 1, was then shared with the second participant and used as the building blocks for participant 2's interview. This process was repeated, resulting in an evolving map which changed following each interview. This method was deemed most congruent with the process of mapping in CAT and the social constructivist epistemological position adopted, working on a changing and flexible map, respectful of all interacting or conflicting perspectives and narratives.

The interviews included a short explanation of CAT mapping and key concepts to orientate the participant to the process. The interviewer systematically described each component of the map asking the participant for their own experiences, as well as asking a set of standardised questions about the development of their sexual identity and how this had changed over time based on interactions with others or society. Attention was paid to the language used and the diversity of experiences, searching for commonalities in RRs and RRPs despite the differing context for each subject. Interviews lasted approximately one hour, and quotations were noted throughout, alongside the mapping process.

Participants were provided with time at the end of their interview to share any reflections or feelings in response to the dialogue. Signposting to LGBTQ charities and support networks was provided as standard.

Finally, the map in its final form was shared with each participant once all interviews had been completed, to achieve data triangulation. The researcher ensured each participant's experiences and language had been captured meaningfully, whilst allowing for some flexibility given the shared ownership of the procedural map.

2.5 Author reflexivity statement

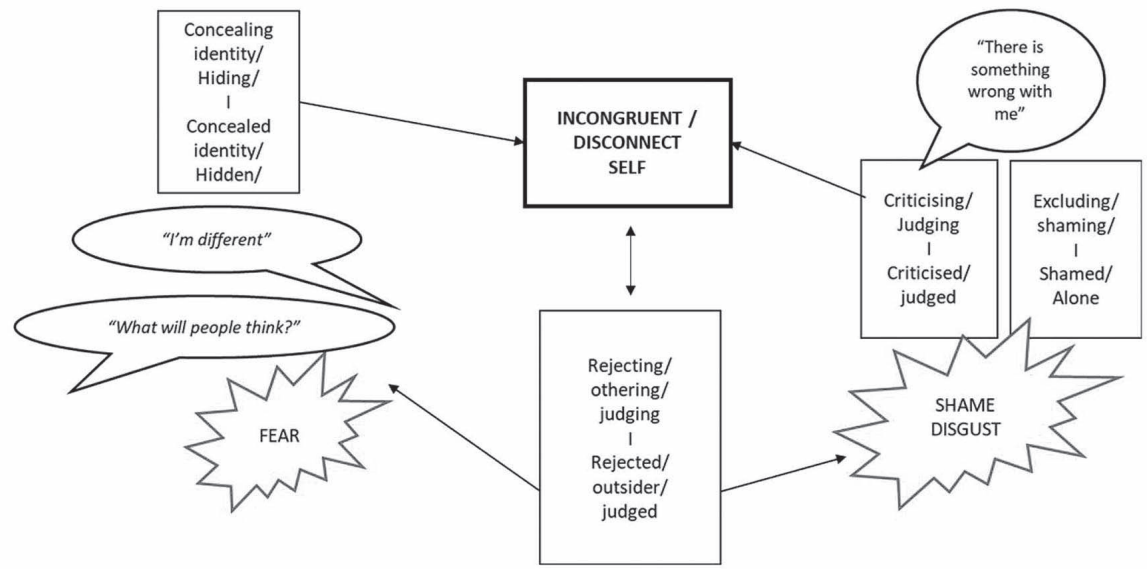
Lainson, Braun and Clarke (2019) discuss the importance of owning one's subjectivity within qualitative research, as researchers play an active role in interpretation of others' experiences. This idea of viewing dialogue and data through an emic lens requires careful consideration. Inviting transparency and reflexivity to this process allowed the researcher to remain consciously aware of the topic, and subsequently the map, from multiple perspectives; as a member of the LGBTQ+ community with their own self-other and self-society experiences, as a clinical psychologist and mental health researcher, and as a trainee CAT practitioner interested in self-development and integration. Maintaining a reflective journal throughout this process enabled the researcher to separate their own procedures and patterns from those shared with them. Keeping a target problem (TP) in mind for the map helped to ground the researcher in curious exploration and co-creation, and not move towards personal experiences and emotional responses. Moreover, the dance between researcher and therapist was conflicting at times. Utilising a clinical tool within the interview created a therapeutic space for exploration which felt somewhat different to the more traditional scripted interview that the researcher was more used to.

3. Results: the changing face of the map

Common RRs and RRPs were identified in each participant interview, regardless of one's other intersecting identities and unique experiences, and the mapping process joined these dots to create a shared way of relating to sexuality. Most self-other RRs were present from the first iteration of the map, as earlier participants found it easier to describe interactions with others and society around coming out or exploring their sexuality. As the interviews progressed, a clear consensus on preferred language emerged, and as participants 4 and 5 were interviewed they were able to build on the preliminary self-other RRs and procedures and relate these to self-self RRs and clear dilemmas for participants.

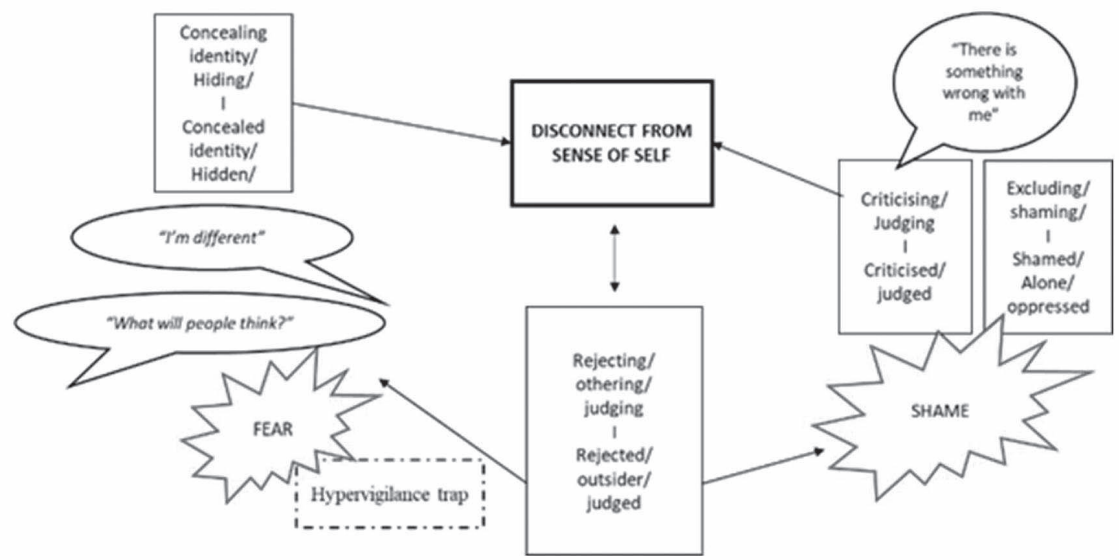
Participants 7 and 8 did not add anything new to the map or suggest different language, however, they corroborated the patterns already documented and spoke about feeling validated and seen having been presented with a later version of the map. The following figures 1- 8 show the developing map as it evolved from participant 1 to participant 8.

Participant 1 map:



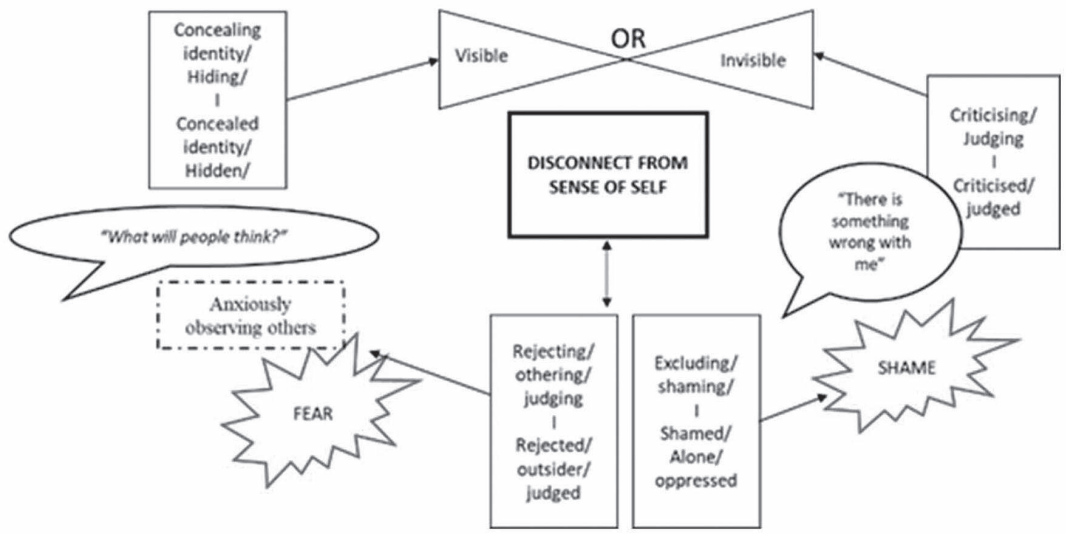
With participant 2 we add a hypervigilance trap alongside the feeling state of fear. Instead of a state of incongruence there was a response of feeling disconnected from a sense of self.

Participant 2 map:



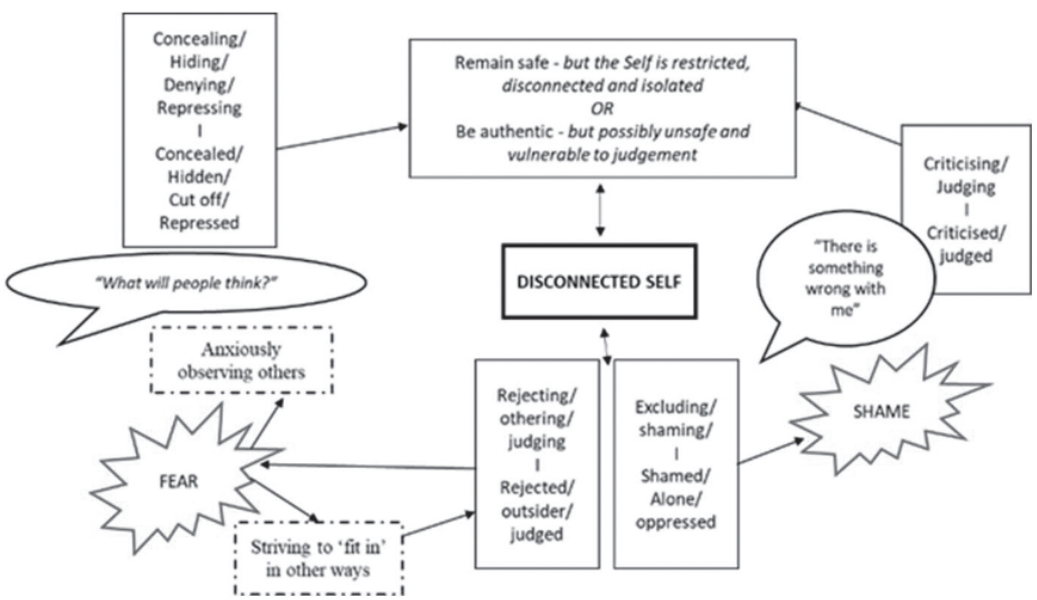
With participant 3 we added a line between feeling visible or invisible and moved the reciprocal role of excluding and shaming to be alongside the rejecting one whilst also anxiously observing others.

Participant 3 map:



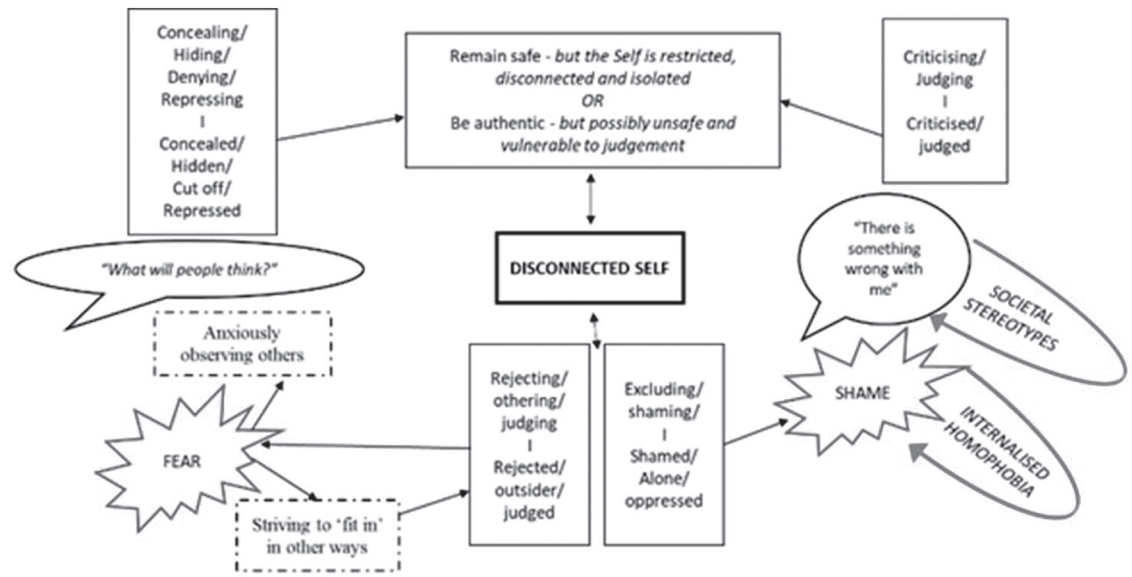
We added with participant 4 an additional reciprocal role dilemma of either remain safe but restricted or be authentic and possibly unsafe and vulnerable to judgement. There was a procedure of striving to fit in in other ways as a response to the fear and rejection.

Participant 4 map



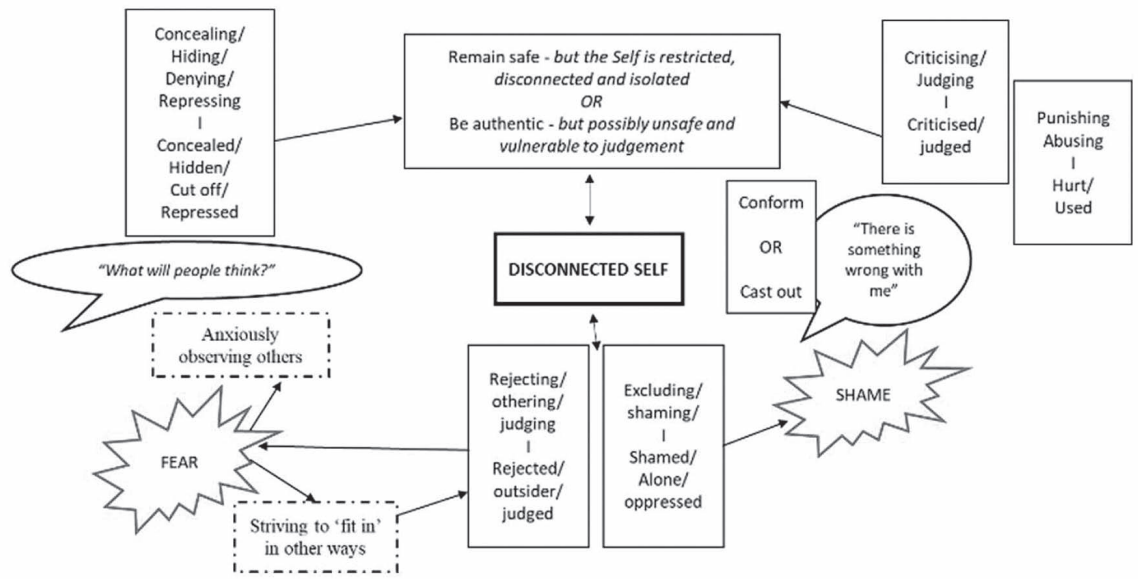
With participant 5 there was a focus also on societal stereotypes and internalised homophobia feeding into shame and feelings of there being something wrong with me.

Participant 5 map:



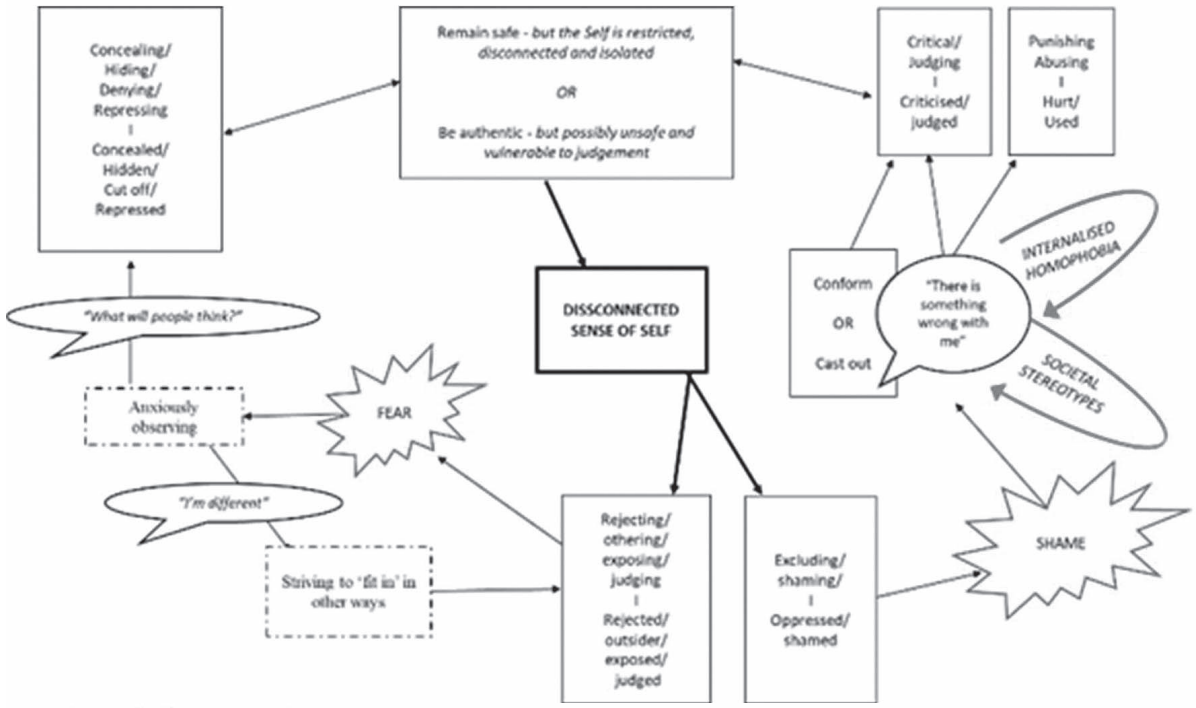
With participant 6 there was an additional dilemma of conform or be cast out and an additional reciprocal role of punishing and abusing to hurt and used.

Participant 6 map:

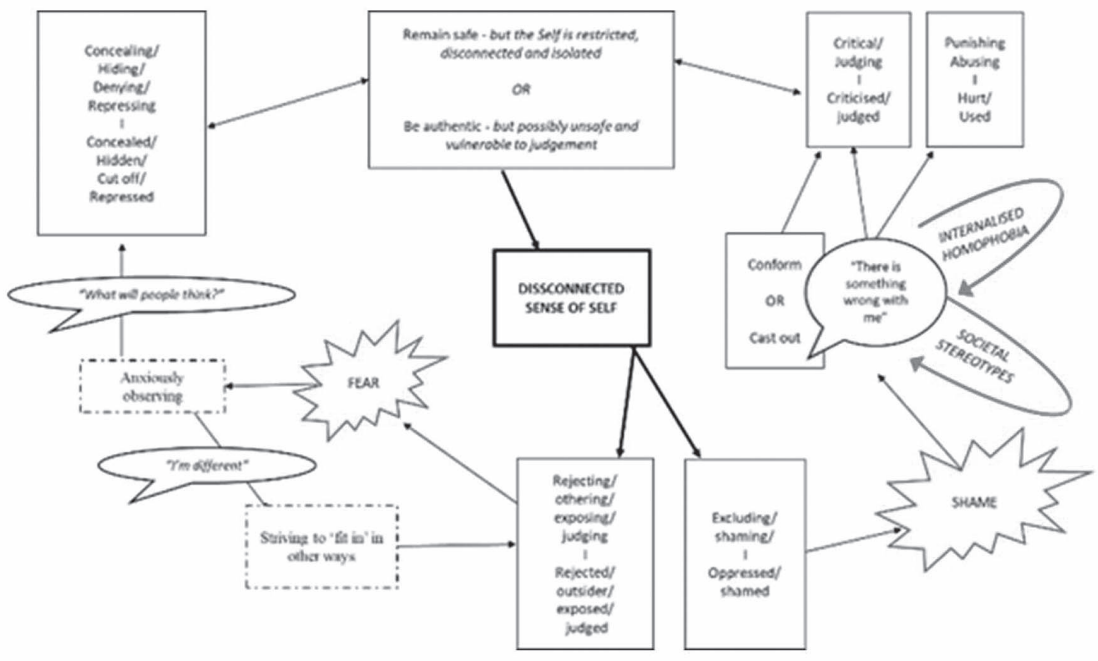


There was a fuller naming and tracing out of striving to fit as a procedure between concealing and being rejected.

Participant 7 map:



Participant 8 map: Maps for participants 7 and 8 were more or less the same as the preceding one.



Following the interviews a final draft of the map was created (figure 2); a co-created CAT map of sexuality. By the last two interviews the map reached saturation and captured the range of stories prevalent across all dialogues. The map is described further in this section and describes a disconnected self-state, self-self, self-other and self-society reciprocal roles, traps, snags and dilemmas.

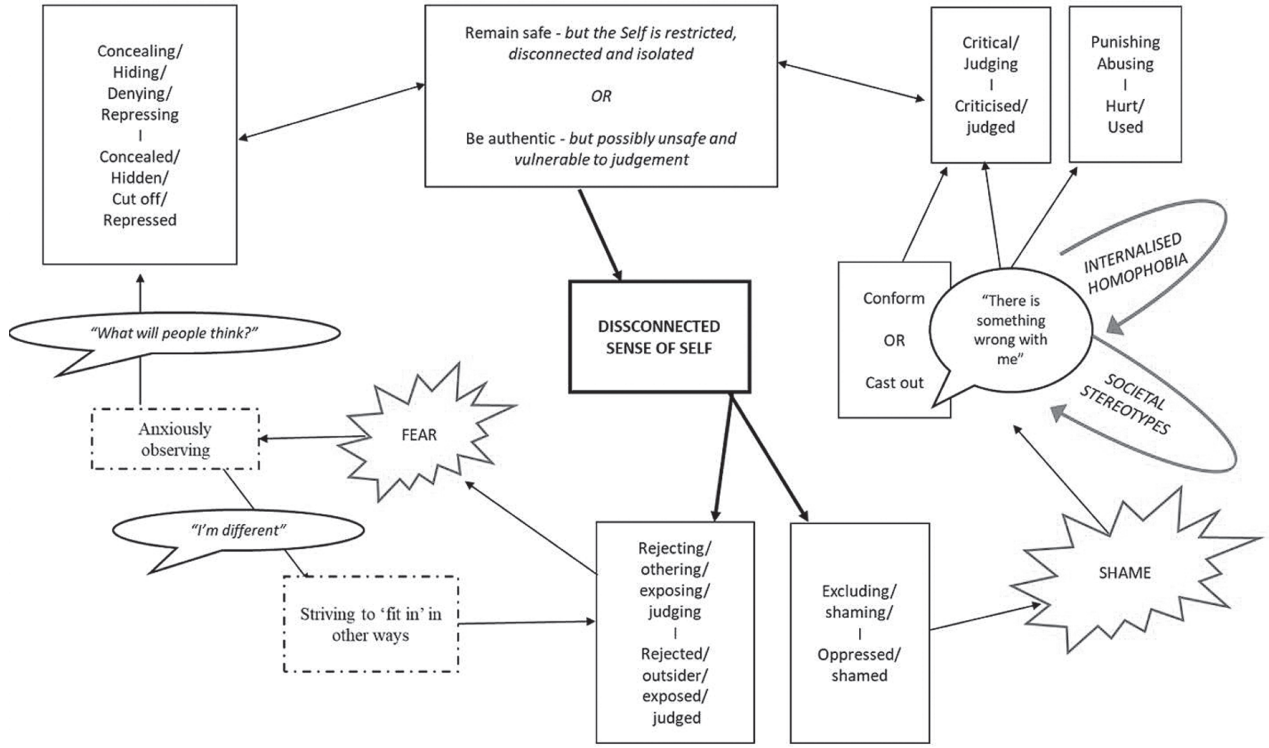


Figure 2: CAT map of sexual diversity

3.1 The disconnected Self

The idea of living with two versions of the Self, described by all eight participants, echoes the identity incongruence and dissonance discussed in the available sexuality and gender identity literature (Morrow & Beckstead, 2004; Przeworski, Peterson, & Piedra, 2021). Potter (2020) draws on Winnicott's attachment theory to describe a 'false Self' that protects or hides the true Self, following harmful interactions with others; 'the legacy of trauma is managed, but at a price of a partial loss of self' (Potter, pg 168, 2020). In the context of sexuality, we understand this trauma as the othering, oppression and criticism described by the participants, causing fear and shame. These RRs, experienced early in development were internalised and contributed to a self-state which felt incongruent with their true self. Ryle and Kerr (2002) name the

consequence of this internalisation a 'dissociated self-state', and Potter (2020) refers to a 'false self'. However, within the context of sexuality and based on the preferred language of participants, it is proposed that this is called the 'disconnected Self'.

3.2 Reciprocal roles and procedures

Experiences of being an 'outsider'

Throughout the dialogue, self-other and self-society RRs emerged describing how early experiences of 'othering/exposing – outsider/different/exposed' became internalised and contributed to unhelpful patterns and procedures. Some participants interacted with messages in the media and on television; for example, a lack of LGBTQ+ representation in Hollywood films, media reports or religious debates about homosexuality being sinful or wrong. Other participants experienced othering directly from caregivers or peers in their early years, as they communicated disgust or rejection when participants shared their true self. This othering was intolerable and was therefore linked to unmanageable feelings of fear and shame. Fear consumed dialogue at times, with examples of being exposed and the consequence of this being shared.

Rejection and the 'anxiously observing trap'

Connected to this fear were the RRs rejecting/judging – rejected/judged, which were also familiar RRs for participants in their interactions with others and the Self:

> 'Being different welcomes judgement and rejection. . . from people who think they should be scared of me or that I'm not normal. . . I just didn't know who I was, so I started to judge myself all the time too. Everything I wore, every time I looked in the mirror.' (P2, pansexual female).

For participants, judgement and rejection filled self-other interactions in early life, and subsequently their self-self-interactions as a teenager and adult. Participants also described rejection from family and friends following coming out as LGBTQ+. These interactions, regardless of how frequently they occurred, became significant relational expectations and influenced participant's thoughts and behaviour moving forward. 'I'm different' and 'what will people think' were powerful beliefs that all eight participants had experienced at some point in their lives, forming part of an 'anxiously observing' trap:

> 'I feel different, therefore I anxiously observe others and my environment, worrying about what people will think of me or do to me. This leads to me hiding my sexuality and striving in other areas to be liked or fit in, but ultimately leaves me feeling like more of an outsider or cut off as I am not being whole self.'

This trap captured the participants desire to fit in and to not feel different, which was often to avoid the familiar RRs of rejecting/othering/exposing/judging. Traps often highlight the cyclic nature of these maladaptive strategies, and for most of the participants this trap contributed to self-self RRs of rejecting/judging. For some participants, the fear of these patterns repeating led to avoidant behaviours, in which they only involved themselves in accepting and affirming circles, removing the need for 'anxiously observing'. Several participants recalled early experiences of accepting – accepted from attuned and compassionate others, however, this did not appear to alleviate the impact of the few negative experiences of rejecting/othering/exposing/judging.

Denying the Self and the 'concealment dilemma'

Participants also described the self-self RR; concealing/hiding/denying/repressing – concealed/hidden/cut off/repressed. This could take many forms; one participant described exploring their sexuality later in life after years of repression and denial due to societal pressures and family values, whereas others described dressing to fit with societal gender norms and binary rules rather than expressing themselves accurately for a fear of this 'outing them'. The degree of concealment described varied but was a shared experience across the whole sample. Ultimately, this concealment led to a dilemma which was universal in all participant narratives and spoke to the everyday repeated 'coming out' that is 'sadly just part of being queer':

> 'Either I stay safe and conceal my sexuality, but I feel restricted, disconnected and isolated from my community and others. . . or I am authentic and true to myself, but potentially unsafe and vulnerable to the judgement of others.'

This dilemma, presenting restricted options born out of these early experiences of being judged or on some occasions abused and hurt by others and society, contributes to the 'disconnected Self'. Participants described this as a 'lose-lose' scenario, which fits a dilemma in CAT, which is described as a false choice (Ryle and Kerr, 2020). One participant described the movement through these procedures very powerfully, capturing the complexity and lasting impact of these early RRs. They explained how previous family rejection regarding their sexuality caused

intense feelings of fear and threat moving forward, as they understandably wanted to avoid the hurt and shame that accompanied this rejection. Fear, prompted by beliefs about the consequence of being different, created hypervigilance around others. This anxiously observing activated their threat system and they found themselves searching for clues or hints about others' values and beliefs; including mentioning LGBTQ+ news stories to assess the responses and facial expressions of others. This state and uncertainty prompted the concealment of their sexuality from others, and on occasions resulted in them denying or ignoring it as they attempted to date opposite sex individuals. Ultimately, this perpetuated the feelings of disconnect and caused them to question their identity, which was very distressing.

Shame and conforming to societal norms

Robert Watson discusses the harmful RR excluding/shaming – excluded/shamed experienced by LGBTQ+ individuals, which is internalised and consumes future interpersonal and intrapersonal relationships (Ryle and Kerr, 2020). All participants had experienced this RR in their relational dance with societal norms, rules and messages, and sadly some participants had experienced it in interactions with others. The belief 'there is something wrong with me' felt powerful throughout the dialogue, as this was discussed on an explicit conscious level and on an unconscious, underlying level. Participants who experienced this belief at an unconscious level talked about internalised homophobia, which refers to the process of repeated negative attitudes, discrimination and abusive and homophobic language becoming internalised and contributing to an internal belief system that views sexuality diversity as wrong or immoral. This powerful snag perpetuates shame and was described by some as a real barrier to integrating and accepting the Self. Similarly, societal stereotypes snag efforts to heal shame and integrate our Self, showing the world diverse sexualities and identities. One participant described how :

> 'I used to think my 'gay self' wasn't worthy of love. . . because I'd been told being gay was a sin and wrong as a kid in Church. So I cut that part of me off for so long. Just hid it, because I thought it was wrong too. I was ashamed of that part of myself because on some level, I learned to believe it was wrong to be gay.' (P4, female lesbian)

These snags perpetuate feelings of shame, and participants described a dilemma which they face in the wake of this shame and societal influence:

> 'Either I conform with societies binary and heteronormative rules and feel like there is something missing, or I live as myself and I am cast out by society for being different.'

Conforming was described in multiple ways with varying degrees of severity regarding the impact on Self-concept or daily life. Some participants lived their lives in a heterosexual relationship to please others, and some conformed through everyday decisions about holding their partners hand in public or correcting a stranger when they misgendered their partner. These decisions were enactments of familiar RRs as participants criticised/judged themselves or faced it from others, or were punished/abused by others and themselves. Ultimately, these actions and interactions lead back to the dilemma of being safe and restricted, or authentic and vulnerable.

3.3 Exiting towards a queer healthy island

In opposition to the disconnected Self introduced in the map, the LGBTQ+ community describe an 'authentic Self'. Therefore, this alternate self-state described by participants, formed the foundation for a queer healthy island. Participants acknowledged the power of reclaiming discriminatory language, with queer being an example of this. Although it is not used and liked by the whole LGBTQ+ community it is now widely accepted as a general term to describe the diversity and flexibility within the LGBTQ+ community, endorsed especially by younger LGBTQ+ individuals.

Wilde McCormack (2017) introduces the concept of healthy islands in CAT, a place where the healthy Self resides and can begin to restore and rebuild after a crisis, or produce a landscape of helpful, revised RRPs. Participants found that entering into accepting/affirming/valuing RRs with others generated a space which felt safe and compassionate enough to develop exits on to a healthy island. As always in CAT, practising and modelling exits can form part of the therapeutic relationship, therefore, creating a safe space and accepting and affirming a client's sexual orientation is crucial. The principles of affirmative therapy are discussed in a CAT context by Watson (see chapter 9; Ryle and Kerr, 2020), highlighting the importance of self-reflexivity and critical engagement with one's own values or bias, keeping up to date with LGBTQ+ issues, acting ethically and curiosity.

A 'healthy island' feels extremely important to create with LGBTQ+ individuals, however, must be created in the context of a culture in which

LGBTQ+ discrimination and hate is still present. It can feel rather hopeless when societal snags cannot be altered and hold a position of power on the map; however, Denman and de Vries (1998) proposed that by understanding feedback (e.g., criticism or judgement) elicited in one's procedures as prejudice, rather than real and valid feedback in response to the Self, we can adjust the internalised self-evaluation based on previous faulty feedback. Indeed, this self-acceptance and self-compassion were discussed frequently during the interviews, and through dialogue were conceptualised as exits fighting against powerful internalised homophobia, shame and discrimination. The words *pride, community, safety, belonging* and *allies* held power within the dialogue, and served as a reminder that these elements are also exits, helping LGBTQ+ individuals feel worthy and equal.

4. Discussion

4.1 Clinical implications

This map of sexual diversity offers a relational alternative to the minority stress model of sexuality and is the first to incorporate identity development and acknowledge relational patterns with others and society that may perpetuate a disconnected self-state. There is notable overlap between the concepts captured in the minority stress model for sexuality and the present CAT map, corroborating that concealment of identity perpetuates distress, and that societal rejection and discrimination impacts wellbeing and identity formation and satisfaction. Moreover, a CAT model of gender dysphoria exists (Laws, 2019) which exposes parallels to the procedures and societal snags identified in the current map for sexuality. Laws (2019) draws attention to the cultural norms prevalent for the individual at the time of exploring or sharing their gender identity, which influences the experiences of self-other interactions. Partial acceptance of self was introduced as an important procedure in the gender dysphoria model. This speaks to the concealment dilemma described in the current sexuality map as individuals make judgements about the degree of acceptance likely from others and modify their identity presentation accordingly. Another similarity between the gender and sexuality maps is the presence of fear and shame as core pain, linked to difference, rejection and oppression. The shared oppression, discrimination and rejection from others regarding both sexuality and gender is important to acknowledge, however, the unique challenges faced by those with gender identity are captured within Laws (2019) model. Gender and sexuality are both aspects of identity which are socially constructed and therefore open to judgement and criticism from others dependent on the culture at the time, and it is worth acknowledging how these two aspects of identity can intersect along with others such as race and class, and impact on how you are perceived or treated by others.

In practice, the CAT map provides a frame of reference for health care professionals providing scope for increased understanding and awareness. Clinically, it is hoped that the map will guide the exploration of sexuality for those who wish to examine this part of the Self and have experienced the familiar RRs identified within this collaborative process. This map is merely a guide, for educational and clinical use, and comes with the caveat that not all LGBTQ+ individuals will share these experiences or wish to recognise and revise these patterns.

4.2 Putting homophobia on the map

All participants spoke about their experiences of homophobia, whether this was direct, indirect or in the form of subtle microagressions that have a cumulative impact. Although progress has been made towards a fair and equal society following decades of LGBTQ+ activism, LGBTQ+ related discrimination and hate crimes are still prevalent today. In fact, we have seen an unprecedented rise in homophobia and transphobia, with Home Office figures demonstrating that sexuality-based hate crimes have risen every year in England and Wales from 2016 to the present day (Home Office, 2021). In 2016/17, there were 8,569 of these crimes recorded by police, however, in 2021 this figure doubled as 17,135 sexuality driven hate crimes were recorded (Home Office, 2021). LGBTQ+ clients are seeking therapy in the midst of these societal and cultural contexts, and as affirmative therapy advocates suggests, therapists should educate themselves to enable empathy, understanding and compassion into the relationship (O'Shaughnessy and Speir, 2018).

Psychotherapy is inherently an individual process concerning one's own states, patterns and procedures, and in CAT, a movement towards a healthier island in which we are consciously aware of unhelpful procedures and able to find exits from these. CAT is rooted in sociocultural and political ideology, stemming from Ryle and Kerr's (2020) understanding of sociocultural self-development and Bahktin's dialogical model of the Self (Bahktin, 1992). Therefore, CAT is perfectly primed to make the relationship between Self and society more explicit, allowing therapists to recognise societal factors as 'snags' for individuals from

minority groups. Mapping societal influences seeks to acknowledge and validate the experiences of our clients, acknowledging that although we can form new ways of relating and find exits from tricky patterns, certain contexts will pull us back in to those unhelpful ways of relating (Ryle and Kerr, 2020).

Potter (2020) introduced the idea of relational awareness, comprising of three dimensions: 1) within us (internal self); 2) between us (interpersonal)' 3) around us (contextually). As CAT practitioners we are encouraged to develop contextual relational awareness that enables insight and reflexivity regarding self-society relationships. In the case of sexuality, this can help to put homophobia on the map. Potter (2020) suggests that CAT practitioners should occupy a position of curiosity about values, systems and societies which enables the untangling of propaganda, ideology and reality. Also, remaining open to diversity and acknowledging power between client and therapist can help mitigate judgements about fairness and help understand the historical imprint of oppression. Finally, mutual aid and an awareness of how one can contribute, organise and lead is important to combat inequalities and challenges in society which leak into the therapy room (Potter, 2020).

CAT therapists inevitably have their own personal and professional relationships with the political and cultural system we exist within, as well patterns and procedures helping or hindering leading and organising skills. Denman and de Vries (1998) discuss the fine line between where therapy ends and political action must begin, which speaks to this dance. The term ally has long been used by the LGBTQ+ community, as cisgender and heterosexual individuals are asked to use their power and privilege to support the community. The LGBTQ+ affirmative therapy movement calls for therapists to be better allies and affirm diverse sexualities, rather than take a neutral and non-discriminatory stance.

4.3 Strengths and limitations

This explorative study utilised a creative and embodied design to construct shared meaning, in which mapping formed part of the interview process. This method was rooted in social constructionist epistemology, thus provided ample opportunity to co-construct a meaningful interpretation of participant experiences, rather than relying entirely on researcher interpretation within a formal analysis stage.

According to the principles of information power (Malterud, Siersma & Guassora, 2016), which informs sample size decisions in qualitative research, a sample of eight participants provided enough rich data for a study with a focussed aim and case-by-case analysis technique. However, a larger sample would allow for improved diversity of the sample and purposive sampling may achieve a more diverse sample in future studies. Moreover, the CAT map of sexuality is a tentative alternative understanding of sexuality which is bound by context but does hold a degree of transferability across the LGBTQ+ population given the method and sampling. However, is not designed to be a generalised or fixed model as per the nature of CAT and qualitative research. To evaluate the clinical utility of the CAT map of sexual diversity, further exploration with clinical samples and within the context of CAT therapy is required.

5. Conclusion

The Self has a complex developmental trajectory, influenced by interactions and observations throughout childhood which are internalised, forming a framework which mitigates one's future interactions with others, self and the world. Harmful experiences, such as rejection, exclusion and othering can internalise unhelpful RRs and feelings of shame, and for individuals with diverse sexualities these harmful interactions can lead to a hiding or masking of one's authentic self. Through dialogue with LGBTQ+ individuals, a CAT map for understanding sexuality and the Self is proposed with the aim of supporting CAT practitioners to make space for sexuality within CAT. The map acknowledges some of the RRs and RRPs likely to be around for LGBTQ+ individuals, and places internalised homophobia and societal influences on the map whilst maintaining relational awareness about the wider context. This weaving together of the theory underpinning the development of the Self and LGBTQ+ history seeks to normalise, educate and most importantly generate further dialogue and thought in relation to how CAT makes space for the self-society relationship. □

Acknowledgments
I'd like to extend my sincere gratitude to each LGBTQ+ individual who gave up their time to discuss their experiences with me, and ultimately co-produce the map.

References:

Alessi, E.J. (2014). A framework for incorporating minority stress theory into treatment with sexual minority clients. *Journal of Gay & Lesbian Mental Health*, 18(1), pp.47-66

Bakhtin, M.M. (1986). 'Speech Genres and Other Late Essays'. in C. Emerson and M. Holquist (Eds.). Trans. V.W. McGee. University of Texas Press: Austin, TX.

Bakhtin, M.M. (1992). 'The Dialogic Imagination: Four Essays.' University of Texas Press: Austin, TX.

Denman, C. & De Vries, P. (1998). 'Cognitive analytic therapy and homosexual orientation' in: Shelley, C (eds.) *Contemporary perspectives on psychotherapy and homosexualities*. London: Free Association.

Home Office, UK Government (2021). Official Statistics Report: Hate crime, England and Wales, 2020-2021. Accessed online at Hate crime, England and Wales, 2020 to 2021 - GOV.UK (www.gov.uk).

Kim, M. S. (2014). 'Doing social constructivist research means making empathic and aesthetic connections with participants'. *European Early Childhood Education Research Journal,* 22(4), 538-553.

Lainson, K., Braun, V., & Clarke, V. (2019). 'Being both narrative practitioner and academic researcher: A reflection on what thematic analysis has to offer narratively informed research'. *International Journal of Narrative Therapy & Community Work*, (4), 86-98.

Laws, A. (2019). 'Gender dysphoria: a psychological model'. *International Journal of Cognitive Analytic Therapy & Relational Mental Health*, 3, 7-27.

Lloyd, J., & Pollard, R. (2018). 'Introduction: Cognitive analytic therapy and the politics of mental health'. In *Cognitive analytic therapy and the politics of mental health* (pp. 1-19). Routledge.

MacDonald, K. (2014). Sexual orientation microaggressions in psychotherapy. Dissertation Abstracts International: Section B: The Sciences and Engineering, 75(2-B(E)).

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). 'Sample size in qualitative interview studies: guided by information power'. *Qualitative health research, 26*(13), 1753-1760.

Morrow, S. L., & Beckstead, A. L. (2004). 'Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy.' *The Counseling Psychologist*, 32(5), 641-650.

Nadal, K. L. (2013). 'Sexual orientation microaggressions: Experiences of lesbian, gay, and bisexual people'. *Thats so Gay! Microaggressions and the Lesbian, Gay, Bisexual, and Transgender Community.*, 50-79. doi:10.1037/14093-004

O'Shaughnessy, T., & Speir, Z. (2018). 'The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis'. *Psychology of Sexual Orientation and Gender Diversity*, 5(1), 82.

Potter, S. (2020). *Therapy with a Map: A Cognitive Analytic Approach to Helping Relationships*. Pavilion Publishing and Media Limited.

Przeworski, A., Peterson, E., & Piedra, A. (2021). 'A systematic review of the efficacy, harmful effects, and ethical issues related to sexual orientation change efforts'. *Clinical Psychology: Science and Practice*, 28(1), 81.

Ryle, A., & Kerr, I. B. (2020). *Introducing cognitive analytic therapy: Principles and practice of a relational approach to mental health*, Second Edition. John Wiley & Sons.

Ryle, A. (1975). 'Self-to-self, self-to-other: The world's shortest account of object relations theory'. *New Psychiatry*, 24, 12-13.

Talbot, J., & Finlay, F. (2022). 'Conversion therapy: change the law not the person'. *Archives of Disease in Childhood*.

Taplin, K., Greenhill, B., Seddon, C., and McGuire, J. (2018). 'Service User Experiences of CAT diagrams: an Interpretative Phenomenological Analysis'. *International Journal of CAT and RMH.* 2, 75-96.

Wilde McCormick, E. (2017). 'Change for the Better: Personal development through practical psychotherapy'. *Change for the Better*, pp.1-312.

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

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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

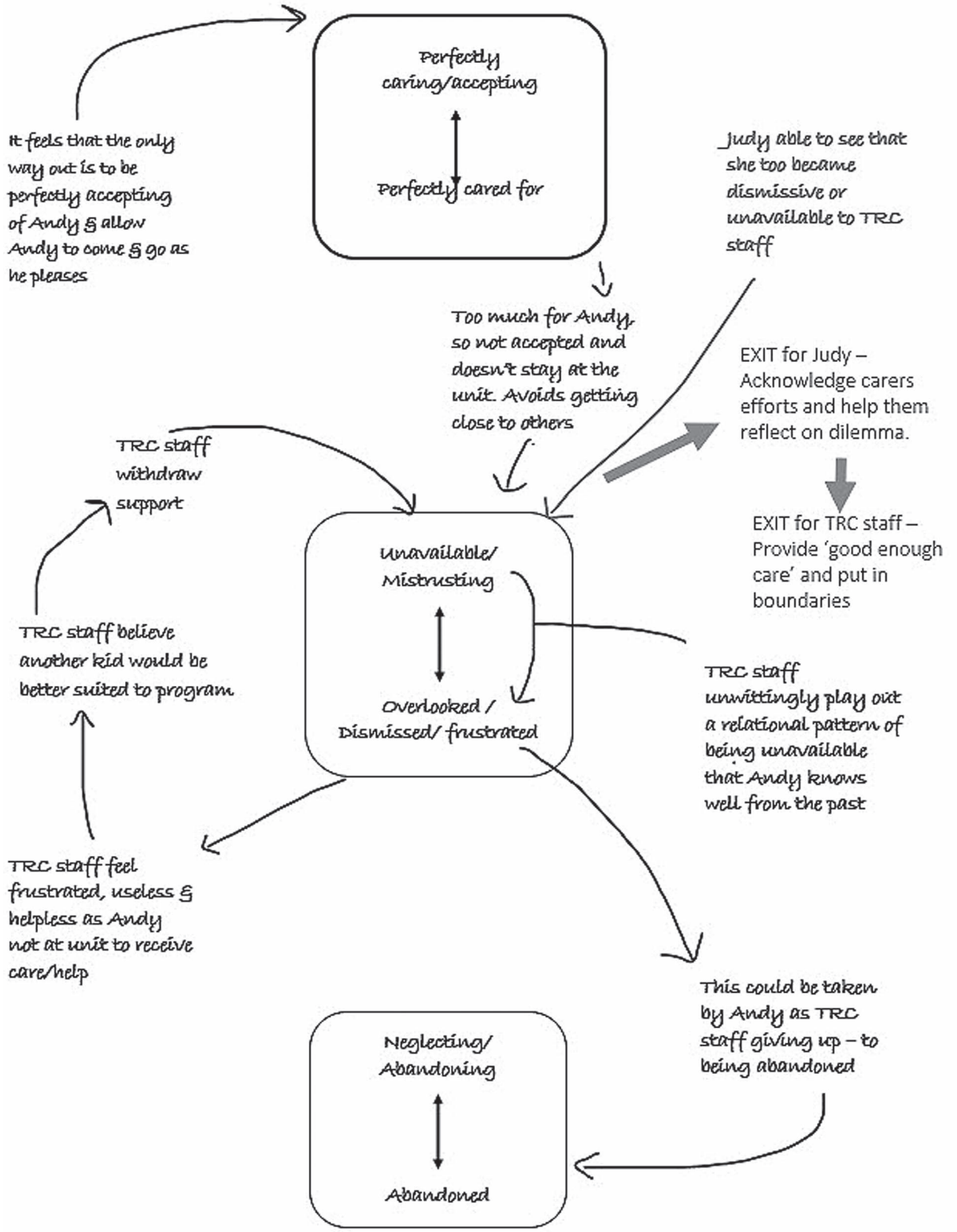

Figure 1: Map completed with Judy

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. □

REFERENCES

Australian Institute of Health and Welfare (2022) *Child protection Australia 2020–21*, AIHW, Australian Government, 15 June 2022. Child Welfare series no. 77. Cat no. CWS 87. Data table T3.

Australian Productivity Commission (2022) *Report on Government Services 2022*, Part F, Section 16: Released on 25 January 2022. viewed 20 July 2022, https://16 Child protection services - Report on Government Services 2022 - Productivity Commission (pc.gov.au)

Caplan, G. (1970). *The theory and practice of mental health consultation*. New York: Basic Books.

Caplan, G., Caplan, R.B. & Erchul, W.P. (1994) Caplanian Mental Health Consultation: Historical background and current status. *Consulting Psychology Journal*, *46*, pp. 1061-4087, viewed 4 April 2022, https://doi: 10.1037/1061-4087.46.4.2

Calvert R., & Kellett S. (2014) Cognitive analytic therapy: a review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*, pp. 253-277, viewed 15 June 2022, https://doi: 10.1111/papt.12020.

Carradice, A. (2017) Supervising CAT consultancy in mental health teams. In Pickvance, D. (Ed) *Cognitive Analytic Supervision: a relational approach*. (pp. 209 – 221) Abingdon USA: Routledge.

Cox, A., Frederico, M., Mosse, H., Radford, L., Ambry, D. & Ryan, C. (2021a) Australian maltreated infants with neurodevelopmentally and trauma-informed interventions provided within relationally-positive and stable environments. *Frontiers in Psychiatry*, *12*, https:// doi: 10.3389/fpsyt.2021.680343

Cox, A., Perry, B.D. & Frederico, M. (2021b) Resourcing the system and enhancing relationships: Pathways to positive outcomes for children impacted by abuse and neglect. *Child Welfare*, *98*, 177-201.

Ghag, J., Kellett, S. & Ackroyd, K. (2021) Psychological consultancy in mental health services: A systematic review of service, staff, and patient outcomes. *Psychology and Psychotherapy Theory, Research and Practice*, *94*, 141-172, viewed 20 July 2021, https://bpspsychub.onlinelibrary.wiley.com/doi/10.1111/papt.12264

Kellett, S., Wilbram, M., Davis, C. & Hardy, G. (2014) Team consultancy using cognitive analytic therapy: a controlled study in assertive outreach. *Journal of Psychiatric and Mental Health Nursing*, *21*, pp. 452-464, viewed 20 July 2021, https://doi: 10.1111/jpm.12123

Kellett, S., Ghag, J., Ackroyd, K., Freshwater, F. Finch, J., Freear, A., Hartley, J. & Simmonds-Buckley, M. (2020) Delivering cognitive analytic consultancy to community mental health teams: Initial practice-based evidence from a multi-site evaluation. *Psychology and Psychotherapy Theory, Research and Practice, 93*, pp. 429-455, viewed 16 July 2021, https://doi:10.1111/papt.12221

Lambert, N.M., Hylander, I., & Sandoval, J.H. (Eds.). (2004). Consultee-Centered Consultation: Improving the Quality of Professional Services in Schools and Community Organizations (1st ed.). Routledge. Viewed 1 September 2021 https://doi.org/10.4324/9781410610355

Mendoza, D.W. (1993) A review of Gerald Caplan's Theory and Practice of mental health consultation. *Journal of Counselling & Development, 71*, 629-635.

Purvis, K.M., Cross, D.R., Dansereau, D.F. & Parris, S.R (2013) Trust-Based Relational Intervention (TBRI): A Systemic Approach to Complex Developmental Trauma. *Child & Youth Services, 34*, pp. 360–386, viewed 17 July 2021, https://doi.org/10.1080/0145935X.2013.859906

Ryle, A. Kerr, I. (2020) *Introducing Cognitive Analytic Therapy, Principles and Practice of a Relational Approach to Mental Health* (2nd ed.). New Jersey: John Wiley & Sons Ltd.

Southall, A. (2005) Consultation in Child and Adolescent Mental Health Services, Oxfordshire, United Kingdom: Radcliffe Publishing Ltd.

Thompson, A.R., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J. & Kerr, I.B. (2008) Multidisciplinary community mental health team staff's experience of a 'skills level' training course in cognitive analytic therapy. *International Journal of Mental Health Nursing, 17*, pp. 131-137, viewed 20 July 2021, https://DOI: 10.1111/j.1447-0349.2008.00521.x

van der Kolk, B.A., & Courtois, C.A. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress, 18*, pp. 385-388.

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

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Introduction

CAT is a time-limited psychotherapy that integrates cognitive and analytic models. It takes a relational approach to therapeutic change, with the collaboration between the therapist and the client playing a central role. CAT derives from Object Relations Theory (Ogden, 1983) and Kelly's Personal Construct Theory (Kelly, 1955) which suggest that early reciprocal interactions with significant others influence an individual's representation of themselves, the world and others. These templates are internalised as reciprocal roles. The objectives of CAT are for the client to identify their target problems and the target problem procedures that keep them stuck in the same patterns of behaviour. Another objective of CAT is to look at the underlying causes of the problems in terms of their early experiences, and to discover that choices and doing things differently ('exits') are possible through recognising their target procedures, reformulating and revising these with different exits. Traps, snags and dilemmas ('target problem procedures') are problematic patterns of social interaction and restricted or damaging self-care (Ryle & Kerr, 2002). CAT targets intrapsychic and interpersonal problems by implementing a phased approach to therapeutic change of reformulation, recognition and revision. In the middle stages of therapy, tools are matched to demands of the phases of therapy (Ryle & Kerr, 2002). These can include the psychotherapy file (Ryle & Kerr, 2002), the six-part story (Dent-Brown, 2001) and compassion-focused ideas.

Emerging evidence suggests that CAT can be utilised to support individuals with a range of physical and emotional conditions. Baronian and Leggett (2020) explored the effectiveness of 8-session CAT for clients with persistent pain. There were large pre–post effects on self-efficacy (d = 1.13) and wellbeing (d =1.50). Reliable change and clinical significance analyses found clinically meaningful results. Many of the clients (67.9%) showed reliable improvement following the CAT intervention. Evans et al. (2017) found that clients with bipolar disorder reflected that the recognition of patterns of mood variability was the most common helpful event during CAT. However, there were no major differences between psychometric outcomes when compared to the treatment as usual (TAU) group. Taylor et al. (2019) reported that clients with non-affective psychosis demonstrated improvement in perceived recovery and personality integration but that there was limited evidence of change in psychotic symptoms. A recent systematic review by Hallam et al. (2020) explored the acceptability, effectiveness, and durability of CAT. Twenty five studies provided pre and post CAT treatment outcomes and were aggregated across three outcome comparisons of depression, functioning, and interpersonal problems. CAT produced large pre-post reductions in depression symptoms (ES = 1.05, 95% CI 0.80–1.29, N = 586), large pre–post improvements in global functioning (ES = 0.86; 95% CI 0.71–1.01, N = 628), and moderate to large improvements in interpersonal problems (ES = 0.74, 95% CI 0.51–0.97, N = 460). At follow-up, all these effects were maintained or improved upon. These findings show positive early indicators of CAT utility for a range of conditions, yet research remains in its infancy.

Some studies have explored the utility of CAT when working with clients with personality disorder. A bibliometric review of CAT found that most of the research has focused on the use of CAT with clients with emotionally unstable personality disorder (35%) (Gimeno & Chiclana, 2016). A systematic review by Calvert and Kellett (2014) explored the effectiveness of CAT and reported that CAT was central to the treatment of personality disorder in 44% of the studies. A randomised controlled trial (RCT) by Clarke, Thomas and James (2013) followed up on the utility of CAT specifically for clients with a personality disorder. The RCT was conducted within the service from which the current dataset was taken and was a robust, high quality study exploring the effectiveness of CAT compared with a TAU condition. CAT participants showed significant improvements in interpersonal functioning and significant reductions in symptomatic distress, in comparison with TAU participants. At post-therapy, CAT participants no longer met symptomatic criteria for personality disorder (33%), whereas all TAU participants remained symptomatic. In another study, CAT and manualised good clinical care (GCC) were compared in an RCT of 86 out-patients, aged 15–18 years, who met two to nine of the DSM–IV criteria for borderline personality disorder. There was no significant difference between the outcomes of the treatment groups at 24 months, but results suggested that patients allocated to CAT improved more rapidly. The current literature suggest that CAT is a promising therapy for complex presentations, but that further research contributions are required to be able to generalise these outcomes more widely.

This paper aimed to examine the psychometric outcomes following a CAT intervention in a psychological therapies service. It is hoped that the findings will contribute to the emerging evidence base for using this type of psychotherapy for clients with longstanding mental health difficulties.

Method

The Service

The Intensive Psychological Therapies Service (IPTS) in Poole offers psychological therapies including CAT, Dialectical Behavioural Therapy (DBT), Radically-Open Dialectical Behavioural Therapy (RO-DBT) and Eye Movement Desensitisation and Reprocessing (EMDR). CAT has been offered at IPTS since the mid 1990s. The use of CAT has increased in this time as the number of accredited and trainee CAT therapists has grown.

CAT Assessment

Clients were referred to IPTS via their community mental health team (CMHT) and were invited to attend an assessment by a member of the IPTS multi-disciplinary team who may or may not have been trained in CAT. The assessment included the completion of psychometric tests and engaging in a clinical interview. The Structured Clinical Interview for DSM-5 (SCID-5) is a semi-structured interview guide administered by a clinician or trained mental health professional. The interview can be used to help professionals make DSM-5 diagnoses. Clients completed the SCID-5 again after CAT. The assessment also gathers information about the client's history, risk issues, current functioning and goals for therapy. The assessments were discussed in a Clinical Decisions Meeting or CDM (with two Clinical Psychologists present) before agreeing to refer the clients for CAT. The clinician who carried out the assessment was from a Mental Health Nursing or an Occupational Therapy background and was trained in at least one core therapy, not necessarily CAT. The two Clinical Psychologists present in the CDM were trained in a number of core therapies, including CAT. The decision about the client's suitability for CAT is based on the client's identified goals being relational and them having an ability to manage emotions, whilst exploring their past and current problems.

Sample and Data Collection

21 clients were assessed as suitable for CAT and completed pre-, mid- and post-therapy outcome measures. When people were referred from a CMHT, they would be assessed as suitable for CAT rather than for the alternative therapies using the following criteria:

- Are they able to relate their past experiences to their current problems in relating to themselves and others?
- Are they able to manage emotional dysregulation without significant harm to self or others?

Clients started and ended therapy between November 2017 and November 2019 and there were no therapy dropouts from any of the 21 clients. The last CAT client was discharged after their follow-up session in February 2020. 14 clients had 24 sessions of therapy, four had 20 sessions and three had 16 sessions. In comparison, 20 clients started DBT, 38 clients started RO-DBT, and 2 clients started EMDR during the same time period.

Therapeutic Content

Therapy followed the basic 16 to 24 session CAT model, involving an initial focus on reformulation, identifying target problem procedures and underlying reciprocal roles. After the reformulation phase of CAT, the therapist would take the case for supervision and discussion in the service's clinical decisions meeting. At this stage, the total number of CAT sessions to be offered was agreed, based on their engagement and the complexity of their presentation. Further sessions involved development of a reformulation and map (previously called a Sequential Diagrammatic Reformulation or SDR), a focus on developing recognition of underlying patterns and procedures, exploration of potential exits, an emphasis on dynamics within the therapeutic relationship and work on the ending of therapy. Each client was offered a follow-up appointment with their therapist three months after the completion of CAT.

Therapist Accreditation

All therapists had completed an Association for Cognitive Analytic Therapy (ACAT) accredited practitioner training course or were in the process of training and were supervised by an ACAT accredited practitioner. Each case was discussed in weekly supervision with an ACAT accredited supervisor.

Outcome measures

Clients consented to complete a series of outcome measures to assess psychological symptoms, wellbeing and functioning, intrapersonal and interpersonal difficulties. Measures were taken at the start, middle and end of CAT. A list of all outcome measures can be found in Table 1 below.

Outcome measure name	What does it measure?	Number of items/ questions on the outcome measure
Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5)	Frequency and intensity of PTSD symptoms	20
Dissociative Experiences Scale (DES)	Severity of dissociative symptoms	28
Inventory of Interpersonal Problems (IIP-32)	Assesses difficulties in interpersonal relationships	32
Clinical Outcomes in Routine Evaluation (CORE-34)	Assesses general psychological distress, wellbeing, risk factors, functioning and physical symptoms	34
Acceptance and Action Questionnaire (AAQ-II)	Measures psychological flexibility and resilience	7
Brief Overcontrol Scale (BOS)	Measures level of overcontrol	17
Symptom Checklist (SCL-90)	Measures the subjective symptom burden in clients with mental disorders	90

Table 1: List and descriptions of all the outcome measures used in this service evaluation

Ethical Consideration

This evaluation was an attempt to explore whether CAT was effective in improving psychological wellbeing and reducing emotional distress. Patient consent to complete outcome measures was given at the start of therapy. The need to submit to a formal ethics committee was considered but following advice from the Trust Clinical Audit Team; this was not required, due to patient consent being given, meeting the NHS trust criteria for client confidentiality and anonymisation for research purposes.

Results

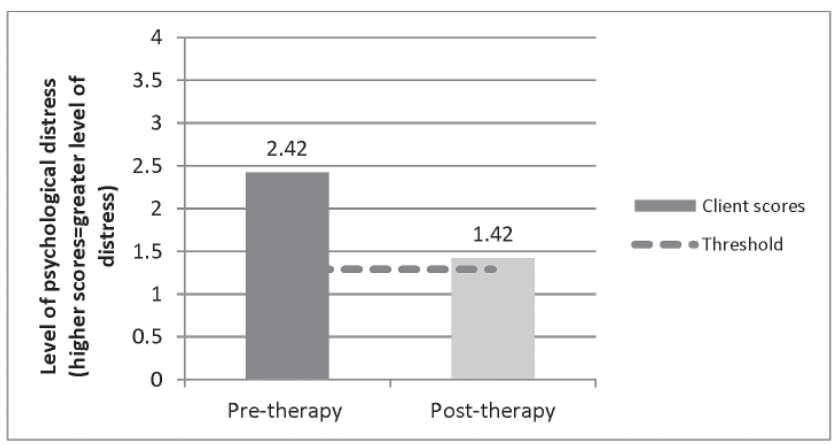
Paired sample t-tests were run using SPSS (Version 26) for the outcomes measures that clients completed pre- and post-CAT. The analysis accounted for missing values across some of the outcome measures – please see Graphs 1-7. Although a strong effort was made to collect psychometric scores at both pre- and post-therapy, some data from participants were missing due to unreturned or incomplete psychometric tests. The authors recoded the missing variables in SPSS before running the analyses. This provided accurate results, only accounting for variables which were available to the authors. Most analyses completed accounted for the whole sample (n=21). However, the number of participants that were included in each analysis can be found in the descriptive statistics (see Table 2 below).

Outcome measure		Mean	N	SD	SEM
CORE	Pre score	2.4162	21	0.67057	0.14633
	Post score	1.4243	21	0.79191	0.17281
BOS	Pre score	63.8571	21	17.83616	3.89217
	Post score	73.2381	21	15.21481	3.32014
PCL-5	Pre score	53.6875	16	10.64405	2.66101
	Post score	24.7500	16	15.97707	3.99427
DES	Pre score	25.5655	20	17.91346	4.00557
	Post score	17.6245	20	13.81355	3.08880
IIP-32	Pre score	2.0119	21	0.52494	0.11455
	Post score	1.3933	21	0.47827	0.10437
AAQ-II	Pre score	14.9524	21	7.72966	1.68675
	Post score	27.1429	21	8.81071	1.92265
SCL-90	Pre score	181.9	20	57.27395	12.80684
	Post score	107.1	20	69.73174	15.59249

Table 2: Paired-sample statistics for each of the outcome measures.
N=number; SD=Standard Deviation; SEM=Standard Error Mean

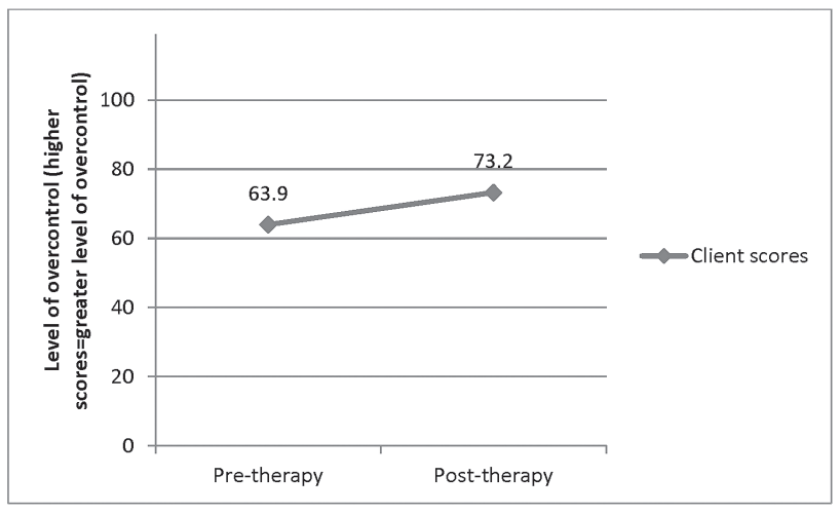
Results showed that there was a statistically significant decrease in clinical symptoms between pre- and post-therapy and this was observed across all the outcome measures described in this paper. For further details on scores, please refer to Graphs 1-7.

Average CORE-34 scores (n=21)



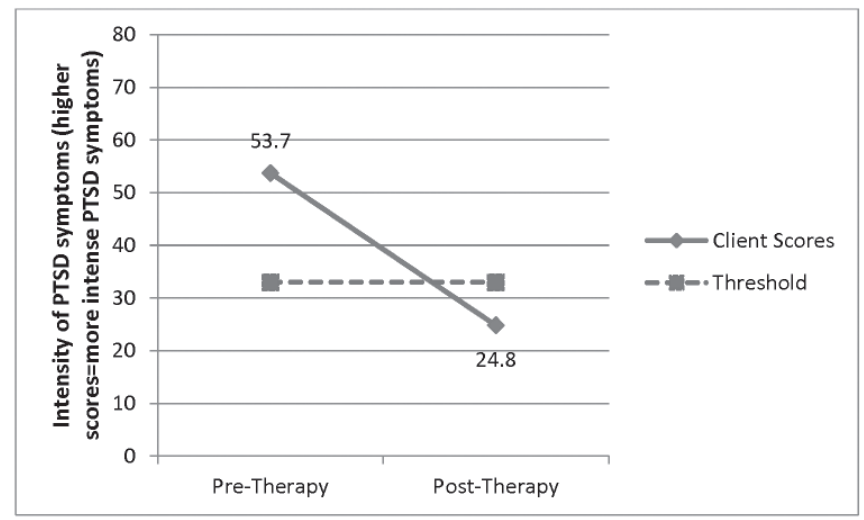
Graph 1: Average scores for pre- and post-CAT on the Clinical Outcomes in Routine Evaluation (CORE-34) outcome measure.

Average BOS scores (n=21)



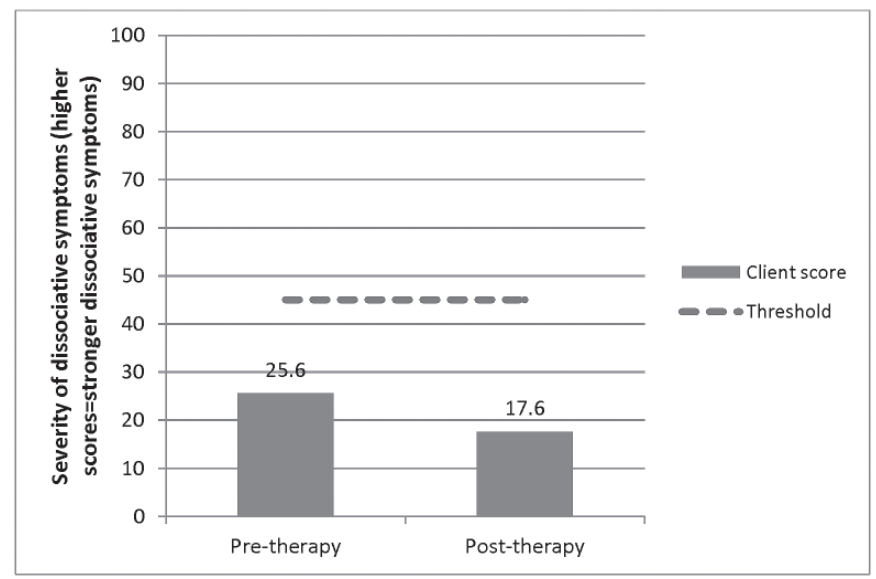
Graph 2: Average scores at pre- and post-CAT on the Brief Overcontrol Scale (BOS) outcome measure. (author's note: these scores represent an improvement).

Average PCL-5 scores (n=16)



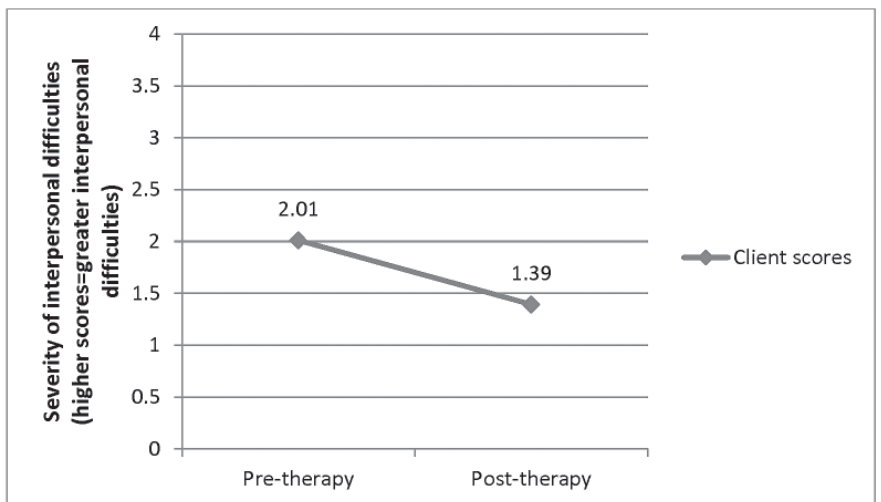
Graph 3: Average scores at pre- and post-CAT on the PTSD Checklist for the DSM-5 (PCL-5) outcome measure.

Average DES scores (n=20)



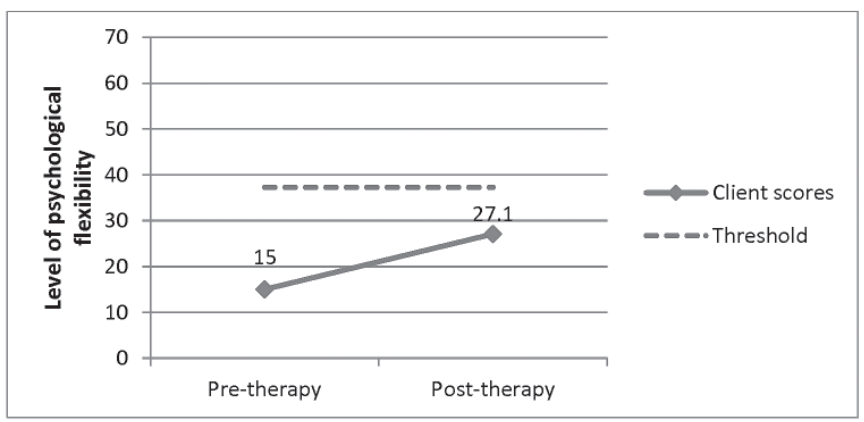
Graph 4: Average scores at pre- and post-CAT on the Dissociative Experiences Scale (DES) outcome measure.

Average IIP-32 scores (n=21)



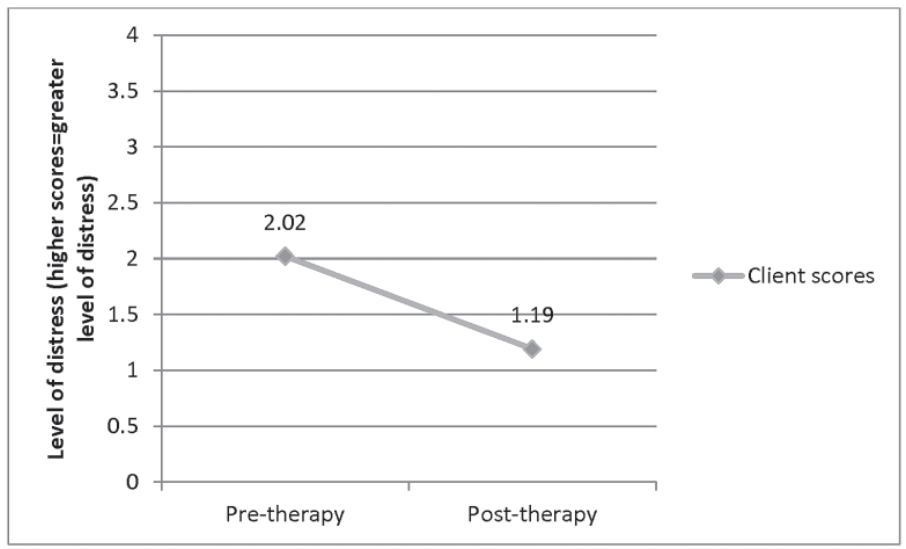
Graph 5: Average scores at pre- and post-CAT on the Inventory of Interpersonal Problems (IIP-32) outcome measure.

Average AAQ-II scores (n=21)



Graph 6: Average scores at pre- and post-CAT on the Acceptance and Action Questionnaire (AAQ-II) outcome measure.

Average SCL-90 scores (n=20)



Graph 7: Average scores at pre- and post-CAT on the Symptom Checklist (SCL-90) outcome measure.

Discussion

Summary

The statistically significant changes in pre- and post-therapy scores across all psychometric measures indicated that there was a substantial improvement in clinical symptoms throughout the therapy period of CAT. More specifically, these changes demonstrated a decrease in pathological symptomatology as well as an increase in psychological flexibility. This demonstrates that CAT could have a positive impact on multiple aspects of psychological wellbeing in clients with complex presentations, like personality disorder. The results suggest that CAT might have played a role in facilitating improvements in interpersonal difficulties, as measured by the IIP-32, and this may have been anticipated due to the relational focus of CAT. However, it is encouraging to reflect that CAT appeared to give rise to benefits across a range of other psychological domains, including dissociation (as shown by the DES), psychological flexibly and experiential avoidance (as shown in the AAQ), and over controlled and obsessional characteristics (as shown in the BOS). These are promising outcomes that support further research into this area.

Strengths and Limitations

There are some limitations to this service evaluation. The small sample size reduces statistical power to determine an effect size and lowers reproducibility. Additionally, the lack of control group and uneven group sizes makes it difficult to generalise the results. There was variation in the number of CAT sessions that the participants attended (e.g. 16, 20 or 24 sessions) but analysis to compare the effect of treatment length was not conducted. Subsequently, any between-group differences cannot be inferred.

It is important to note that even though a statistically significant reduction in clinical symptoms was observed, there would need to be additional studies to compare CAT to other therapies and reproduction of the current results, to definitively indicate that it was CAT that led to symptom reduction.

The service evaluation may have benefited from describing demographic characteristics, such as ethnicity and age, to help recognise patterns of service access and qualitative data would allow assessment of whether the change that was measured was consistent with the lived experience of the therapy.

Clinical Implications

These findings suggest that CAT can be utilised effectively in therapeutic work with clients with personality disorder. It is hoped that this will add to the emerging evidence for offering CAT and help to develop knowledge and awareness about this form of psychotherapy. The results also suggest that CAT can be effective in supporting improvements across a range of psychological constructs, not just relational factors, as may be anticipated from a relational psychotherapy.

The authors who were delivering CAT as a therapy hoped that in starting this piece of work they would find that CAT was beneficial to clients with significant interpersonal difficulties. These outcomes further strengthened their belief that CAT is an effective time-limited intervention for people with longstanding mental health difficulties.

Recommendations for Future Service Evaluation/Research

The results of the present study invite recommendations for future service evaluation/research:

- To continue to gather outcome data to add to the evidence base and to replicate the service evaluation with a larger client sample.
- To look at clinical and significant change between pre- and mid-therapy scores on the outcome measures.
- To gather qualitative information from clients to allow for a richer and deeper understanding of the client's experience of change during CAT.
- To gather service demographics to explore the characteristics of the clients accessing IPTS and to compare against local and national data. This will support social inclusion and facilitate service development in accordance with the needs of client population.
- To ensure that the client sample is representative of the wider population and that more detailed demographic data were provided (e.g. gender, age, ethnicity, etc.)
- Using a randomised controlled trial methodology to compare CAT to a control group to demonstrate the causal link between CAT and and decrease in clinical symptoms. □

References

Baronian, R., & Leggett, S. J. (2020). Brief cognitive analytic therapy for adults with chronic pain: a preliminary evaluation of treatment outcome. *British Journal of Pain, 14*(1), 57–67. doi.org/10.1177/2049463719858119

Calvert, R. & Kellett, S. (2014). Cognitive analytic therapy: a review of the outcome evidence base for treatment. *Psychology and Psychotherapy, 87*(3): 253-277.

Chanen, A.M., Jackson, H.J., McCutcheon, L.K., et al. (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *The British Journal of Psychiatry, 193*, 477–484.

Clarke, S., Thomas, P. & James, K. (2013). Cognitive analytic therapy for personality disorder: randomised controlled trial. *The British Journal of Psychiatry, 202*, 129–134. doi: 10.1192/bjp.bp.112.108670

Dent-Brown, K. (2001). Story as therapeutic tool: The Six-Part Story Method. *Context, 55*, 22-23.

Evans, M., Kellett, S., Heyland, S., Hall, J., & Majid, S. (2017). Cognitive analytic therapy for bipolar disorder: A pilot randomised controlled trial. *Clinical Psychology & Psychotherapy, 24*, 22–35. doi.org/10.1002/cpp.2065

Gimeno, E. & Chiclana, C. (2016). Cognitive analytic therapy: A bibliometric review. European Psychiatry, 33, doi: 10.1016/j.eurpsy.2016.01.581

Hallam, C., Simmonds-Buckley, M., Kellett. S., Greenhill. B. & Jones, A. (2020). The acceptability, effectiveness, and durability of cognitive analytic therapy: Systematic review and meta analysis. *Psychology and Psychotherapy*. doi.org/10.1111/papt.12286

Kelly, G. A. (1955). *The psychology of personal constructs. Vol. 1. A theory of personality. Vol. 2. Clinical diagnosis and psychotherapy.* W. W. Norton.

Ogden, T. (1983). The concept of internal object relations. *International Journal of Psycho-Analysis, 64*, 227-241.

Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice.* Oxford, UK: Wiley-Blackwell.

Taylor, P., Perry, A., Hutton, P., Tan, R., Fisher, N., Focone, C., Griffiths, D., & Seddon, C. (2018). Cognitive analytic therapy for psychosis: A case series. *Psychology and Psychotherapy: Theory, Research and Practice,1–20.* doi.org/10.1111/papt.12183

Evaluating the Covid Struggles List:

A CAT scaffolding tool for supporting staff well-being

Dr CLAIRE MAYER, Dr STEVE JEFFERIS

Abstract: This paper describes the evaluation of a CAT-informed tool to support reflective practice, the Covid Struggles List (CSL). The tool captures the experiences of staff in a UK Mental Health NHS Trust early in the Covid-19 pandemic, framed as CAT 'procedures'. The evaluation aimed to explore how the tool had been used, the experience of those using it, and the potential implications for future use of CAT-informed approaches with staff, teams and organisations.

Across 19 responses to an online questionnaire, thematic analysis produced six themes: *'I see me; I feel seen'; 'Widely applicable and accessible'; 'Collective validation'; 'Permission to talk, and to feel'; 'Opening up possibilities'; and 'Developing psychological skills'.* An unintended benefit of the CSL was the emotional benefit described by the scaffolders for themselves. The evaluation confirmed the potential acceptability and applicability of CAT-informed tools to support staff well-being across settings and professions, and that this can be done quickly, effectively and at low cost.

Keywords: COVID, Scaffolding, CAT, wellbeing, reflective practice

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Introduction

The Covid-19 pandemic

The spread of SARS-COV2, the virus that causes Covid-19, was declared a pandemic by the World Health Organisation on March 11th 2020. During March, the governments of the United Kingdom called a national lockdown. By the end of March 2020, 23,539 people in the UK had been admitted to hospital with Covid-19, 4,425 people had died and 38,436 had tested positive for the virus (UK Government, 2020).

Against this background, healthcare workers continued to work, and to adapt and deliver health services in unprecedented circumstances. Retrospective research (e.g., Rains et al., 2020) found the concerns of staff working in mental health services at the time to centre on anxieties about infection from Covid, lack of access to Personal Protective Equipment, difficulties in moving from face-to-face to remote working, staff sickness absence and worries about potential re-deployment to meet changing service demands. Simultaneously, many staff were supporting patients grappling with their own worries, as well as seismic shifts in their social contact, routines and activities. Staff working in in-patient settings had additional challenges, such as how to confine patients to their rooms to isolate. Services and staff were required to adapt quickly in a context of personal and professional uncertainty.

Cognitive Analytic Therapy as a model for teams, organisations and systems

CAT–informed approaches are becoming well established in work with teams, organisations and systems (Corbridge et al., 2017). '5 Session CAT' is a consultation model for psychologically informed care planning, involving client and care co-ordinator (Carradice, 2013). CAT has been used for team formulation, such as on an in-patient unit for women with a diagnosis of personality disorder (Stratton and Tan, 2019). It has supported the management of difficult relationships and the resulting governance issues in health teams (e.g., Walsh, 1996). Kirkland & Marshall (2021) identify a wide range of ways CAT can support reflective practice in forensic settings. Carson and Bristow (2015) make the case for how CAT can help colleagues, teams, leaders and the NHS at a systemic level. The CAT-informed 'Helper's Dance List' (Potter, 2013), which inspired the Covid Struggles List (CSL), emerged from conversations with those caring for people with intellectual disabilities about their common experiences, framed as CAT 'procedures'.

The Covid Struggles List

In the context of the distinct challenges facing health service staff during the pandemic and given the potential of the CAT model and its tools to support and contain staff, the second author developed the CSL (Jefferis, 2020) (see Appendix). Working in a specialist CAT therapy service within a UK Mental Health Trust, there was a systemic pull to dive in as 'psychological experts' to offer staff psychological interventions. However, there was emerging evidence from China (Chen et al., 2020) that organisational presumptions about what support was needed did not always match staff ideas of what was helpful. Accordingly, in the first month of lockdown, reflective consultations were held with individual staff and groups of team leaders about their experiences, capturing their views on what could support staff well-being. During these consultations, the process of reflection itself appeared to be most helpful, including naming struggles and hearing others' experiences. There were striking similarities in the challenges described by staff members from different teams. From these conversations the staff experiences were summarised in the form of CAT procedures (here renamed 'struggles') on a simple, two-page document, intended for use as a tool to scaffold reflective practice.

The main themes of the struggles were adaptation, identity, connection, threat, authority, exhaustion, heroism, home vs work, boundaries and overwhelm. In writing the procedures the emphasis was on accessible description, and largely avoided technical CAT language, with the exception that some struggles were explicitly framed as either/or 'dilemmas'. The original consultees had named some 'exits' including voicing and normalising struggles, self-permission, compassion and connecting. These were included on the CSL as a way of offering hope and opening up discussion of possibilities. However, the main aim was to promote reflection rather than find solutions. The CSL was refined through further staff consultation, and then distributed freely and widely; through internal trust networks, by email through professional CAT networks, and on social media via the second author and via ACAT. Informal feedback from health professionals across the country indicated that they and others were using it in their workplaces, which suggested more in-depth evaluation would be beneficial.

Evaluation rationale and aims

With the take up of the CSL via these networks came an opportunity to evaluate its use: to inform future development of the use of CAT with staff, to consider the use and value of CAT tools within reflective practice, and to contribute to the growing evidence base for CAT scaffolding and consultation approaches. The evaluation set out to look at how the CSL had been used to scaffold reflective practice across different settings and professions, and to explore perceptions of the CSL and its impact.

It was in effect a proof-of-concept exercise, centred on what could

be learned from the experience of the CSL that could be applied more widely and in the future.

Kirkpatrick and Kirkpatrick (2006) set out four levels of impact evaluation that apply here: reaction, learning, behaviour, results. This evaluation focuses primarily at the levels of reaction and learning, touching on subjective perceptions of behaviour change.

Method

Procedure

A10-itemquestionnaire was developed and hosted on www.survey monkey.com. This asked about the respondent, their views on the CSL, how they had used it, their perceptions of its impact, others' reactions to it and their thoughts on what makes 'good' scaffolding tools. The questionnaire collected quantitative and qualitative data; three questions had closed options and the rest were free text.

The target participants were professionals who had used the tool in their own work settings to scaffold others' reflective practice. They were recruited through convenience sampling (Cresswell & Clark, 2011). The link to the survey was distributed by email by the second author to those who had expressed an interest in the CSL, shared on Twitter, and circulated through internal NHS trust networks. The survey was open for one month during mid-2020, and 19 responses were received. Participants answered anonymously.

The evaluation formed part of the first author's course requirements for a Doctorate in Clinical Psychology. Authorisation was given by the course's university host, and by the host NHS trust Research and Development team.

Analysis

Descriptive statistics were developed from the closed response questions. Thematic analysis was conducted on free text using Braun and Clarke's (2006) steps: familiarisation with the data, coding, generating initial themes, reviewing themes, defining and naming themes, and writing up. NVivo 12 for Mac aided analysis. Comments on the original Twitter and Facebook posts distributing the CSL were used to triangulate the findings, as was a word frequency word cloud generated from survey responses.

Results

A. Descriptive statistics

The majority of respondents (7 of 19) were Clinical Psychologists. The remainder came from other professions including different therapy modalities, a psychiatrist, an assistant psychologist, an administrator and a librarian. As regards levels of familiarity with CAT, there was 1 CAT supervisor, 8 CAT practitioners, and the remainder had either a non-specialist general awareness, or no awareness, of CAT. 11 were from mental health NHS trusts, 5 from acute NHS trusts, 2 from non-NHS organisations and 1 unstated. Most received the CSL indirectly from colleagues or via social media or the internet, with Twitter the most common route of access. All respondents from outside the local area were CAT practitioners or supervisors and found the CSL through social media.

B. Thematic analysis[1]

The six themes emerging from the analysis are described below.

1. I see me; I feel seen

One of the most striking elements of the feedback is the near universal resonance of the CSL to how the respondents themselves felt at the time, both personally and professionally. In seeing this named, it helped them to feel 'seen', validating and normalising their feelings and experiences during the early stages of the pandemic. It also enabled them to realise these were widely shared:

> 'OMG, that's me! Exhausted and jaded, wanting to hide away.' (P3)

> 'It was most helpful to have a list making the common struggles easily accessible and helping me to think and make things I was already thinking but hadn't really named.' (P10)

> 'it was incredibly normalising to read the range of responses.'(P19)

Explicit recognition of the personal resonance of the CSL was most common amongst those with senior roles and those who were CAT qualified. This resonance appeared to be the impetus to share the CSL and to use it with colleagues and teams. It contributed to the 'removal of "other" status', and was 'a tool for all.' (P11)

[1] Participant reference is given after each

2.. Widely applicable and accessible

The CSL had been used in a wide variety of ways. Some respondents explicitly mentioned its influence on their own thinking and practice, in helping them reflect personally and professionally. A number had used it with clients. Most had used it as a tool to start discussions with staff: in reflective practice sessions, in team meetings and in individual meetings, as well as distributing it by email. Two had not shared it further.

The range of settings and staff the CSL had been used in and with is notable in its breadth. Settings included: in acute and urgent care, the Frontline19 support service for NHS staff, an administrative team, a community brain injury team and adult social care. Those it was shared and discussed with were: Nurses, healthcare support workers, Occupational Therapists, Doctors, Community Psychiatric Nurses, Managers, Clinical Psychologists, Psychiatrists, a Benefits Advisor, Fundraiser, shielding staff, staff who had been redeployed, housekeeping staff and schools. Its accessibility to non-psychologists was seen as a strength:

> 'I was slightly apprehensive about sharing it with a ward team (not psychologists) because of the level of self-reflection needed, however everyone was able to use and relate to it.' (P12)

A number of respondents mentioned that being located remotely from team members hindered their ability both to use the CSL more pro-actively and to gauge others' response to it. There were other limits to its usefulness for some:

> 'Others [colleagues] either weren't bothered, had their own ideas in place or just didn't want to admit that there were problems with themselves or the workplace.' (P1)

> 'We were all just trying to adjust to offering therapy remotely and incredibly busy. Conversations (when they happened) tended to be kept light and focused on practical problems.' (P19)

3. Collective validation

The CSL helped to validate and normalise teams' and colleagues' feelings and experiences. Seeing these written down and named had been powerful:

> 'I used it to present to my team as a CPD session during lockdown. It was extremely helpful and resonated with a lot of people in the team. It helped us make sense of our experiences.' (P12)

In many places the CSL had been a conduit for people sharing feelings, difficulties and experiences with each other, and to make collective sense of these, allowing for both similarity and difference:

> 'Feedback was. . . it was good to be able to talk through their experiences and that the struggles list made sense of a lot of what they had been feeling.' (P10)

Perceptions of the impact included staff feeling: less angry and anxious, more listened to, energised and connected with and understanding of each other, and able to open up conversations that carried on after the session:

> 'It has helped them think about how they work with their teams, re-charged their batteries to an extent.' (P4)

> 'Received very positive feedback on the sessions, some people in the team said it almost felt like therapy and created a safe space for us to think/ reflect and share experiences/ thoughts /feelings.' (P12)

> 'Tools like this normalise distress and help people share connections with each other.' (P10)

4. Permission to talk, and to feel

The CSL normalised the unprecedented personal and professional struggles of staff during the pandemic:

> 'Staff found it humanising and it gave permission for staff to voice previously unvoiced feelings.' (P1)

> 'I remember people being more forthcoming in sharing examples about not feeling like a hero and it was really validating.' (P8)

It enabled conversations to happen that may have been difficult or avoided, at a time of uncertainty and pressure:

> 'It helped open discussion about the way difficult team dynamics had emerged.' (P7)

> 'It was a way to scaffold a conversation in teams where talking about feelings are seen as a weakness (prison setting).' (P14)

It provided a structure for reflection, a 'tool to invite conversations' (P11), that was unthreatening, easily accessible, reflected difference and resonated emotionally:

> 'Knowing what's normal makes things that feel shameful, embarrassing or unspeakable, possible to talk about.' (P10)

5. Opening up possibilities

The CSL was intentionally non-directive, giving ideas to explore not instructions.

> 'They present different possibilities – thus enable exploration of difference – not everyone thinks or feels like me. They give ideas, points for discussion – not rights or wrongs.' (P4)

> 'It was not at all patronising. It did not make grand claims but gave practical, uncomplicated ideas to try as suggestions only. It did not tell us what to do, which I always appreciate.' (P20)

Conversations based around the CSL had been a springboard to changes in ways of working: setting up a 'wobble room', instigating a team check in at the end of the week, and thinking about Covid's effect on the service, its clients and the team:

> 'We then made our own document of neurorehabilitation struggles to share within the team, tracking how Covid affected our population and some of the barriers we faced. This was not in a CAT style, but it was a space for reflection and documenting what was happening at the time and how we felt about it.' (P8)

Through collective use of the CSL, new and shared understandings emerged:

> 'I used it with a team of nurses who had been redeployed. It provoked lots of really helpful discussion and a sharing of feelings and experiences. Particularly helpful was the 'hero' pattern. None felt they were frontline staff and that the 'others' were heroes. All members of the team had been ill with Covid. This discussion helped them see that there were no heroes but that they were all heroes.' (P10)

6. Developing psychological skills

The tool supported staff to develop psychological skills such as reflection, acceptance, problem solving and flexibility. It also helped to develop this capacity within teams, helping them to stop and reflect collectively:

> 'Lots of people identifying with the themes, individuals feeling empowered to reflect on their professional and personal journeys in relation to COVID, greater willingness to accept the situation/ look for positives.' (P5)

> 'It helped them observe what was happening without being pulled into it to the same extent.' (P7)

For those respondents less experienced in CAT, their resonance with the CSL and the validation it provided that their own experiences were shared, seemed to give them the confidence to share the CSL more widely and with enthusiasm. A librarian, for example, shared it with their family who then shared it with colleagues. An Assistant Psychologist used it to facilitate a discussion within their own team:

> 'It was validating and also gave me more courage to discuss this with colleagues!' (P8)

The CSL's accessibility was described in its being 'of the moment', as well as short, simple and clear. Suggestions to make it more accessible included use of visuals such as maps, more simple language and updates to reflect the changing situation as the pandemic progressed.

Discussion

This evaluation set out to explore how the CAT-informed CSL had been used to scaffold reflective practice across different settings and professions, along with perceptions of the CSL and its impact. A summary of the perceived impact of the CSL by respondents against three levels of Kirkpatrick and Kirkpatrick's (2006) evaluation framework is shown in Figure 1.

Reaction:	Accessible, adaptable, timely, validating, normalising and flexible. Less angry and anxious, more connected and energised
Learning:	About own and others' emotional experiences, and similarities and difference in theseIndividual and collective psychological skills of reflection, acceptance, problem solving and flexibility
Behaviour:	Sharing of experiences and feelings, including where different Exploring possibilities and coming up with solutions

Figure 1 Impact of the CSL against Kirkpatrick and Kirkpatrick framework (2006)

What can CAT offer to support staff well-being?

The conversations the CSL enabled were described by respondents in ways that suggested they felt unusual in their openness, validation and collegiality. In their survey of the mental health workforce, Johnson et al. (2011) describe the emotional strain, exhaustion and burnout that can damage morale, exacerbated by 'unhealthy' team and relationship dynamics. Foster et al. (2020) found this workforce affected by bullying, workplace tension and feelings of a lack of organisational support. Against this background, there is an ongoing need for support beyond Covid. This evaluation shows how CAT could potentially scaffold reflective practice on an ongoing basis in a way that is experienced as unthreatening and productive, helping to strengthen well-being and create a greater sense of psychological safety at work (Summers et al., 2020).

The equalising nature of the CSL was seen as positive. It enabled identification with rather than distancing from others. Multiple layers of 'us and them' are often apparent in mental health services (MacCallum, 2002); between staff and 'patients', qualified and non-qualified staff, 'management' and others, and different professions. The CSL was able to cut through these. The CSL seemed to bolster the confidence of a range of differently qualified staff to have a voice and to use the CSL as a tool to support others, both of which had been identified by Stratton and Tan (2019) as barriers to psychological working in teams. Evidence from this evaluation suggests the potential of CAT to scaffold reflective practice in mental health in ways that are non-threatening and normalising.

How applicable and acceptable are CAT informed concepts and tools to a wider audience?

The evaluation confirmed early potential for the acceptability and applicability of CAT-informed approaches to staff across settings and professions. The primary focus of the CSL on validation and Figure 2 normalisation of experiences and feelings by naming and documenting them, appeared a major strength. This is in line with the value Ryle and Kerr (2020) place on CAT's close and accurate description of states and problems being of value in itself, as illustrated in figure 2.

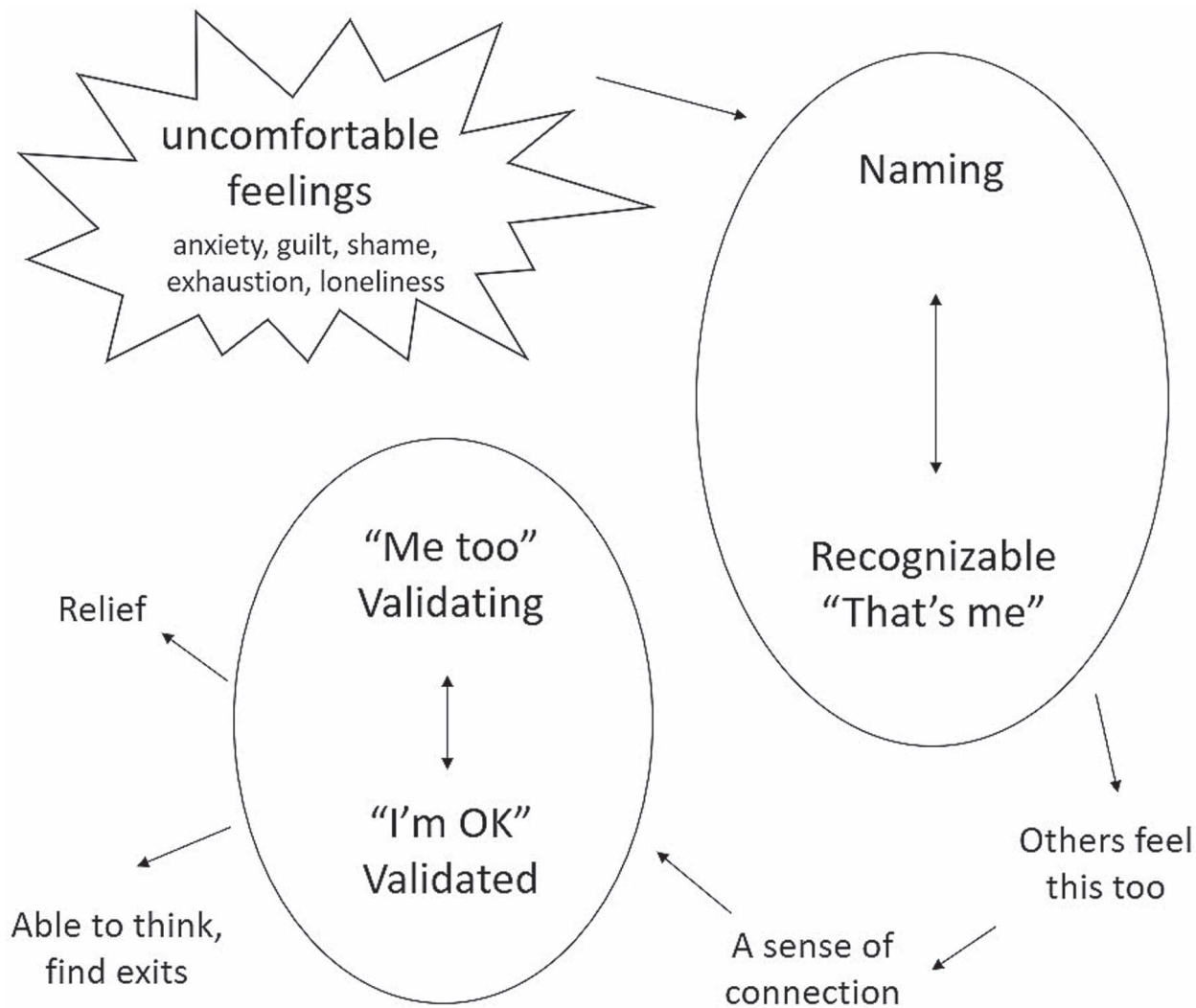

Figure 2 CAT Map of Evaluation Findings (Jefferis, 2021)

One of the CSL's strengths was in its reflection of different potential positions. It was not seen to prescribe a particular approach or 'answer' and solutions grew organically with the'CSL providing the space for these to emerge; it was encouraging not telling. Relational and collaborative aspects are core to CAT and the collective use of the tool was particularly powerful for teams in creating shared sense-making, legitimising discussion, and opening up possibilities for further conversations, connections and alternatives. CAT concepts can be difficult to grasp and understand, even for those who are training in the approach (Catalyse, 2013). However, the CSL seemed to strike the right balance for wider accessibility, as seen in the high number of respondents to the survey who were not CAT practitioners. The CSL's normalising and non-pathologising approach to distress felt a good fit to support staff well-being, even with those who had had no or limited prior experience of CAT. The Covid pandemic has seen a range of 'expert' psychological help offered for NHS staff; the development of this tool based on consultation with staff and wider feedback suggests other collective approaches also have efficacy.

What can we learn about how to best 'scaffold the scaffolders'?

An unintended benefit of the CSL was the emotional benefit described by the respondents for themselves, in line with figure 2. It was not just a tool for scaffolding others. Summers et al. (2020) identified the psychological practitioner workforce as an at-risk group for mental health issues. The CSL gave scaffolders permission to feel, and to struggle, as well as the scaffolded.

Psychology remains loyal to the traditional in its dissemination and sharing; speaking at conferences, publishing in academic journals and writing a book are still career milestones to be ticked off. The CSL has shown the potential of free social media, in this case Twitter and Facebook, to reach a wider audience quickly, effectively and expansively.

Further exploration of actual and future potential channels of dissemination would be beneficial. Future evaluation of such tools could take a more formal approach to specifying and measuring desired outcomes.

Strengths

The evaluation contributes to an emerging evidence base for the individual and collective impact of CAT-informed tools across team, organisational and systemic levels. It suggests a 'scaffolder' may not always be needed to support implementation. The evaluation design enabled a rapid turnaround and input from a geographically dispersed range of respondents. An unintended, but valuable, result of the design was that the evaluation reached, and received input from, both CAT practitioners and other types and levels of professional.

Limitations

While the CSL reached a fairly wide audience, the invitation to contribute to the evaluation will have only reached a subset of that group, and those who participated are a smaller group still. This inevitably limits the conclusions which can be fairly drawn from the results. The evaluation could have been enhanced by getting feedback from the 'scaffolded' rather than just the 'scaffolders'. The Covid pandemic was unique in its universality, and potentially the levels of common experience, which may have influenced the resonance of the CSL as a tool.

Conclusion

This evaluation of the CSL shows that there is potential to utilise CAT expertise and tools to support staff well-being across teams, organisations and systems, and to do this quickly, effectively and at very low cost. The development of this tool based on consultation with staff and wider feedback suggests collective CAT-informed approaches to support staff well-being have efficacy. □

References

Association of Cognitive Analytic Therapy, (x). *What is CAT?* Retrieved 16th March 2021, from https://www.acat.me.uk/factsheets/What-is-CAT-Understanding.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Carradice, A. (2013). 'Five Session CAT' Consultancy: Using CAT to Guide Care Planning with People Diagnosed with Personality

Disorder within Community Mental Health Teams. *Clinical psychology & psychotherapy*, *20*(4), 359-367.

Carson, R. & Bristow, J. (2015). Collaborating with Management in the NHS in difficult times. *Reformulation*, Summer, 30-36.

Catalyse, (2015). *Glossary of CAT terms and concepts.* Retrieved 16th March 2021 from https://catalyse.uk.com/wp-content/uploads/sites/3/2015/12/Glossary-of-CAT-terms-and-concepts-V2.pdf

Cresswell, J. W., & Plano Clark, V. L. (2011). Designing and Conducting mixed method research (2nd ed.). Thousand Oaks, California: Sage.

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., He, L., Sheng, C., Cai, Y., Li, X. and Wang, J., 2020. Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet Psychiatry*, 7(4), pp.e15-e16.

Corbridge, C., Brummer, L., & Coid, P. (2017). *Cognitive analytic therapy: Distinctive features*. Abingdon: Routledge.

Covid 19 Psychological Research Consortium, (2021). Retrieved, 16th March 2021 from https://www.sheffield.ac.uk/psychology-consortium-covid19

Foster, K., Roche, M., Giandinoto, J.A., Platania Phung, C. and Furness, T., 2020. Mental health matters: A cross sectional study of mental health nurses' health related quality of life and work related stressors. *International journal of mental health nursing*.

Jefferis, S. (2020). *Covid Struggles List*. Retrieved, 16th March 2021 from https://drive.google.com/file/d/15-iukqr8EW-76Daql7T8Jm5zfBBApU4-/view

Jefferis, S. (2021). *The Covid Struggles List and the development of CAT tools for team reflection.* Presentation to ACAT Conference 25th September 2020 . Retrieved, 16th March 2021 from https://www.youtube.com/watch?v=UMrUWD7XC0Y

Johnson, S., Osborn, D.P., Araya, R., Wearn, E., Paul, M., Stafford, M., Wellman, N., Nolan, F., Killaspy, H., Lloyd-Evans, B. and Anderson, E., 2012. Morale in the English mental health workforce: questionnaire survey. *The British Journal of Psychiatry*, *201*(3), pp.239-246.

Kirkland, J and Marshall, J. (2021). Reflective Practice in Forensic Settings: A Cognitive Analytic Approach to Developing Shared Thinking. Pavilion.

Kirkpatrick, D., & Kirkpatrick, J. (2006). *Evaluating training programs: The four levels.* Berrett-Koehler Publishers.

Leeds Clearing House, (2019). *Clearing House for Postgraduate Courses in Clinical Psychology Equal Opportunities data – 2019 Entry*. Retrieved, 16th March 2021 from https://www.leeds.ac.uk/chpccp/equalopps2019.pdf

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014.

Potter, S. (2013) The Helper's Dance List. In: Lloyd, J. and Clayton, P. *Cognitive Analytic Therapy for People with Intellectual Disabilities and their Carers*. London: Jessica Kingsley Publishers, pp.89-121.

Rains, L.S., Johnson, S., Barnett, P., Steare, T., Needle, J.J., Carr, S., Taylor, B.L., Bentivegna, F., Edbrooke-Childs, J., Scott, H.R. and Rees, J., 2021. Early impacts of the COVID-19 pandemic on mental health care and on people with mental health conditions: framework synthesis of international experiences and responses. *Social psychiatry and psychiatric epidemiology*, *56*(1), pp.13-24.

Royal College of Psychiatrists, (2020). Retrieved, 16th March 2021 from https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/05/15/psychiatrists-see-alarming-rise-in-patients-needing-urgent-and-emergency-care

Ryle, A., & Kerr, I. B. (2020). *Introducing cognitive analytic therapy: Principles and practice of a relational approach to mental health.* Chichester, UK: John Wiley & Sons.

Stratton, R., & Tan, R. (2019). Cognitive analytic team formulation: learning and challenges for multidisciplinary inpatient staff. *Mental Health Review Journal*.

Summers, E. M., Morris, R. C., Bhutani, G. E., Rao, A. S., & Clarke, J. C. (2020). A survey of psychological practitioner workplace well being. *Clinical Psychology & Psychotherapy*.

UK Government, (2020). Retrieved, 16th March 2021 from https://coronavirus.data.gov.uk/details/cases

Walsh, S. (1996). Adapting cognitive analytic therapy to make sense of psychologically harmful work environments. *British Journal of Medical Psychology*, *69*(1), 3-20.

APPENDIX: THE COVID STRUGGLES LIST

Author's note: The version reproduced below is the original list, on which the evaluation was completed. In June 2021 an updated version was created, and reflects the struggles reported by staff once the pandemic had moved beyond its initial phase. This updated version is freely available on the internet via this link: https://tinyurl.com/CovidStrugglesV2

The original list is reproduced from Kirkland, J and Marshall, J. (2021). *Reflective Practice in Forensic Settings: A Cognitive Analytic Approach to Developing Shared Thinking* with the permission of Pavilion Publishing and Media.

Many of us are facing unprecedented challenges in our work. This is a list of common experiences and dilemmas described by staff in a mental health and disability setting in the wake of the pandemic. The aim is to illustrate how many of these struggles are normal, and shared between us – we are all human and doing the best we can. It has been informed by the theory and practice of Cognitive Analytic Therapy.

How do we talk about it? There are stresses around but people are not talking about it. What are people feeling? How do I ask?

Who am I going to be? I want to do my bit, but my normal job may not be possible or may not be needed now. How long will I have to wait to find out? Who will I be then? Was my old job not important? Will I be able to do the new one?

Too much change. So much has changed, in my job, my family and the world, without time to adjust or say goodbye, that it can all feel too much.

Where did the team go? Some of the things that held us together have gone now, because we changed roles, or aren't in the same place now. I miss the team.

How can I help when we're this far apart? I try to adapt and help from a distance but can't be sure if I'm getting it right.

The lost connection. I can feel isolated by my new working life. How do I stay connected with people?

Soldiering on exhausted. The changes to my work have left me tired and drained. I must keep going because others need me.

If I put myself first, **I feel guilty.** I might know I need to put myself first e.g. by having downtime, or protecting myself better from risks, but it's a crisis and if I do that I will feel guilty (or the organisation might make me feel like that)

The 'overwhelmed' dilemma. The volume of information and instructions changes so quickly, and different sources conflict. It is too much. Sometimes I don't know what to do or what to believe. I'either cut off from the flow of information (but something important might get missed) or immerse myself in it (and get exhausted again – perhaps I have trouble switching off)

The 'boundaries' dilemma. The world has changed so maybe we need to be flexible. But it can seem like either I stick to what I would normally do (but someone's needs don't get met) or I change the boundaries but then it doesn't feel OK

'In the line of fire'. My job means I can't socially distance and may be at risk of being infected or infecting others. I try to rise to the challenge, but it might mean I'm putting me, my family, or other patients at risk, which worries me.

The 'authority' dilemmas. With so much uncertainty, I know people want clarity and simplicity. But:

(i) I don't always have the answers, and don't know what to say to help; and
(ii) I can be torn between either telling people what to do (which they may find too controlling) or trying to make decisions together but risk spreading the uncertainty.

All of these may lead to problems in the relationships with people over whom I have some authority.

The 'rush or reflect' dilemma. There is so much pressure to get things decided and done now, I may rush into things without thinking it through. However, if I stop and reflect, I fear it may then be too late.

Are YOU a hero? I may be invited to be a hero: by the world around us (clapping for the NHS), by my organisation, by myself. That can feel good, exciting, special. But:

(i) If not a hero, I may feel overlooked, left out, even resentful.

(ii) If I can't be a hero (for instance if I need to stay out of things for my own health) I may feel guilty

(iii) No one can be a hero all the time. What happens then? It may feel like we are never allowed to make mistakes, to not know the answers, or not to be firing on all cylinders.

Absorbing the stresses of others. People I am trying to help might be very stressed and struggling to cope. I do my best to help manage their anxiety but then I am left with the anxiety myself, which can take its toll.

Work or home? Home is topsy-turvy because of money, children, people close to me who are vulnerable, or all of these. I can feel split between putting my time and effort into what's needed at home, and what's needed at work. I might feel confused or overwhelmed or feel guilty about having to put one set of needs above the other; or feel guilty about not meeting either set of needs.

The hairline cracks. At work, if relationships have been difficult before the crisis, the extra pressure that everyone is under may make it even harder now. Communication between us might be difficult, or we get locked in argument on bones of contention.

Who is to blame? When things are less than perfect, we may want to find someone to blame. That can feel good but may make others less able to do their jobs well and may not help us when it is our turn for some compassion.

Ideas Worth Trying

What helps to manage these struggles will differ for each of us as people, and differ across our work settings. This is a developing list of general strategies which people we have spoken to have found helpful at times. In Cognitive Analytic Therapy these are known as 'exits'.

- Voicing the struggles, without shame

- Recognise this is a process. Have permission to take one day at a time.

- Normalising - recognise the struggles are universal and normal: we are all human and all in it together, and we can support each other.

- Organise yourselves for connection.
  - For remote workers – extra check ins, virtual coffee time, WhatsApp groups – but discuss what people find useful and what is too–much.
  - For present workers – creative ways to do things together–e.g., socially distanced lunches; explicitly ask how each other is doing.

- Create space for yourself and each other, and give permission to use it (e.g., use physical and virtual 'wobble rooms')

- Keep some 'anchors' to your familiar working life (e.g., start and finish work times, team rituals such as regular team meeting times; use 'setting events' for working at home e.g., use a specific chair/desk)

- Reconnect with things that have meaning and set simple goals.

- Attend to the basics: sleep, food, physical safety.

- Pay attention to boundaries and what feels comfortable; give yourself permission to separate work & home

- Shift your focus – remember the world is bigger than Covid.

Cohort outcome study of cognitive analytic therapy in a private practice

IRENE ELIA

Abstract:
Background: The evidence base for effectiveness of cognitive analytic therapy (CAT) in private practice is limited. **Aims:** To assess effectiveness of the author's private practice in reducing global distress, measured by Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), and to hypothesis-test if CORE-OM change (delta) from beginning to end of therapy significantly correlates with client-therapist goodbye letter concordance, a newly devised indicator. **Methods:** CORE-OM deltas were correlated with pre-CAT scores and with client-therapist Goodbye letter concordance for presence/absence of reciprocal roles (RR), target problem (TP), and traps, dilemmas, and snags (T,D,S). Deltas were compared to those identified in a systematic review by the author.

Results: Of 103 clients (36.26± 9.43 years, 79% women, receiving 15.75± 2.56 CAT sessions for anxiety, depression, and relationship problems), 53 had complete datasets. The mean pre-CAT CORE-OM score of 1.21± 0.68 dropped by 0.50± 0.54 at the end of CAT ($P<0.001$); (by 0.60± 0.53 without trainees, $P<0.001$). 51% of the whole cohort (62.5% without trainees) showed reliable improvement (≥ 0.50 points). CORE-OM deltas, which were typical of nine CAT studies from the systematic review, were correlated with pre-CAT scores ($r= 0.726$, $P<0.001$). Goodbye letter concordances (RR=81%, TP=81%, T,D,S=58%) were not significantly correlated to CORE-OM deltas. **Conclusion:** Following CAT, the cohort showed a highly significant and predictable improvement in CORE-OM measured distress, with more than half showing reliable improvement. High Goodbye letter concordance suggested shared understanding that may have

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enabled positive change but was not significantly correlated with CORE-OM deltas, perhaps because concordance indicates shared understanding not captured by CORE-OM, and CORE-OM measures distress not captured by concordance.

Key words: 'cognitive analytic therapy', 'outcome', CORE-OM, 'Goodbye letters', 'private practice', 'effectiveness'

Introduction

Cognitive Analytic Therapy (CAT) is a time-limited therapy (usually 16 sessions, once/week) that helps clients see unhelpful behaviours, thoughts, and feelings (Ryle and Kerr, 2020). As this requires the client to observe and reflect, CAT is not used with clients actively abusing substances or in florid psychosis. However, the evidence base for effectiveness of CAT is not strong and could be improved (Calvert and Kellett, 2014, Martin et al., 2021, Hallam et al., 2021, Baker, 2003).

The effectiveness of CAT can be measured in many ways, both by independent clinical evaluation and self-reported outcome. Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) is a validated, reproducible and widely used tool that assesses distress (Evans et al., 2002), used here to retrospectively explore CAT effectiveness over a period of 17 years in the author's private practice.

Another potential way to assess effectiveness of CAT concerns the Goodbye letters, which are usually written by clients at the end of CAT to reflect their understanding of and feelings about therapy and what remains to be worked on. The therapist also writes a Goodbye letter summarising what has been understood and some key experiences that have helped the client recognise and start to revise any problematic patterns. It has been the author's impression that concordance between client and therapist content shows that a client 'gets' what is going on with them and feels less distress because they know what they're doing and what they may need to change. On this basis, it was hypothesized that concordance between client and therapist Goodbye letters in mentioning CAT elements (target problem (TP), reciprocal role(s) (RRs), traps, dilemmas, or snags (T,D,S)), which frame self-understanding, could potentially show therapy has been effective.

While some large multi-centre studies and reviews have used CORE-OM to assess the effectiveness of an amalgamation of different psychological treatments (Gilbert et al., 2005, Stiles et al., 2015, Barkham et al., 2005), or a combination of self-report tools including CORE-OM to assess the effectiveness of CAT (Calvert and Kellett, 2014, Hallam et al., 2021), none focussed on the specific use of CORE-OM to evaluate only CAT. Also, the author is unaware of any study establishing correlational validity between CORE-OM deltas and any form of evaluation of Goodbye letters.

The aims here are to assess the effectiveness of the author's CAT practice using change in CORE-OM as an objective indicator of improvement or deterioration in global distress, and to examine the novel hypothesis that concordance of CAT elements in client and therapist Goodbye letters relates to a drop in CORE-OM score. In addition, in order to put the results in perspective a systematic review is to be udertaken to compare results of this study with those reported in peer-reviewed studies using a change in CORE-OM score (usually along with other tools) to assess CAT effectiveness.

Methods

Overview

This study was undertaken retrospectively, during the covid pandemic 2020-21, using an available sample of clients seen between 2001 and 2018 in Cambridge. If clients were on anti-depressants or other medications from their GP, they continued until they consulted their GP about stopping. No one had another form of psychotherapy while receiving CAT. Clients were given a CORE-OM to complete in session 1 (pre-CAT) and another in the penultimate or last session (post-CAT). The pre-CAT score may be referred to as the initial (or first) score and the post-CAT score as the final (or second) score. Clients wrote a Goodbye letter; the therapist wrote a Goodbye letter to each of them.

Retrospective client enrolment and cohort characteristics

Out of 103 clients who started CAT, 50 were excluded for reasons shown in Figure 1. Either they dropped out due to lack of funds/insurance (N=24) or were excluded because they hadn't completed one or both CORE-OM forms (N=17). See Table 1 for baseline characteristics of the sample of 53. Of these, 41 had a 16-session CAT, six had eight sessions, one had 10 sessions, one had 15 sessions, two had 17, and two had 24. Twenty-three of the cohort were involved in psychology/psychiatry, and of these 13 were training to be clinical psychologists/therapists. CAT

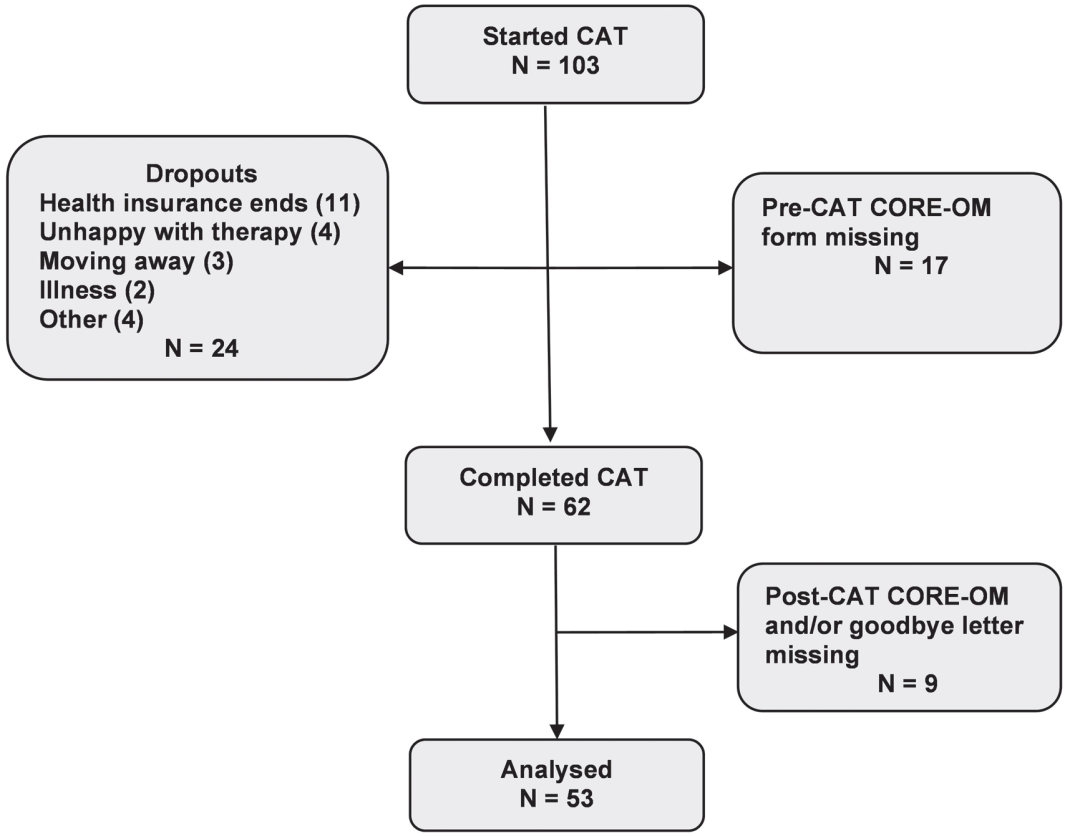

Figure 1 Flow chart of study from starting CAT to data analysis

Table 1 Baseline characteristics of clients and number of CAT sessions

	All subjects N=53	Without trainees N=40	Trainees N=13	P-Value Trainees vs rest
Mean age (range in years)	36.26±9.43 (21-73)	36.92±10.19 (21-73)	34.23±6.48 (27-45)	0.376[a]
Gender F/M (%/%)	42/11 (79.2/20.8)	30/10 (75.0/25.0)	12/1 (92.3/7.7)	0.181[b]
Mean number of CAT sessions	15.75±2.56	15.78±2.70	15.69±2.18	0.921[a]

Results for age and number of sessions are presented as mean ± standard deviation (SD)
[a] unpaired t-test
[b] chi square test

therapy was an academic requirement for them; most would not otherwise have come for therapy.

Scoring CORE-OM and Goodbye letter concordance

The total score from CORE-OM forms was divided by the number of questions (34) to give a mean score. The change in mean score (initial minus final score; delta CORE-OM, or CORE-OM delta) was calculated, with a positive score representing improvement and a negative score deterioration. After reading the Goodbye letters and noting any mention of TP, RRs, and T, D, S. the results were analysed using two methods. In Method 1, whenever the client or therapist mentioned an element, it was labelled as Yes and Yes/Yes if they both mentioned the element. This is referred to as concordance or agreement. When a CAT element was not mentioned in either Goodbye letter (No/No), whether because they were not relevant to or only briefly/incompletely discussed in therapy, it was still considered 'concordance'. However, a relevant element's absence from only one of the letters (therapist/client: No/Yes or Yes/No) represented a lack of concordance. A more stringent approach is taken in Method 2, which holds that absence of an element in a Goodbye letter could have occurred not only due to not being included in the therapy, but also from intentional/unintentional omission from the letter or from lack of understanding by the client. So, any letter labelled No either for the therapist or the client (No/No, No/Yes, Yes/No) embodies uncertainty. With Method 2, therefore, the only certain concordance would be Yes/Yes. The remaining cases could all theoretically be concordant or non-concordant; we just don't know. Therefore, Method 2, using sensitivity/uncertainty analysis, expresses concordance as a range, from a minimum of certain concordance (Yes/Yes) to a maximum potential concordance.

Relationship of CORE-OM delta to Goodbye letter concordance

The relationship of CORE-OM delta to goodbye letter concordance was assessed by regressing CORE-OM on concordance for individual CAT elements (point-biserial correlation: 1=concordance, 0=no concordance) as well as on the sum of individual CAT element concordances.

Comparison with other studies identified through systematic literature search

A systematic review, undertaken on 28 August 2021, followed standard

procedures (Egger et al., 2001, Gough et al., 2017). The key words used in MEDLINE and PsychINFO were 'cognitive' and''analytic' and''therapy'. Cross referencing and secondary searches were also undertaken. The inclusion criteria were as follows: adults (≥ 18 years) receiving CAT in any setting; single and multiple therapists; public and private sector; pre-post CAT designs, including randomised controlled trials with pre-post CAT in one of the trial arms; and primary outcome being CORE-OM delta (pre- minus post CAT CORE-OM measured at the end of therapy).

Statistics

Statistical analyses were carried out on the entire cohort (N=53) and on groups: 40 non-trainees, 13 trainees, 30 with non-psychology-psychiatry jobs, 23 with psychology-psychiatry jobs. In addition to the descritpive statistics shown in Table 1, CORE-OM deltas were analyzed by regression analysis and paired or unpaired t-tests. The Statistical Package for the Social Sciences (SPSS version 27) was used. P-values of <0.05 were considered significant. Results are presented as mean± SD.

Cut-off points for CORE-OM scores between this cohort ('clinical') and the general population ('non-clinical') datasets, and between reliable and non-reliable changes (either for improvement or deterioration) were established using standard methodology (Jacobson and Truax, 1991). To calculate these cut-off points, use was made of the mean± SD of the cohort's CORE-OM scores and those of the general population of Great Britain (4.8± 4.3) (Connell et al., 2007). To calculate reliable changes (not measurement error or chance), use was made of the standard deviation of the cohort's CORE-OM scores and of an internal CORE-OM consistency score (i.e., the CORE-OM reliability or reproducability score, here the Crombach's alpha) of 0.93, chosen so as to fall between 0.91 used by Connel et al. 2007 and 0.95 for clinical samples reported by others (Evans et al., 2002, Barkham et al., 2005, Trujillo et al., 2016).

Ethics

Since this study is a service evaluation, approval from the Local Ethics Committee was not sought. However, the data were handled anonymously and with confidentiality throughout the study.

Results

The study group (N=53) did not differ significantly from the people not included in the study (N=50): for age (36.26± 9.43 vs 39.90± 0.56 respectively; P=0.745), sex (F/M: 42/11; vs 37/13; P=0.529), or pre-CAT CORE-OM scores (1.21± 0.69 vs 1.24± 0.71; P=0.38). During the study, no clients attempted suicide, revealed suicidal thoughts, or were admitted to hospital for mental health issues.

Baseline characteristics of cohort and subcohorts

The baseline characteristics of the entire cohort and of subgroups of 'trainees' and 'non-trainess' are shown in Table 1. There was no significant difference in age, sex distribution, or number of sessions received between trainees and non-trainees. While non-trainees received CAT because of depression, anxiety, and/or relationship problems, the trainees needed CAT for their qualification.

CORE-OM scores, CORE-OM deltas, and clinical cut-offs

CORE-OM scores: The pre-CAT CORE-OM scores ranged from 0.06 to 2.97, with 19% having scores <0.5 (very little/no distress) and 15% having scores >2.0 (moderate to severe distress) (https://therapymeetsnumbers.com/made-to-measure-core/). The majority (49%) had low to moderate distress (scores of 0.6–1.5). Table 2 shows the mean pre-CAT score for the whole cohort was 1.21, and that the mean pre-CAT score for non-trainees was significantly higher (P=0.001) at 1.37.

Table 2 CORE-OM scores before and after CAT by trainee status

	Whole cohort N=53	Non-trainees N=40	trainees N=13	P-Value trainees vs non-trainees[a]
Pre-CAT CORE-OM score	1.21±0.68	1.37±0.67	0.70±0.67	0.001
Post-CAT CORE-OM score	0.71±0.47	0.77±0.49	0.53±0.37	0.114
Delta CORE-OM	0.50±0.54	0.60±0.53	0.17±0.44	0.010
P-value for delta CORE-OM[b]	<0.001	<0.001	0.19	

Results are presented as mean ± standard deviation (SD)
[a] unpaired t-test
[b] paired t-test

CORE-OM deltas

Table 2 shows a highly significant (P<0.001) reduction in the whole cohort's mean final CORE-OM score, which was on average 0.50 points (41%) less than its mean initial score. Without the trainees, the reduction was even greater: 0.60 points (44%). This was related to an'overall improvement in 91% of the entire cohort and in 93% if trainees were excluded. Trainees had smaller deltas (P=0.01).

Table 3 below shows that the mean of the initial CORE-OM scores for the psychology/psychiatry group (N=23) was significantly lower (P<0.001) than that of the rest of the cohort (N=30). Their mean delta CORE-OM score was also less than for the rest of the cohort (P<0.02) (Table 3).

	Whole cohort N=53	Non-psych[a] N=30	Psych[a] N=23	P-Value Non-psych vs Psych[b]
CORE-OM score pre-CAT	1.21±0.68	1.50±0.62	0.83±0.55	<0.001
CORE-OM score post-CAT	0.71±0.47	0.84±0.49	0.54±0.38	0.018
Delta CORE-OM	0.50±0.54	0.65±0.49	0.30±0.53	0.014
P-value for delta CORE-OM[c]	<0.001	<0.001	0.015	

Results are presented as mean ± standard deviation (SD).
[a] Non-psych=not in a psychology/psychiatry profession; Psych=in psychology/psychiatry profession
[b] unpaired t-test
[c] paired t-test

Table 3 CORE-OM before and after CAT by profession

When the trainees were excluded, so that the number of subjects in the Psych group was reduced to only 10, the P-values for comparisons with the Non-psych group became less strong (e.g., post-CAT scores (0.84± 0.49 vs 0.55± 0.42; P=0.099) or deltas (0.66± 0.50 vs 0.46± 0.62; P=0.311), but remained significant for the pre-CAT CORE-OM scores (1.01± 0.69 vs 1.50± 0.62; P=0.042).

Clinical cut-offs and reliable CORE-OM deltas

Using the procedure of Jacobson and Truax (Jacobson and Truax, 1991) on the dataset, it was shown that a reliable delta CORE-OM involved either a reduction by ≥ 0.5 (reliable improvement) or an increase by ≥ 0.5 (reliable deterioration), in agreement with Connell et al (Connell et al., 2007) and others (Evans et al., 2017b, Kellett et al., 2020) and https://therapymeetsnumbers.com/made-to-measure-core/).

The 'clinical' distress cut-off points between the cohort/subgroup (53 clients/40 without trainees) and the general population (535 people) (Connell et al., 2007) were found to be 0.763 and 0.837, respectively. Both cut-offs were lower than the 0.99 found by Connell et al (Connell et al., 2007) because mean pre-CAT CORE-OM scores here were lower than Connell et al's. Following CAT, fewer clients had CORE-OM scores above the clinical distress cut-off (dots above horizontal line on Figure 2) than they had before CAT (dots to right of the vertical line Figure 2).

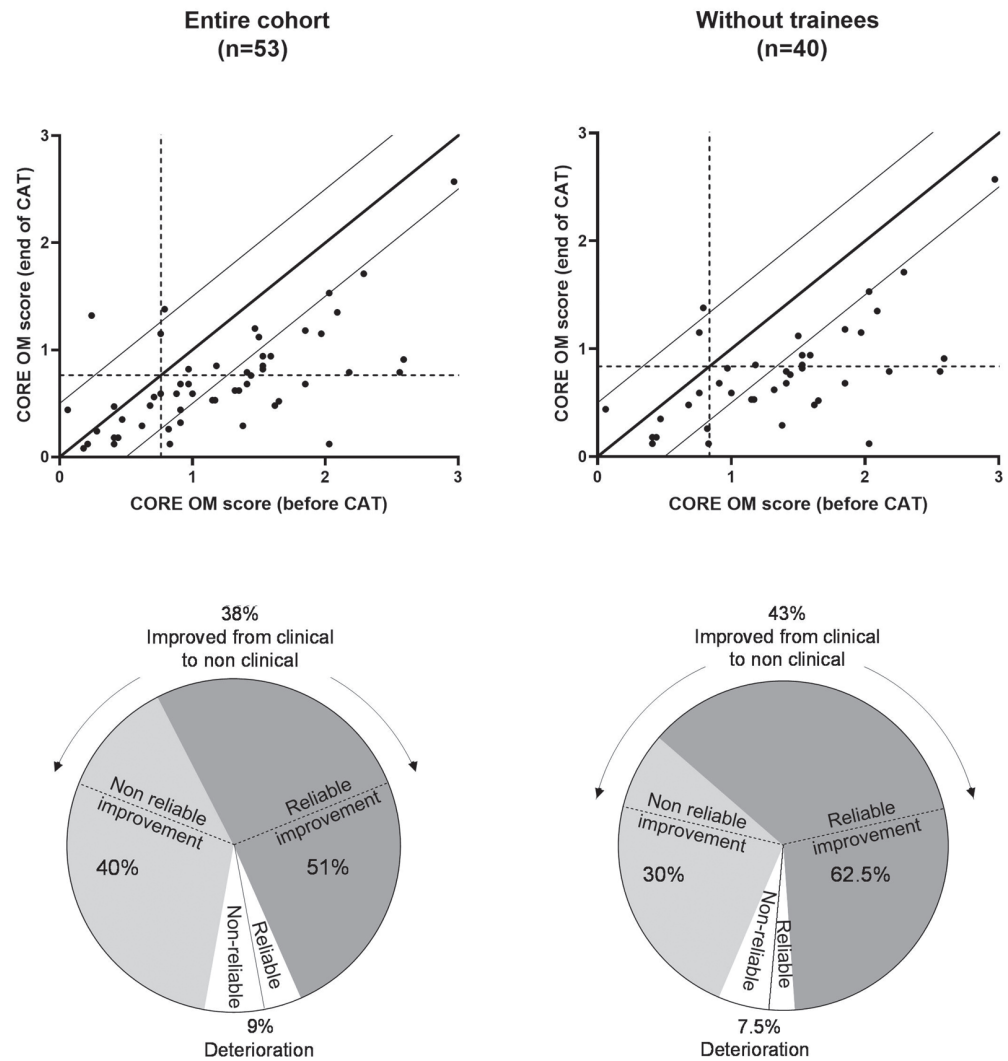

Figure 2 Effect of CAT on CORE-OM deltas (*left,* whole cohort; *right,* cohort without trainees) Thick central tramline on graphs represents no change; lower and upper tramlines indicate the cut-off points for reliabe improvement and reliable deterioration, respectively. Pie charts show overall improvement: reliable (dark gray) plus non-reliable (light gray). Dotted lines indicate the cut-off point between clinical and non-clinical status.

Most clients had a pre-CAT CORE-OM score above the clinical cut-off ('distressed'), but 28% had an initial CORE-OM score below it ('not distressed'), symbolised by the solid dots to left of the vertical lines on the graphs in Figure 2. Among those that had pre-CAT CORE-OM scores above the clinical cut-off, there was 46% improvement following CAT (47% in the cohort without trainees), and in the quarter with the greatest drop in CORE-OM score, the range of improvement was 64-93%.

More than half of the cohort showed reliably lower CORE-OM scores following CAT (reduction in distress): 51% of the entire cohort and 62.5% of the non-trainees (dots below the lowest tramline on the graphs of Figure 2). Clients (dots) that are below this tramline as well as below the horizontal dotted line on graphs in Figure 2 reliably improved from 'clinical' to 'non-clinical' distress status, corresponding to 26% of the cohort and 35% of the cohort without trainees. Reliable deterioration (dots above the highest tramline) occurred in only two clients (3.8% of whole cohort) and just one client (2.5% of cohort minus trainees). Overall, 30% of the cohort without trainees showed non-reliable change, either toward improvement or toward deterioration, as represented by the dots between the lower and upper tramlines in Figure 2; 45% with trainees.

Relationship of CORE-OM delta to pre-CAT CORE-OM score

Close inspection of the graphs in Figure 2 shows that after CAT, clients with higher initial scores showed greater improvement (greater downward displacement of dot from a 'no change' position on the central tramline). Indeed, there was a highly significant correlation ($P<0.001$) between the reduction in CORE-OM score (pre-CAT minus post-CAT score) and the pre-CAT score for both the entire cohort ($r=0.726$)) and the cohort without the trainees ($r=0.692$) (Figure 3).'Those with high initial scores tended to have greater absolute and greater proportional reductions in CORE-OM scores following CAT. For the entire cohort, the regression equation (post-CAT score=-0.197 + 0.575 pre-CAT score) predicts that in a client with a pre-CAT score of 0.5 the reduction in CORE-OM following CAT is 0.09 (18% reduction in distress); with a pre-CAT score of 1 it is 0.38 (38% reduction in distress); with pre-CAT of 2 it is 0.95 (48%); and with 3 it is 1.53 (51%). When the pre-CAT score is 1.21 (the mean pre-CAT value of this population), the predicted reduction of 0.50 (41%) corresponds exactly to the observed mean reduction. A similar pattern is predicted by the regression equation for the cohort without trainees (post-CAT score=-0.149 + 0.549 pre-CAT score).

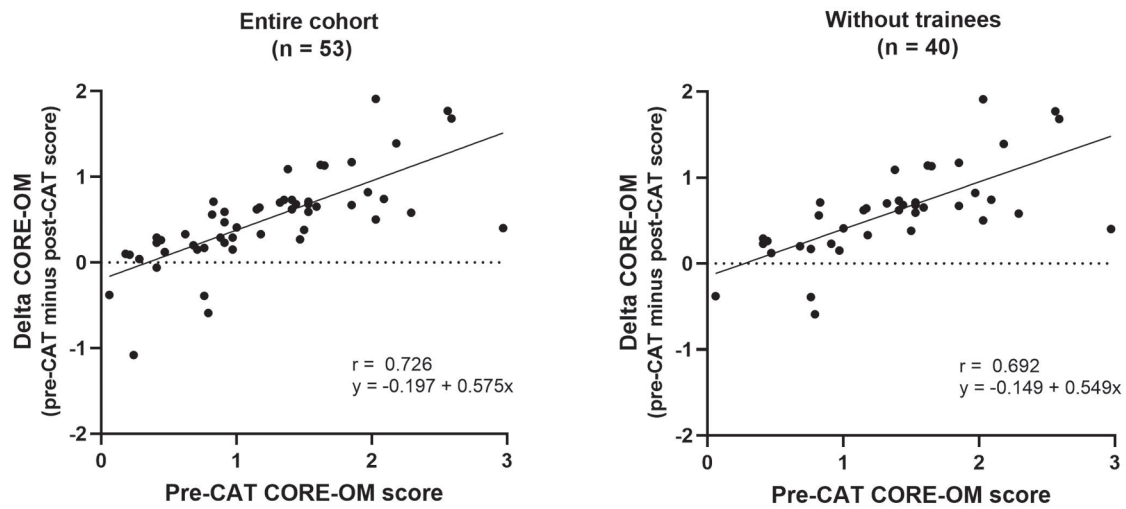

Figure 3 Relationship between delta CORE-OM and the pre-CAT score: entire cohort (left side) vs the entire cohort without the trainees (right). Solid line indicates predicted CORE-OM scores.

Figure 4 shows that the percent improvement in CORE-OM following CAT increases curvilinearly with increasing pre-CAT CORE-OM score, with

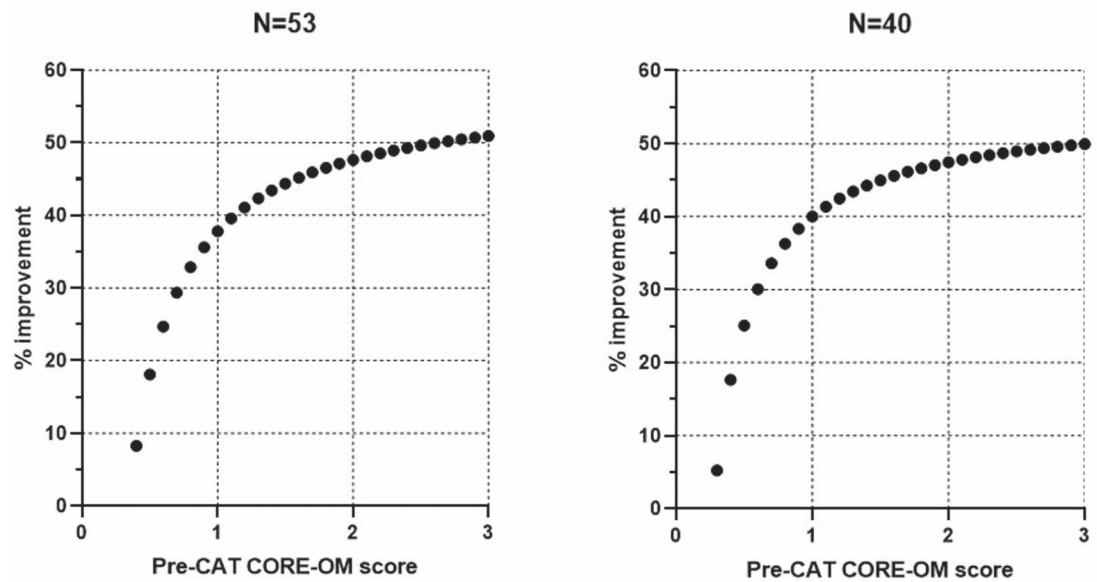

Figure 4 Relationship between Pre-CAT CORE-OM score and percent improvement in CORE-OM following CAT in the group of 53 clients (left; entire cohort; y = 77.5 - (19.7/x)) and 40 clients (right, without trainees y = 54.9 - (14.90/x)). (Percent improvement in CORE-OM = 100 times predicted CORE-OM delta – solid line in Figure 3 – divided by pre-CAT CORE-OM.)

greater percent improvement in those with higher initial pre-CAT scores. For example, those with pre-CAT CORE-OM scores from 1 to 3, (representing 65% of non-trainee clients) might expect a 40-50% improvement; those with scores from 0.5 to 1, (as in 20% of all clients) might see 25-49% improvement; and with scores from 0 to 0.5 could expect <25% improvement or even no improvement. So, improvement is seen to be predictable.

Goodbye letters: CAT elements, client-therapist concordance, relationship to delta CORE-OM

Mention of CAT elements in Goodbye letters: Table 4 shows the frequency with which CAT elements are mentioned in the Goodbye letters, from which it can calculated that the proportion of trainees (N=13) vs non-trainees (N=40) doing so was as follows for each element: RR 85% vs 80%; TP 92% vs 85%; T,D,S 54% vs 48%. (In all cases the P values were between 0.5-1.0 by Chi-squared test.)

Goodbye letter concordance: Using Method 1, the upper half of Table 4 shows that for the whole cohort, the extent of concordance between therapist and client in the goodbye letters (top left + bottom right in each set of four in Table 4) was very good for RR and TP (both scoring 43/53, 81.1%) but less good for T, D, S (31/53, 58.5%), a pattern reflected in the cohort without trainees (lower Table 4). With Method 2 (sensitivity/uncertainty analysis) the results are reported as a range from a minimum certain concordance (Yes/Yes; lower right number in each set of four on Table 4) to a maximum of 100% (always 53/53 for the entire cohort or 40/40 for cohort minus the trainees). For the entire cohort, the concordance between Therapist and Client on CAT elements ranges from 81-100% for RR; 74-100% for TP, and 42-100% for T, D, S. For the cohort without trainees, the concordance ranges were 80-100%, 73-100% and 38-100%, respectively.

Relationship of CORE-OM delta to Goodbye letter concordance: CORE-OM delta was found to be weakly but non-significantly related to the amount of concordance between therapist and client for individual CAT elements (r=0.05 for RR, r= 0.08 for TP and r= 0.11 for T, D, S) for the whole cohort; (r= 0.09 for RR, r= <-0.01 for TP, and r=< -0.01 for T, D, S) for the cohort without trainees, and to all three elements combined: r =0.12 for the whole cohort and r= 0.17 for the cohort without trainees. After adjustment for pre-CAT CORE-OM scores, all correlations between CORE-OM deltas and concordances remained non-significant, both for

			Client		Concordance			
					Method 1		Method 2	
			No	Yes	N	%	N	%
Entire cohort (N=53)								
RR	Therapist	No	**0**	0	43	81	43-53	81-100
		Yes	10	**43**				
TP	Therapist	No	**4**	7	43	81	39-53	74-100
		Yes	3	**39**				
T, D, S	Therapist	No	**9**	4	31	58	22-53	42-100
		Yes	18	**22**				
Without trainees (N=40)								
RR	Therapist	No	**0**	0	32	80	32-40	80-100
		Yes	8	**32**				
TP	Therapist	No	**3**	5	32	80	29-40	73-100
		Yes	3	**29**				
T, D, S	Therapist	No	**7**	4	22	55	15-40	38-100
		Yes	14	**15**				

Table 4 Concordance of therapist and client letters for CAT elements (entire cohort and cohort without trainees) by Methods 1 and 2.

the results of Method 1 and the lowest % concordances for Method 2. Analysis for the huge number of other permutations - Yes/No, No/No, No/Yes - between the lowest and highest percentage points was not done.

Comparison with other studies identified through systematic literature search

Out of a total of 3,529 publications retrieved from Medline and PsychINFO, cross-referencing, and secondary literature searches only nine were eligible for inclusion (Baronian and Leggett, 2020, Birtchnell et al., 2004, Clarke et al., 2013, Darongkamas et al., 2017, Evans et al., 2017b, Kellett et al., 2013, Kellett et al., 2020, Martin et al., 2021, Williams and Craven-Staines, 2017). Although all examined the effect of CAT on CORE-OM, they were heterogenous. They differed in multiple ways: study design (pre-post CAT cohort studies or randomised controlled studies); sample size (7-53); enrolment (prospective, retrospective); underlying client conditions (chronic pain, personality disorders, bipolar disorder, anxiety/depression or unspecified); age (mean age of studies 36-73); sex (50-82% women); type of practice (private, public); CAT format (one study involved group CAT). They also differed in the type of analysis: 'complete

case analysis' (all data exists, as in this study) vs 'intention to treat analysis' (some missing data imputed) and in the method of calculating cut-off points and reliable CORE-OM deltas. The present study tended to have pre-CAT CORE-OM scores (mean 1.21 in the entire cohort; 1.37 in the cohort without trainees) towards the lower end of the range reported by the other studies (1.30-2.18), but it produced typical CORE-OM deltas 0.50 for all vs 0.61 without trainees (cf. 0.36-0.83); typical levels of reliable improvement 50.9% vs 62.5% (cf. 41.2-71.4%); and typical levels of reliable clinical improvement 26.4% vs 35% (cf. 17.6-42.9%).

Discussion

This study has shown that more than 90% of the cohort had reduced CORE-OM measured distress following CAT, with more than half showing reliable improvement. The change was significantly correlated with pre-CAT scores, but not with Goodbye letter concordance as assessed here. The data were analysed with trainees (N=53) and without the trainees (N=40) because the trainees would not have come to therapy unless they needed to do so for their qualification. They also differed from the rest of the cohort in having significantly lower initial scores and non-significant deltas.

Effect of CAT on CORE-OM measured distress

The reduction in global distress of the 53 subjects in the cohort, measured by CORE-OM delta, was not only statistically significant it was also clinically significant, with sizable mean reduction of over 40%. Furthermore, among those with initial scores indicating clinical distress, just over a quarter showed a 63-94% reduction in CORE-OM scores, suggesting that in these individuals most of the distress was eliminated by the end of CAT. The reliable 'deterioration' (negative delta) in 2 clients could have shown they had had a bad week (CORE-OM refers only to the previous week) or possibly that therapy had increased their ability to trust and so they completed CORE-OM more openly.

The results of this study are encouraging, since 91% of the cohort showed improvement in CORE-OM score, and 51% showed reliable improvement (i.e., distinguishable from measurement error or chance), with 26% moving from clinical to non-clinical condition. Without trainees, reliable improvement was even better: 63%, with change from clinical to non-clinical in 35% of clients. Only 3.8% showed a reliable deterioration in the entire cohort; 2.5% without the trainees. These results are intermediate amongst studies that have investigated the effect of CAT on CORE-OM (see below).

Pre-CAT CORE-OM distress was found to be less in the sub-cohort of those involved in psychology or psychiatry professions (Psych). They had lower initial CORE-OM scores (Table 3), and the psychology trainees, who were over half of this sub-cohort, had even lower initial scores. This suggests that these clients were less distressed than the rest, although it is possible that they might have been reluctant to show a high CORE-OM score, thinking they might be judged unsuitable to continue their training. Such guarding for fear of appearing 'not well enough' in the profession was mentioned by Williams'(Williams, 2013). Ideally, to examine this possibility, an independent in-depth clinical evaluation of distress would be required.

Relationship of CORE-OM delta to Pre-CAT scores

An interesting finding is the linear relationship between pre-CAT scores and the deltas that indicate the decline in distress. So, a client's pre-CAT CORE-OM score predicts the extent to which their distress improves following CAT (Figure 3 shows this linear relationship). This correlation holds from low to high pre-CAT scores, meaning as the pre-CAT score increases, there is a progressively greater absolute and proportional reduction in post-CAT CORE-OM, indicating improvement in distress. For example, a pre-CAT score of 0.5 predicts a drop of 0.09 or an 18% improvement in distress, while a pre-CAT score of 2.0 predicts a drop of 0.95 or a 48% improvement (see Figure 4). Although people providing and receiving CAT do not usually consider the extent to which improvement is likely to occur following CAT, this study suggests it can be predicted from the pre-CAT CORE-OM score, similar to the way risk of bone fracture in osteoporosis or risk of a cardiovascular event can be predicted. Consequently, those with the lowest pre-CAT scores, who are expected to have little or no improvement, might consider not having CAT, saving money, and improving their spirits in other ways. Still, these are typical responses; some people do better and others worse than expected; therefore, this can only be a guide.

A possible explanation for this relationship is that more severely distressed individuals are more responsive to CAT than those less severely distressed. Low initial pre-CAT CORE-OM scores in some individuals (like trainees) could affect this relationship, since they cannot exhibit large

reductions in CORE-OM scores, given that the lowest possible score is zero (the 'floor' effect). Thus, 18% of the total cohort who had'pre-CAT scores of <0.5 could not have reduced their scores by 0.5 points and so could not show a reliable improvement. This included most CAT trainees who were, however, too few to abolish the significant relationship between initial score and deltas seen for the entire cohort (N=53).

Another explanation for the relationship between the delta CORE-OM following CAT and the initial CORE-OM score concerns the statistical phenomenon of regression to the mean, which is the tendency for extremely high or low scores to come closer to the mean on retesting. The contribution of these two possible explanations cannot be accurately separated in this cohort study, although it is possible to do so in studies that include a control group (e.g., randomised control trials).

A relationship between initial CORE-OM score and the delta measured at the end of CAT does not appear to have been previously reported. However, a study at Maudsley Mental Health Trust (Evans et al., 2017a) did report a weak correlation (r=0.35) between first session CORE-OM scores and deltas following an amalgamation of different psychological therapies. Their correlation may have been much weaker than mine (r=0.73), not only because different therapies were provided by a variety of therapists (in 3-189 sessions) but also because they dealt with a more heterogeneous client group, including those suffering from severe conditions. An earlier study from the same Trust (Beck et al., 2015) also used a variety of different psychological therapies and reported an even lower correlation (r=0.31). However, this was for the relationship between CORE-OM scores at assessment (not the first session) and deltas after therapy. The waiting period from assessment to start of CAT was variable, typically several months, and so the study is not comparable to the present study.

Goodbye letters: CAT elements, client-therapist concordance, relationship to delta CORE-OM

Mention of CAT elements in Goodbye letters: It can be suggested that trainees were more likely than non-trainees to mention CAT elements in their Goodbye letters because they have recently learned the terms and/or wish to show their knowledge to their therapist. However, the data suggest that the differences between trainees and non-trainees in the use of CAT words were minor, very far from being significant, and would require very large samples to be formally examined. In any case, for any client (trainee or not), using CAT language to report distress does not necessarily mean that their distress is better managed, but it might indicate a first step in distress reduction.

Goodbye letter concordance: Through their narrative commentary in Goodbye letters, clients may show that CAT has raised their consciousness (Weiskrantz, 1997) of some of their unhelpful attitudes, words, and actions. Therefore, inclusion of CAT elements – target problem (TP), reciprocal roles (RRs), and Traps (T), Dilemmas (D), and Snags (S)– in a client's Goodbye letter and corroborated by therapist's Goodbye narrative seemed indicative of some understanding of where change is needed.

The study found that concordance between therapist and client was high for RR (81% for full cohort and 80% for non-trainees) and for TP (81%/80%), but substantially less for T, D, S (58%/55%) (Table 4). This lower concordance of T, D, S may be because for some clients grasping reciprocal roles and target problem(s) is sufficient to carry on recognition and revision of their patterns, and so T, D, S are not introduced. Even when T, D, S are explained, they may be more complex and difficult for clients to put into words and so be omitted from Goodbye letters, raising some doubt about their concordance as an indicator of awareness of what needs to change.

In addition, there is also some statistical uncertainty about concordance, indicated by the range of results obtained by Method 2 (see Results Table 4).

While concordance would seem to suggest that clients did 'get' what was being discussed in therapy, lack of concordance may not indicate a lack of comprehension. Some clients who understood their TP, RRs, and even their T, D, S may have focussed on something else in their Goodbye letter: for example, detailing changes in their circumstances and feelings or thanking/criticising the therapist. Clients weren't given instructions about what to include in their letters. Instruction to use CAT language might have made concordance analysis easier but obviously would have biased results.

Even when there is client-therapist concordance for CAT elements, the letters may not be registering diverse aspects of the client's distress, captured by CORE-OM. And CORE-OM, although measuring distress reliably, refers only to the previous week and does not touch upon CAT-understanding developed over the previous months in therapy. CORE-OM cannot rate a client's ability to use CAT-understanding to reduce their distress, an ability important in the long-term (Ryle and Kerr, 2020).

Relationship between CORE-OM deltas and Goodbye letter concordance: The study found no significant correlation between CORE-OM deltas and Goodbye letter concordance. This may be because CORE-OM deltas and Goodbye letter concordance are expressing and measuring different things.

BOX

Author's reflection: In hindsight, and for reasons indicated in the Discussion, a non-significant correlation between CORE-OM and Goodbye letter CAT-element concordance might have been expected. However, having read through more than 100 client Goodbye letters, it was learned that clients generally understood and were grateful for what was discussed, whether or not CAT elements were mentioned. The author was moved by their honesty, captivated by their ability to reflect, and pleased to see that even when disagreement or enduring resistance were touched on, there was always record of how CAT had made a deep impression. Like a good novel, a good therapy is absorbed, mulled over, revisited, and debated within the self, even years later. It was felt that concordance and other content in the Goodbye letters conveyed this spirit even if not correlated significantly to CORE-OM deltas.

As the discussion just above indicates, Goodbye letter concordance may not always be a robust indicator of reduced distress (CAT effectiveness) and is associated with some statistical uncertainty. Lack of correlation may also simply reflect that the client's letters give a more personal indication of distress change (CAT effectiveness) than CORE-OM. There could also be problems with CORE-OM as an overall measure of CAT's effectiveness as shown in studies that have used not only CORE-OM deltas to assess CAT effectiveness but also a variety of other tools, such as anxiety and depression questionnaires, personality structure questionnaires, and the Work and Social Adjustment Scale. Pre-post CAT changes registered as the effect size indices of tools other than CORE-OM can vary widely, sometimes several-fold, and while pre-post CORE-OM effect size indices were not extreme, they could differ twofold or more than that of other tools'(Evans et al., 2017b, Kellett et al., 2013). Also, a recent study observed that 71% % of clients reported at least one of the items of greatest importance to them was not covered by CORE-OM, highlighting the importance of an individualized outcome measure, such as a Goodbye letter (Sales et al., 2018).

Comparison with other studies identified through systematic literature search

The author compared the effectiveness of this CAT practice with those of CAT practice in nine other studies that used CORE-OM as an outcome measure. Five studies analysed data from only 7-17 clients, and only one had as many clients as this study. Unlike the author's private practice with just one therapist, seven of the eight studies with a one-to-one CAT format had multiple therapists (3-22); only one was in the private sector but used three therapists'(Baronian and Leggett, 2020); and only one had just one therapist (Kellett et al., 2020). The case-mix of clients in the author's practice (anxiety/depression/personal relationship difficulties) did not match that of several other studies; for example, two involved only clients with chronic pain'(Birtchnell et al., 2004, Baronian and Leggett, 2020) and one had only clients with bipolar disorder (Evans et al., 2017b). With these confounding variables, it is difficult to directly compare this study with others. Nevertheless, it was found that non-trainee clients had a mean pre-CAT CORE-OM score within the range of the other studies, albeit toward the lower end of the distribution, and a similar proportion of clients with reliable improvement and reliable clinically significant improvement. In this study, the proportion of clients with complete datasets (51%) also fell in the range of studies using CORE-OM to evaluate CAT effectiveness (≤ 41-91%) and was much higher than other retrospective studies using CORE-OM to judge effectiveness of a mixture of therapies (19% (Evans et al., 2017a); 10% (Beck et al., 2015).

Limitations

This study has several limitations.

1) While follow-up can be informative, it was not an aim to look at CORE-OMs filled in during the follow-up session, which is usually three months after CAT ends. This means that for this study, it could not be shown how sustained the improvement may have been.

2) Care should be taken not to generalise the findings of this study, which included an unusually high proportion of clients involved with the psychology/psychiatry profession.

3) The pre-post CAT study design was retrospective and uncontrolled, which makes it difficult to assess or predict if some clients would have improved without CAT. The only two RCTs that

examined the effect of a control group (receiving 'treatment as usual') on CORE-OM deltas reported very different results: one of them reported that CORE-OM deltas were almost as large as in the CAT group (Evans et al., 2017b) and the other that they were very much smaller than in the CAT group (Clarke et al., 2013).

4) The distribution and collection of CORE-OM forms in the author's CAT practice was patchy because there were no prior plans to undertake a study, with the result that only 51% were complete and amenable to paired analysis (pre-post CAT). Therefore, the present study is at risk of selection bias, although no evidence for this was found from the excluded clients' baseline characteristics – age, sex, pre-CAT CORE-OM scores – which did not differ significantly from those of included clients. Also, although data collection and entry were objective and checked, they were made by the author, which adds another small risk of bias.

5) An independent in-depth clinical evaluation of changes in each client would have complemented the CORE-OMs and Goodbye letters, but such evaluation was never available to the author.

6) Since Goodbye letters often do not include CAT elements and many CAT therapists don't even use Goodbye letters, the results of this study cannot be generalised.

Conclusion

This private practice study of clients with depression, anxiety, and/or relational problems has shown that for the cohort with and without trainees the mean reduction in CORE-OM measured distress following CAT exceeded 40% and most of that improvement was reliable. The study reports for the first time that improvements in CORE-OM measured distress are predictable from pre-CAT CORE-OM scores, which is of potential value to CAT practice. No significant relationship was found between improvements in CORE-OM measured distress and Goodbye letter concordance between client and therapist, perhaps because of the complexity of accurately comparing different aspects of CAT effectiveness (e.g., distress reduction vs. recognising and revising unhelpful patterns). □

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References

Baker, J. 2003. Evaluation of CAT in GP Practice. *Reformulation,* Spring 2003, 16-17.

Barkham, M., Gilbert, N., Connell, J., Marshall, C. & Twigg, E. 2005. Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems in psychological therapy services based in primary and secondary care settings. *Br J Psychiatry,* 186, 239-46.

Baronian, R. & Leggett, S. J. 2020. Brief cognitive analytic therapy for adults with chronic pain: a preliminary evaluation of treatment outcome. *British Journal of Pain,* 14, 57-67.

Beck, A., Burdett, M. & Lewis, H. 2015. The association between waiting for psychological therapy and therapy outcomes as measured by the CORE-OM. *Br J Clin Psychol,* 54, 233-48.

Birtchnell, J., Denman, C. & Okhai, F. 2004. Cognitive analytic therapy: Comparing two measures of improvement. *Psychology and Psychotherapy: Theory, Research and Practice,* 77, 479-492.

Calvert, R. & Kellett, S. 2014. Cognitive analytic therapy: a review of the outcome evidence base for treatment. *Psychol Psychother,* 87, 253-77.

Clarke, S., Thomas, P. & James, K. 2013. Cognitive analytic therapy for personality disorder: Randomised controlled trial. *British Journal of Psychiatry,* 202, 129-134.

Connell, J., Barkham, M., Stiles, W. B., Twigg, E., Singleton, N., Evans, O. & Miles, J. N. 2007. Distribution of CORE-OM scores in a general population, clinical cut-off points and comparison with the CIS-R. *Br J Psychiatry,* 190, 69-74.

Darongkamas, J., Newell, A., Hewitt-Moran, T. & Jordan, S. 2017. Clinical outcomes of congitive analytic therapy delivered by trainees. *Reformulation, Winter,* 6, 1-12.

Egger, M., Smith, G. D. & Altman, D. G. 2001. *Systematic Reviews in Health Care,* London, BMJ Publishing Group.

Evans, C., Connell, J., Barkham, M., Margison, F., Mcgrath, G., Mellor-Clark, J. & Audin, K. 2002. Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. *Br J Psychiatry,* 180, 51-60.

Evans, L. J., Beck, A. & Burdett, M. 2017a. The effect of length, duration, and intensity of psychological therapy on CORE global distress scores. *Psychol Psychother,* 90, 389-400.

Evans, M., Kellett, S., Heyland, S., Hall, J. & Majid, S. 2017b. Cognitive Analytic Therapy for Bipolar Disorder: A Pilot Randomized Controlled Trial. *Clinical psychology & psychotherapy,* 24, 22-35.

Gilbert, N., Barkham, M., Richards, A. & Cameron, I. 2005. The effectiveness of a primary care mental health service delivering brief psychological interventions: a benchmarking study using the CORE system. *Primary Care Mental Health,* 3, 241-251.

Gough, D., Oliver, S. & Thomas, J. 2017. *An Introduction to Systematic Reviews,* London, Sage Publishing Ltd.

Hallam, C., Simmonds-Buckley, M., Kellett, S., Greenhill, B. & Jones, A. 2021. The acceptability, effectiveness, and durability of cognitive analytic therapy: Systematic review and meta-analysis. *Psychology and psychotherapy,* 94, 8-35.

Jacobson, N. S. & Truax, P. 1991. Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *J Consult Clin Psychol,* 59, 12-9.

Kellett, S., Bennett, D., Ryle, T. & Thake, A. 2013. Cognitive analytic therapy for borderline personality disorder: therapist competence and therapeutic effectiveness in routine practice. *Clinical psychology & psychotherapy,* 20, 216-225.

Kellett, S., Easton, K., Cooper, M., Millings, A., Simmonds-Buckley, M. & Parry, G. 2020. Evaluation of a mobile app to enhance relational awareness and change during cognitive analytic therapy: Mixed methods case series. *JMIR Mental Health,* 7.

Martin, E., Byrne, G., Connon, G. & Power, L. 2021. An exploration of group cognitive analytic therapy for anxiety and depression. *Psychology and psychotherapy,* 94, 79-95.

Ryle, A. & Kerr, I. B. 2020. *Introducing Cognitive Analytic Therapy: Principles and Practice of a Relational Approach to Mental Health,* Hoboken, NJ, John Wiley & Sons, Inc.

Sales, C. M., Neves, I. T., Alves, P. G. & Ashworth, M. 2018. Capturing and missing the patient's story through outcome measures: A thematic comparison of patient-generated items in PSYCHLOPS with CORE-OM and PHQ-9. *Health Expect,* 21, 615-619.

Stiles, W. B., Barkham, M. & Wheeler, S. 2015. Duration of psychological therapy: relation to recovery and improvement rates in UK routine practice. [corrected]. *Br J Psychiatry,* 207, 115-22.

Trujillo, A., Feixas, G., Bados, A., Garcia-Grau, E., Salla, M., Medina, J. C., Montesano, A., Soriano, J., Medeiros-Ferreira, L., Canete, J., Corbella, S., Grau, A., Lana, F. & Evans, C. 2016. Psychometric properties of the Spanish version of the Clinical Outcomes in Routine Evaluation - Outcome Measure. *Neuropsychiatr Dis Treat,* 12, 1457-66.

Weiskrantz, L. 1997. *Consciousness Lost and Found,* Oxford, Oxford University Press.

Williams, B. 2013. Past hurts and therapeutic talent. *Reformulation*, 39-42.

Williams, T. & Craven-Staines, S. 2017. Exploring the efficacy of cognitive analytic therapy. *Int. Journal of CAT & RMH,* 1, 164-178.

'A Space to Think and Connect'

A Team Wellbeing Initiative in the thick of the COVID-19 Pandemic

SIOBAIN BONFIELD, JANINE DAVIES

Abstract: 'A Space to Think and Connect' was a wellbeing initiative developed in response to the COVID-19 pandemic. The initiative was created to provide teams working in a public health service with the opportunity to come together to talk about (feel and process) the impact of the pandemic on their work and working relationships. This wellbeing initiative drew upon the existing evidence-base for supportive early intervention for people exposed to trauma, or potentially traumatic events (Richins, et al., 2019) and the rapid guidance developed during the early phase of the pandemic on psychological help for people working in healthcare (traumagroup.org; kingsfund.org.au) which highlighted the need for peer support programmes as forums that focused on talking about emotional and social challenges related to working in healthcare during COVID-19. Our practical focus was on team cohesion (Greenberg, 2020; Billings, et al., 2020) and what we thought was needed, and would be backed within our system.

As the name suggests, a key purpose of the initiative was to provide 'protected' thinking time that allowed teams to take time out from the tasks of their roles and focus on how they were working together at a time of increased stress and pressure. We wanted the groups to be more process driven than solution focused and to create relational awareness by holding open a space for meaningful conversation of experiences with mixed views tolerated, and themes and patterns identified. It aimed to provide a space for feelings to be heard, acknowledged, and processed together with colleagues working within the same system who 'understood enough' of each other's worlds to catch on and connect. It was an opportunity to connect with colleagues and feel less alone and more 'together' (Figure 1). How this

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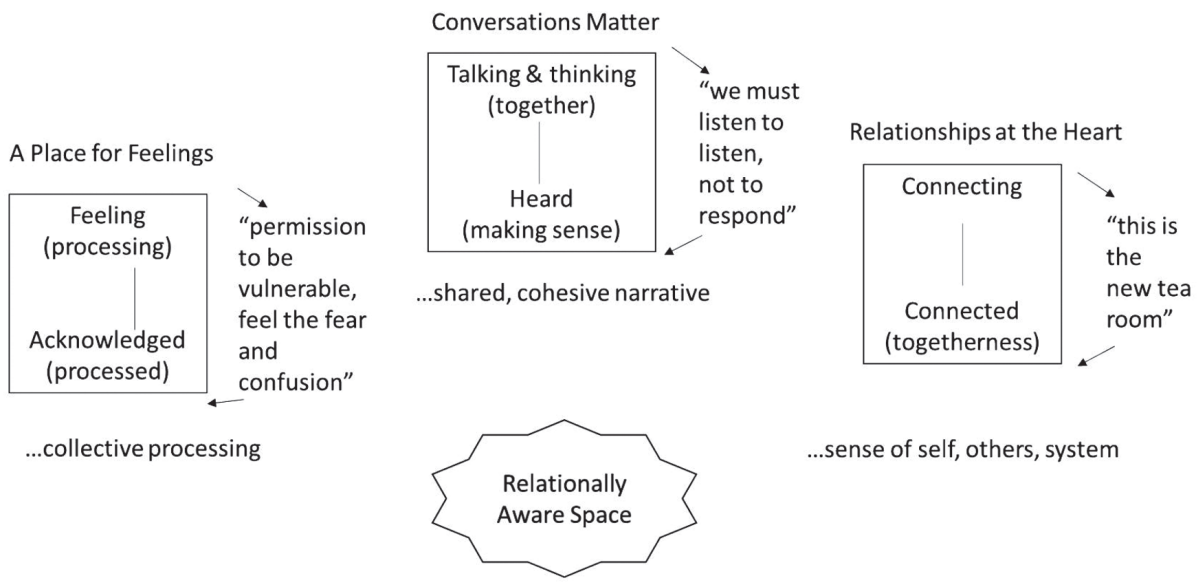


Figure 1: Relational process behind 'A Space to Think and Connect,' with quotations from participants.

initiative was run is described in this paper, including the pilot measure used to try to capture relational awareness and qualitative feedback. It tells the story of what we did at a time of personal and organisational and societal crisis and offers some evaluative data.

Background

During the early phase of the pandemic, literature reported on the psychological impact of the pandemic on the mental health of healthcare workers (Greenberg, et al., 2020; Greene, et al., 2021) and the need for early intervention to enhance coping and provide needed support given increased risk of experiencing work-related stress, burnout and general mental health problems (Chana, et al., 2015; Howgego, et al., 2005).

As it did all over the world, the COVID-19 pandemic had widespread impact in Melbourne, Victoria, Australia, and we experienced some challenging restricted measures. Many people were personally affected (lockdowns, home schooling, job losses etc.) as well as professionally impacted (in relation to public health this meant redeployment, frequent protocol changes, COVID-19 contagion and much more). When trauma and adversity occurs at a community and collective level, it is known to have widespread impact including a sense of disconnection within and between groups, pervasive fear, and lack of security and safety (Treisman, 2021). Whilst we are not saying that everyone experienced COVID-19 as 'traumatic', the widespread impact meant that most were impacted in some way in our local community. Working in public health at the time added an extra layer of impact, as feelings of fear were around within the system – as one participant said, 'it's in the air'. Responding to this was a complex relational task as many individuals were coping personally on top of having to navigate the push and pull of feelings of colleagues also under stress and absorbing the 'fear' within the broader systems of work and community. Within the workplace specifically there was a disruption to familiar professional narratives and teams and the broader system operating in survival mode and more narrow ways of relating and coping as an understandable consequence.

In specific relation to the pandemic, Greenberg, et al., (2020) spoke about how group discussions had an important role in helping people develop a meaningful narrative (or shared story) and that this was a protective factor against the challenges experienced by healthcare workers. Peer group processes are also known to have a supportive function for teams, strengthening camaraderie and protecting against the long-term impact of stressful and traumatic experiences (Richins, et al., 2019).

Purpose

We wanted to create an early intervention, 'workforce wellbeing' initiative that built upon peer group processes and the strength of teams to support each other, through having relationally aware conversations that enhanced connection, helped shared meaning making, and provided a place for feelings. We drew upon Potter's (2022) description: 'Relational awareness is the awareness of patterns of interaction that happen within us, between us and around us and which we achieve, or limit, together by sharing and negotiating our feelings, ideas and values'. In this spirit we called it a 'A Space to Think and Connect'. It needed to be process driven and relationally focused so that teams could connect through meaningful, non-blaming conversations, that allowed for mixed views, perspective taking, making links (self-others, past-present), naming patterns and highlighting shared experiences for the re-working of stories together. It meant keeping the reflective thinking space going, not getting pulled into problem solving or trying to find solutions (although highlighting what teams needed from each other was important) and ensuring

that the conversation did not go round in circles or get stuck on blaming or criticising (self, others, systems). It meant facilitating the group so that vulnerability was allowed, so that there was a place for feelings and emotions to be expressed and held by the group 'hovering and shimmering' within and between the difficult places' (Potter, 2020).

Method

'A Space to Think and Connect' involved four, one-hour group sessions, usually held once a week for four weeks, in person or remotely. The block of four group sessions allowed for momentum to gather and for the team to feel safe to be able to speak about and explore together, what they were going through. The initiative was available to any team or group of people working within the public health system in which we worked.

During each group the facilitators' outlined the parameters of the space including the core purpose. The groups were confidential, and the facilitators would check in with participants afterwards if indicated (i.e. level of distress and support with coping) and participants could contact the facilitators if follow-up with needed.

All facilitators attended a briefing which included the rationale behind the initiative, key purpose of the group spaces and guidelines about how to structure each group session and the overarching process over the four groups sessions. There were guidelines developed for the facilitators on how to facilitate the groups in a relational, process driven way including how to get the conversation going such as:

> 'What have peopled noticed (within themselves or others) in relation to the impact of the pandemic at work?'
>
> 'At a time like this it is as important to talk about how we are working together, as much as what we are doing or the tasks of the role – what have peopled noticed has changed in their working relationships?'
>
> 'Whilst it can be incredibly hard to speak about what you are going through, it is possible that your colleagues are thinking and feeling similar things, either way, speaking about this together can help us feel more connected and reduce the sense of isolation – would anyone like to say what's coming up for them?'
>
> 'What changes have you noticed in yourself and others at work, related to the pandemic?'

Guidelines on how to keep the thinking space going included:

> 'What are you noticing as we speak about this?'
>
> 'Does anyone else think or feel the same or have a different experience?'
>
> 'Is this something that it shared by others?'
>
> 'Is this a familiar pattern or theme?'
>
> 'What's it like to hear others say these things or to feel these things?'

Ten-minutes before the end each meeting was brought to a close and the facilitators would provide a summary of what was covered, highlighting themes and relational patterns, and reflecting on the process within the group e.g.

> 'How did we work together today in this space?'
>
> 'Was it easy or hard to speak?'
>
> 'How were moments of difficulty managed? Is there anything left to say today or that we need to continue to focus on or re-visit?'
>
> 'What can be taken away from today in terms of helpful ways of coping or things that have come up today?'

During the second, third and fourth group meetings, the facilitators would review the overall purpose of the initiative, the parameters, and expectations of the 1-hour session and summarise the key themes, patterns and discoveries from the previous group. At the fourth and final group space, time was spent reviewing the whole process and pulling together what was discovered, what people were taking away and what they were going to focus on as a team moving forward.

A small group of senior multi-disciplinary mental health clinicians from within the service were involved with this initiative and used their core clinical skills to facilitate the groups. The Cognitive Analytic Therapy trained facilitators were able to also use mapping to support the process, including mapping the patterns of interaction (reciprocal roles and

procedures), feeling states and ways of coping. At the discretion of the facilitators, there were times when letters were written to the group, summarising what was discovered together, and the process experienced, to support the development of a cohesive, shared narrative that included learnings and a sense of things that can be taken from this experience (see later in the paper).

Each block of four groups had two facilitators, whereby the primary facilitator took a lead role in introducing the group, defining the parameters including confidentiality, facilitating the discussion and ending. The secondary facilitator focused on: documenting who was attending for the purposes of evaluation and in case follow-up was needed in times of distress being exhibited; helping the primary facilitator to not get pulled into problem solving or stuck on finding solutions. Additionally: they monitored the (often virtual) space to ensure that anyone who wanted to speak had the opportunity; watched to see if any participant was expressing an emotion that needed to be attended to; monitored the online chat; ensured that the group ran on time and sent all participants an e-mail link to complete the evaluation measure post each session. Supervision was provided from a CAT practitioner to support the facilitators, retain the focus of the initiative, and monitor feedback. Holding in mind that this initiative was developed quickly, in response to the rapid and unpredictable pace of the pandemic, we used feedback from both participants and facilitators to make tweaks which aimed to improve the initiative on an ongoing basis.

Evaluation

After attending each group space, participants were e-mailed a link to anonymously complete a pilot measure of relational awareness: 'Relational Awareness Measure-*brief version'* (RAM-*bv*) (Potter and Bonfield, 2020). It contained only seven items and we hoped this would encourage participants to complete it online. The RAM-*bv* comes from Potter's (2020, 2022) work analysing the textual variety of multiple team reflective practice sessions over many years and his description of the dimensions and qualities that define relational awareness. Content validity has been assessed via a comprehensive item generation process and content expert review. It remains under ongoing evaluation and is free to use by mental health professionals. Within this context, the RAM-*bv* was used to micro-monitor the level of relational awareness experienced during each group space, which was the key purpose behind the initiative. During the last few months of the initiative running in 2021, we added an additional question: please name one thing that you found valuable about 'A Space to Think and Connect'.

Findings

'A Space to Think and Connect' was initially offered to teams working within Peninsula Health's Mental Health Program, Victoria, Australia. Through word of mouth, we were asked to offer the spaces to teams working in the general hospital, including those working on the COVID-19 wards and Suspected COVID-19 wards. During 2020 and 2021, forty-six groups sessions took place, with 361 participants attending, from 16

Relational Awareness Measure - *brief version* (RAM-*bv*)	**Missing data**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
1. We had time to reflect on what we thought & felt about the current work situation	1 1.08%		2 2.16%	31 33.48%	74 79.92%
2. We helped each other speak up and voice our opinions & feelings	1 1.08%		8 8.64%	33 35.64%	66 71.28%
3. The way the discussion was managed was open, clear & honest	2 2.16%		2 2.16%	25 27%	79 85.32%
4. There was room for mixed feelings & uncertainty in our discussions	12 13.08%	1 1.08%	5 5.45%	34 37.06%	57 62.13%
5. We made links & could see patterns	7 7.56%		11 11.88%	45 48.6%	45 48.6%
6. We respected our differences of background, identity & way of life	5 5.4%		2 2.16%	36 38.88%	65 70.2%
7. We trod carefully over difficult & sensitive issues	9 9.72%		10 10.8%	43 46.44%	46 49.68%

Table 1. Summary of response to the RAM-*bv* for 108 occasions (30% of the time).

different teams and including a range of disciplines (both clinical and non-clinical). The RAM-*bv* was sent to all participants and completed on 108 occasions (or 30% of the time), and we are unsure as to the reasons for this low completion rate, hypothesising that many attendees were working on the wards and did not have much time. The results are summarised in Table 1.

Table 1 shows that for the most part, the spaces provided time for reflection (thinking and feeling) on the impact of the pandemic on work and working relationships. The findings indicate that the group spaces helped teams to speak together and voice their opinions and feelings, providing room for mixed feelings and uncertainty, making links and identifying shared patterns (interactional, feelings, ways of coping, learnings) and were able to tread carefully over difficult and sensitive issues. There was, mostly, respect for differences of background and identity.

In relation to the 'neither agree nor disagree' responses, there were certainly challenges experienced in navigating topics such as the divisive nature of the pandemic (including making sense of some of the broader community perspectives on the pandemic such as feelings of alienation), exploring changes to work practice, not being solution focused on problem-solving, staying with the push and pull of powerful feelings (including fear) and tolerating uncertainty.

We had twenty responses to the additional question that was added towards the end of 2021. In relation to these responses, the authors identified a number of themes (summarised in Table 2).

A number of patterns and themes emerged in the group spaces. Throughout the pandemic, and most notably during the early phase, the unpredictability and uncertainty of the situation was related to 'intense' feelings of fear. The unfolding situation felt 'unsafe' with fears about serious illness and contagion (self and others). The unpredictability and uncertainty was connected to''not knowing' what was going to happen with the virus and its impact at work and it was this that was spoken about in relation to 'overwhelming' feelings and being 'in survival mode.' Individuals, teams and the system were in survival mode as a way of coping, yet this impacted reflective and relational capacity as'people (and the system) reverted to more narrow ways of relating, which manifest in patterns of interaction such as controlling-to-controlled (hypothesised to try and gain certainty and reduce anxiety, only to feel more overwhelmed with this was not achieved or conflict between people triggered)

Theme	Name one thing you found valuable
Connection	"The openness and personal connection" "Ability to connect with others and gain an understanding that my feelings / thoughts were shared by others" "Connecting with other {discipline}, hearing their ideas" "Connecting with other {discipline} and {specific team} and reflecting on our experiences"
Sharing Experiences	"Hearing that we are all experiencing the same things" "Knowing that all the {disciplines} no matter what department they are from, were experiencing similar things" "Being aware that this {team} all have similar experiences and issues" "Hearing the experiences of others helps to validate and normalize my own experience" "It was good to see other people's experiences during the pandemic" "Acknowledgement that we are all feeling similar things" "I feel through this, a very different way of life. I appreciate being able to come to work as so many people are struggling"
Reducing isolation	"Sharing experiences reduces the sense of isolation" "Hearing others in the same situation and not feeling on your own"
The Group Space	"Time for us as a team" "Safe space to chat" "Felt safe talking about our issues and stress"

Table 2: Responses to 'Name one thing you found valuable' about 'A Space to Think and Connect' summarised by themes.

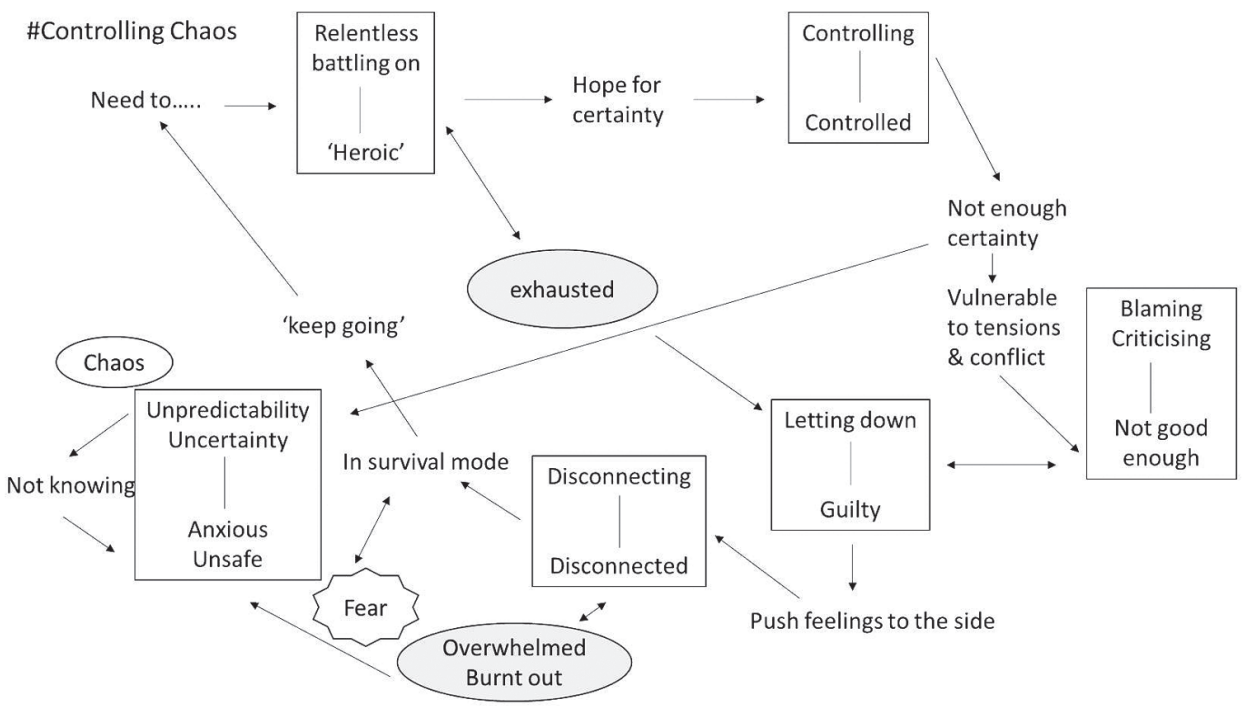
and blaming and criticising-to-not good enough (relating to the unrelenting tasks and striving to 'keep up and keep going' so as not to let anyone down).

The shared pattern of disconnecting-to-disconnected was spoken about in relation to the multiple changes in work practice that were both understandable and necessary, but disconnecting nonetheless: PPE, redeployment, furlough, losing 'the team room,' physical distancing (less opportunity 'for banter' or 'de-briefing') and remote working. There was a loss of familiar professional narratives and safe spaces to retreat to as a team and 'relentless battling on' became a familiar narrative. The constant changes and demands on healthcare meant that healthcare workers were 'drowning in work' yet had to keep going ('be heroic') to provide an 'essential service' and to avoid feeling guilty by 'letting down' colleagues. The relentlessness of the situation meant the hoped for place of certainty and 'heroic' care was unsustainable, with exhaustion and fatigue and the counter position of 'letting down' experienced.

The divisive nature of the pandemic was often spoken about 'COVID-19 divides people, at home, at work, in the community.' The divisions related to vaccination mandates, severity of the virus, treatment options, workplace changes, and lockdowns. There was division felt between healthcare workers and the community, with the former speaking about how latter group had 'no idea' what it was like to be working in healthcare at the time. Examples of this including the daily reporting of COVID-19 cases having a different meaning for healthcare workers with them knowing 'what this really meant' in terms of hospitalisation and possible deaths, whilst for others in the local community it meant mostly restrictions and economic impacts. Nursing staff in particular spoke about the challenges in nursing people with COVID-19 including how patients' condition can 'quickly change' and that they were having to deal with 'more deaths than usual.' There was a split noticed between those that saw healthcare workers as 'heroic' versus those that were frightened of them (contagion) and/or angry as they were seen as aligning with vaccination mandates.

Conversations that highlighted shared patterns and themes, allowed

Figure 2



for collective meaning-making such as understanding different ways of coping with feelings of fear and uncertainty and how this influences how we interact with ourselves and each other and how we can get stuck in one position or yo-yo between one place and another (see controlling chaos map Figure 2).

The map in Figure 2 was primarily developed by one team, but shared, reflected up, and added to, by others usually when the same, or similar themes, were being discussed. This allowed us to share common themes and experiences, deepening the collective and shared understanding and narrative, across teams. It was also used by the facilitators to self-reflect on the challenges experienced by many teams, as well as that of the facilitators in terms of holding some difficult feelings and not getting hijacked by the uncertainty and overwhelm. For example, CAT procedures such as: it is 'safer' to be blaming and angry, than it is to feel criticised and not good enough. Or: feeling unsafe and anxious, we seek certainty and can become controlling or feel controlled'which can lead to becoming blaming and criticising or feeling exhausted but fearing letting colleagues down can lead to 'relentlessly battle on' and to be seen as 'heroic', only to feel more pressure, exhaustion and burnout over time. Mapping these out through conversations and sometimes on paper as in Figure 2 helped sustain a level of relational awareness and reflective capacity.

We learnt from participants to highlight 'learnings and ways of coping' at the end of each group. In line with CAT language, these were sometimes called 'exits,' with other names used including take-away's and learnings. Things spoken about included: making time to savour moments for incidental conversations and connection; not underestimating the importance of focusing on what I need (or my colleagues need) in any moment; look out for 'moments of joy' (the sunrise on the way to work; or the sounds of the birds); go back to basics (the garden; craft; walking with the dog); zoom parties; talk to each other (make time outside of work if needed); have a balance between information about COVID-19 – turn the news off if needed and tell your family/loved ones that you don't want to talk about it; give each other permission to take time off, even if it's only a '½ day'. If feeling totally overwhelmed, recognise that fear is understandable 'it's okay to feel this way'; sit with not knowing (as opposed to trying to find the answers); build relationships with those that you wouldn't usually get to know; remember that if a colleague is being different to how they usually are, they are probably not coping and ask 'are you okay?' as opposed to getting into arguments; and

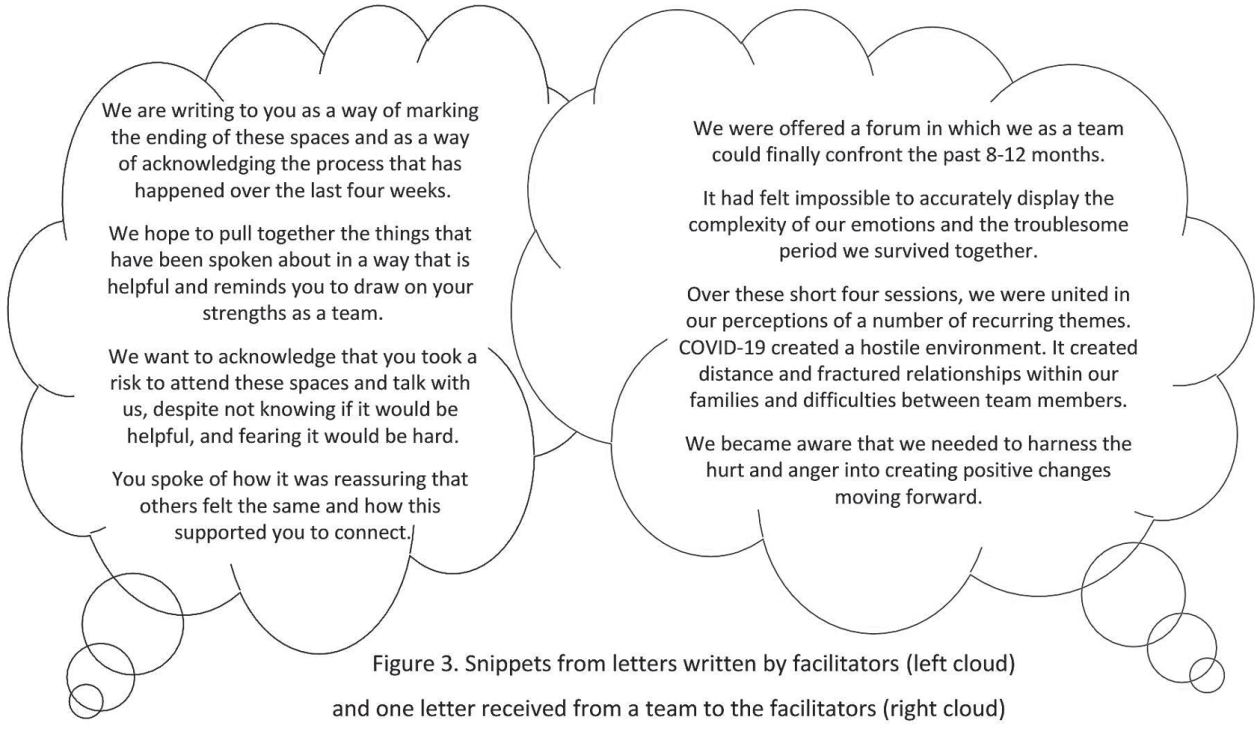


Figure 3. Snippets from letters written by facilitators (left cloud) and one letter received from a team to the facilitators (right cloud)

remember we are more likely to understand what is being experienced.

In specific relation to the divisive theme, some teams spoke about there being 'no winners' or 'easy answers' and there needing to be 'less divisiveness and more shades of grey'. Other qualitative feedback included the group spaces having a role in 'facilitating common ground' through the hearing of each other's experiences and comfort in knowing that others felt the same, that they supported connection at a time of 'disconnect' and allowed naming and 'sitting with' vulnerability and confusion.

The group meetings were not always 'easy' spaces with powerful emotions often expressed and strong opinions voiced. Challenges in facilitating the spaces included not letting the conversation get lost in blaming or criticising (self, others or system). It included not letting the discussion get hijacked by systems issues, in providing solutions, or go round in circles talking at each other without much relational awareness. It meant recognising the dance of feeling overwhelmed and acknowledging our own sense of helplessness in not being able to do more given the understandable (and realistic) anxieties faced by many teams we spent time with.

On a few occasions the facilitators wrote a letter to the group summarising the process and reflecting on the journey together. Whilst this was not part of the original protocol of the initiative, it organically developed through working with groups who were developing a narrative that was helping them find meaning. Some snippets from letters written to groups are shown on the left cloud in Figure 3 and snippets from a letter written back to the facilitators are shown on the right cloud in Figure 3.

Discussion

'A Space to Think and Connect' was developed in response to the rapidly unfolding COVID-19 pandemic. It was an attempt at providing a relational response to a pandemic that was divisive and disconnecting and impacting on relationships through limiting relational awareness and reflective capacity. Throughout this process we were remined about the therapeutic role of letter writing, or providing written narratives (paragraphs), that captured key moments shared by teams and were thus used to support meaning making. We also learnt to routinely use mapping as a key component of the discussions, helping to anchor them, capture key moments and ensure they were conversationally meaningful. For the CAT practitioners, this meant identifying one or two key reciprocal roles and procedures, whilst for non-CAT practitioners it meant 'words on paper' that captured enough of the themes and flavour of the discussion. More use of CAT templates could be considered for future iterations, alongside using pre and post measures to better capture how these kinds of reflective spaces are experienced.

At the time this initiative was developed, there were only a few CAT practitioners in the organisation, thus it was not possible to use the CAT model in its traditional form. However, CAT thinking underpinned this initiative and CAT tools played a role in supporting the discussion 'spaces' to be run a certain way and within a'relational framework. All the facilitators were senior clinicians with training and supervision provided by a CAT practitioner, which was enough for the initiative to meet its core purpose. Given the wide-ranging impact of the pandemic, and the increasing number of traumatic events in the world more broadly, it is important to consider the upscaling of therapeutic interventions so that they have greater reach across the organisation.

Conclusion

We imagine many readers will be familiar with the accounts arising in this brief evaluative study. This initiative was implemented in the early phase of the pandemic, in response to the intense fear that was experienced by many working in public health and the multi-layered impact the pandemic was having at work including on relationships. Through providing protected time for teams to come together to stop, think and feel with others working within the same system, we hope it had a supportive and holding function. The evidence from our evaluation is encouraging. The 'divisive' theme spoken about by many teams reinforces the need for a focus on relationships to navigate, and counteract, tensions and fragmentation. Indeed, the group format and process-driven facilitation meant that there was a focus on how people were working together and that peer group processes enabled experiences and feelings to be voiced and heard. □

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References

Billings, J., Greene, T., Kember, T., Grey, N., El-Leithy, S., Lee, D., Kennerley, H., Albert, I., Robertson, M., Brewin, C., & Bloomfield, M. 2020. Supporting Hospital Staff During Covid-219: Early Interventions. *Occupational Medicine*. doi:10.1093/occmed/kqaa098

Chana, N., Kennedy, P, and Chessell, ZJ. 2015. Nursing staff's emotional well-being and caring behaviours.*Journal of Clinical Nursing*. 24 (19-20).

Greene, T., Harju-Seppanen, Adeniji., Steel, C., Grey, N., Brewin, C., Bloomfield., & Billings, J. 2021. Predictors and rates of PTSD, depression and anxiety in UK frontline health and social care workers during Covid-19. *European Journal of Psychotraumatology*. 12(1). https://doi.org/10.1080/20008198.2021.1882781

Greenberg, N., Docherty, M., Gnanapragasam, S., and Wessely, S. 2020. Managing mental health challenges faced by healthcare workers during the covid-19 pandemic. *BMJ*. 368: m1211.

Howgego, IM., Owen, C., Meldrum, L., Yellowlees, P. Dark, F., and Parslow, R. 2005. An exploratory study examining rates of trauma and PTSD and its effect on client outcomes in community mental health. *BMC Psychiatry*. 5:21. P1-17.

Potter & Bonfield, 2020. Relational Awareness Measure (RAM): Process of Development.https://www.mapandtalk.com/_files/ugd/524d79_83b895c156fb41e0a7aa10c972d006d2.pdf.

Potter, 2020. *Therapy with a Map. A Cognitive Analytic Approach to Helping Relationships.* Shoreham-on-Sea Pavilion Publishing.

Potter, 2022. *Talking with a Map* Shoreham-on-Sea Pavilion Publishing.

Richins, Gauntlett, Tehrani, Hesketh, Weston, Carter & Amlôt. 2019. Scoping Review: Early Post-Trauma Interventions in Organisations; Final Report; Public Health England.

The Kings Fund. https://www.kingsfund.org.uk/publications/creating-space-conversations-covid-19

Trauma Group. 2020 Covid trauma Response Working Group. https://www.traumagroup.org/

Treisman, K. 2021. *A Treasure Box for Creating Trauma-Informed Organisations. Volume 1*. Jessica Kingsley Publishers. London and Philadelphia.

Use of self in teaching reciprocal roles

EIRINI VASILAKI, JANE BRADLEY, YASMIN TANFIELD

Abstract: The aim of this small study was to explore the Community Mental Health Team (CMHT) staff experience of attending a one-day relational training informed by Cognitive Analytic Therapy concepts (Reciprocal Role Procedures (RRP)) and other tools such as CAT mapping. The training placed particular emphasis on applying relational skills in day-to-day practice. Fifteen CMHT staff attended the training and completed a feedback questionnaire. Following this, six CMHT staff agreed to participate in a 30-minute semi-structured interview. The areas covered by the interview included questions about views of training, reflections on participants' ability to draw Reciprocal Roles (RRs), supervision, and everyday practice. Interviews were analysed using thematic analysis and a double-blinded research approach. Besides indicating that CAT relational skills-based training was perceived as valuable, the findings highlight that the trainer's willingness to use 'self' has a positive impact on the participating staff's ability to engage in reflective practice. Barriers to self-reflection were also highlighted. The findings are discussed in relation to previous research but also in relation to implications on delivering relational based training to CMHTs. Future research ideas as well as limitations of the present study are also explored.

Keywords: community mental health staff, Cognitive Analytic Therapy, self-reflection, training, barriers, appropriate self-disclosure.

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Introduction

Community Mental Health Team's (CMHTs) adopt a multi-disciplinary model of working, with an aim to meet the complex needs of individuals with mental health difficulties. This comes with advantages but also with some potential challenges.

Previous studies have shown positive results on staff's ability to work with 'complex' presentations, whenever Cognitive Analytic Therapy (CAT) concepts were applied (Thompson et al, 2008; Jones & Annestey, 2018; Clinkscales et al., 2018). The key element among these studies was that their training days and or reflective groups were guided by the concepts of Reciprocal Role Procedures (RRPs) and the use of Sequential Diagrammatic Reformulation (SDRs) (Ryle, 1991).

In CAT, RRPs are understood as other to self, self to self and self to other. They help map out relational procedures (Ryle, 1991) which are sequences combining perception, knowledge, aim-directed actions, and affect (Ryle & Fawkes, 2007). RRPs are thought to be developed and internalised during early life and individuals will have a repertoire of RRPs, some adaptive and some less adaptive (Ryle, 1991). Clinkscales, Tan, Jones (2018) argue that developing this relational understanding with service users can be beneficial to teams. The CAT model has been used as a consultation tool to aid reflective practice, and or service-care delivery. Research has shown that skills-based training, informed by CAT, can support staff to develop a shared and common language that can help them to work with complex clients and make better use of consultation sessions (Thompson et al 2008). Several challenges can arise when CMHT staff are invited to engage in reflective practice informed by CAT thinking. These may include the lack of a shared language, different training backgrounds but also tensions arising from the invitation to shift awareness onto self as well as on the other (Westacott, 2017). These challenges can affect the quality of reflective practice but also how well staff engage and apply relational thinking in their day-to-day practice.

The Study

Aims

The current small-scale study was conducted within an NHS Community Mental Health Affective Disorders Team (CMHT). The service typically works with service users with severe mental health difficulties, and it is defined by a multidisciplinary team-based approach. The present study aims are a) to explore staff's subjective experience of receiving a one-day relational training informed by CAT key concepts, and b) to explore how staff have experienced the invitation to reflect on their own reciprocal roles.

Overview of the Training Day

Reflecting on previous examples of brief relational and CAT informed training courses (e.g., Thompson et al 2008), a one-day training course was developed. The aim was to support multidisciplinary CMHT staff to learn about RRPs, practice relational mapping (draw RRPs) and to learn how to use them with the aim to understand complex relational dynamics. The content of the training included a) learning about the concept of RRs and b) practice skills such as learning to draw/map RRPs as identified in client's histories.

The CMHT staff were supported to engage with the content of the training by the trainer (second author) sharing her personal life story while mapping relevant RRs. The trainer also shared a personal example of how those RRs were re-enacted in a therapy session with a client (consent to share information anonymously was ascertained). The aim of this was for the trainer to 'model' personal engagement with the self to self simultaneously with the self with others interaction of reciprocal roles.

Materials for the study

A semi structured but open-ended interview schedule was adapted and developed from the work of Thompson (2008) and Hunter (2015). The areas covered by the interview included open ended questions about CMHT staff views on how they did experience the training, and their reflection on being invited to learn how to draw RRs.

Participants and Procedure

Fifteen CMHT staff participated in the training day. They received an information sheet and consent form to participate to the current study. NHS ethical approval was obtained. Out of the fifteen who attended, six staff responded to the researcher's invitation to participate on an approximately 30 to 60 minutes interview. A total of six participants (five community mental health nurses and one psychiatrist) were interviewed. The interviews took place at the participant's work base. The mean

number of years for which participants had been qualified was 11 (range eight to nineteen years). Participants were all experienced in working with complex presentations and in a community setting. Of the six participants interviewed, only one had attended an introduction to CAT training in the past.

Analysis

Qualitative data was collected by six participating staff, via 30-60 minutes semi-structured interviews. The anonymised transcripts and 'quotes' from the evaluations were analysed using thematic analysis (Braun and Clarke, 2006), and by using a double-blinded research approach. The first author (EV) engaged with reading the transcripts multiple times and organised the data into themes and subthemes using the method of coding. The third author (YT) also followed a similar process independently. The phase of agreeing on the overarching themes was conducted by both first (EV) and third (YT) author.

Results

From the analysis of the six 30 minutes semi-structured interviews, three main themes emerged:

- 3 Rs (Reformulation, Recognition and Revision)
- CMHT staff part of the 'relational dance'
- Barriers to relational thinking on day-to-day practice.

Theme 1. The 3 Rs Reformulation, Recognition and Revision

All six staff described feeling 'stuck' with service users and stated that the teaching day has helped them to use the time to think through the roles and relationships underlying the feelings around being stuck.

> '. . . clients where I felt stuck with, clients where they felt like we were failing them, and where team members were experienced different feelings. . . it has been helpful to pause and think of those in the training day. . .' (P2)

All six staff were able to develop an understanding of their clients early relational patterns (3Rs: Reformulation) and as a result, to feel less entangled with unhelpful feelings and reactions (e.g., taking less personally, service users challenging reactions). This has enabled staff (five out of six) to feel more able to reflect on their own personal reactions, to notice both poles of reciprocal roles, and to consider re-enactments (3Rs: Recognition).

> '. . . well, the particular client I talked about, was sensitive to feeling let down by services when she rang for support and certain phrases staff used. . . it was helpful to understand her past. . . think about her 'bad' map. . . how we unintentionally may end up in her 'bad' map. . . ' (P3)

Further, by engaging in a non-judgmental, self-reflective and compassionate 'dialogue', all six staff commented on how this has helped them to support clients to develop alternative and healthier ways of relating, both with services and others (3Rs: Revision).

> '. . . As a team to recognise where this distress is coming from and how it is being maintained, I think. . . it has been helpful when we had people who we felt stuck with, the training day and supervision gave us the opportunity to rethink the person. . . and to end up changing the treatment plan or how we approach what we do with this client. . . (P1)

Theme 2: CMHT staff 'part' of relational 'dance'

This theme highlighted how community mental health staff received and experienced the invitation to reflect and draw their own reciprocal roles as part of the training day and to engage in a CAT mapping activity. The process of self-reflection is often familiar to psychological therapists and psychology staff in general but not necessarily to non-psychology staff. All six staff commented that the invitation to reflect on their own reciprocal roles was hard but valuable.

> '. . . so we need to reflect on our personal stuff. . . on our self-drawing my own map. . . it was not easy. I did not know how to do it – I have never done it before. . . ' (P6)

> '. . . it is hard. . . really hard. . . thinking about yourself. . . and your own stuff. . . ' (P4)

All six participants valued the trainers non-judgmental and compassionate relational approach built around appropriate self-disclosure when they were invited to engage in self-reflection.

> '. . . it is stressful for some staff, and they may become defensive

> and for this reason, I feel that when the trainer shared personal examples of RRs that were played out in therapy with a client, this helped me to be more open to self-reflection and think about how my own relational patterns may come out in my work and how I can avoid this and or why and how I may be joining the maps of some of my clients. . . (P2)

> '. . . seeing the trainer doing hers. And sharing her own store. It was quite helpful but intense. . . ' (P6)

Theme 3: Barriers to 'relational thinking' on to day-to-day practice

Four participants commented on some pitfalls to the use of their relational thinking in day-to-day practice. Some of these barriers include lack of time, pressures, and lack of capacity.

> '. . . pressure of workload, we have lost staff and we do not have time. No time to think.' (P4)

> '. . . the challenge of not having time. You know when you are really busy. . . is one of those things. . . that puts off people.' (P1)

This theme highlights how obstacles often arise from the system in which CMHTs operate from and how this has a negative impact on their ability to engage in reflective practice.

Participants also highlighted other barriers to reflective practice. Specifically, participants commented on the systemic issues that often characterise NHS teams and appear to act as obstacles in staff ability to slow down and engage in relational reflective practice.

Discussion

This small scale study comes with limitations. It was intended to be a multi-site study across different teams but was cut short by the arrival of COVID which was frustrating having got through the lengthy process of research clearance. It is based on only six interviews and might best be considered as a research note. The present study's findings whilst small scale highlight that CAT relational skills-based training for the participating CMHT staff is perceived as valuable as well as having a positive impact on their ability to engage in reflective practice.

The first step that was identified was the value of 'slowing down' and having time for self to think together. The study indicates that CAT mapping and RRPs can be a useful tool to support CMHT staff to engage in reflective practice.

The second step, linked to how the training day was delivered. The following 'training' invitations were helpful a), to engage in a compassionate understanding of their service users' life story and to understand how RRPs are developed (3Rs, Reformulation), b) to learn to recognise RRPs (3Rs, Recognition) and c) to begin to consider alternative healthier ways to relate with their service users and ultimately to avoid re-enactments (3Rs, Revision) through attention to one's own feelings.

The study also may suggest that how training is delivered may play a role in increasing CMHT staff's Zone of Proximal Development (ZPD, Vygotsky's 1978) when learning to practice the 3Rs. CAT places significant emphasis on the concept of *scaffolding* (Bruner, 1986: 77). Bruner's theory of scaffolding was influenced by Vygotsky's (1978) theory of the ZPD. Learning needs to happen within the learner's ZPD (Vygotsky, 1978). Scaffolding is defined as what a good teacher provides to the child when she/he tries to learn a new skill and they are not ready to learn it independently (Nehmad, 2017). In a similar way, Nehmad (2017, p. 23) states that all good supervision and teaching should take place within the person's ZPD, where the facilitator acts as *'external mental function'* for the learner.

The qualitative data may tentatively indicate the trainer's ability to 'model' the relational approach by using 'self' while teaching the use of RRPs and the 3Rs can increase CMHT staff ZPD and readiness to engage in relational reflective practice. We are left wondering whether trainers' willingness to disclose personal examples are important in supporting CMHT staff to be less guarded and more likely to engage in reflective practice. Whilst each trainer and training situation is unique, trainers' willingness to self-disclose can help CMHT staff to stretch themselves within each other's zones of proximal educational development and engage more fully in meaningful learning. More research is needed into when and how to make appropriate use of modelling self-disclosure both to illustrate the cognitive and emotional aspects of reciprocal role ideas and to model the risk, safety and trust of personal engagement. □

References

Baumgart, J.G., Kane, H., El-Hage, W., Deloyer, J., Maes, C., Lebas, M.C., Marazziti, D., Thome, J., Fond-Harmant, L., Denis, F. (2021). The early impact of Covid 19 pandemic on mental Health facilities and psychiatric professionals. *International Journal of Environmental*

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), pp. 77-101.

Bruner, J. (1986). *Actual minds, possible worlds.* Harvard University Press.

Gunn, J. E., & Pistole, M. C. (2012). Trainee supervisor attachment: Explaining the alliance and disclosure in supervision. *Training and Education in Professional Psychology, 6*(4), pp.229–237

Hepple, J (2019). CAT reflective practice groups. *Reformulation*, Winter, pp.22-25

Hunter, S.V.E (2015) 'Exploring metacognition the narratives of therapeutic ruptures with staff within forensic mental health'. Unpublished D Clin Psy thesis.

Jefferis, S. (2021). *The covid struggle list.* Available at www.engage.acat.org.uk (Accessed 31 October 2022).

Jones, L. and Annesley, P. (2018). 'Part of being human': evaluating the 4Ps model to support inpatient staff teams in reflecting on interpersonal dynamics.' 14(4), pp. 232-241

Morrall, P.A. (1997). Professionalism and Community Psychiatric Nursing: a case study of four mental health teams. *Journal of Advance Nursing, 25*(6), pp. 1133-1137.

Nehmad, A. (2017). 'The healthy supervisor: A CAT understanding of the process of psychotherapy supervision' in Pickvance, D. (ed). *Cognitive Analytic Supervision*. Routledge: London, pp. 19-36.

Ryle, A. (1991). *Cognitive Analytic Therapy- Active Participation in Change: New participation in change.* John Willey & Sons: London

Ryle, A. & Fawkes, L. (2007). Multiplicity of Selves and Others: Cognitive Analytic Therapy. *Journal of Clinical Psychology, 63*(2), 165-174.

Thompson, A.R., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J. and Kerr, I. (2008). Multidisciplinary community mental health team staff's experience of a 'skills level' training course in cognitive analytic therapy. *International Journal of Mental Health Nursing, 17*(2), pp.131-137

Vygotsky, L. S. (1978). *Mind in Society: The Development of Higher Psychological Processes.* Cambridge, MA: Harvard University Press.

Westacott, M. (2017). 'Supervising non – CAT therapists' in Pickvance, D. (ed). *Cognitive Analytic Supervision.* Routledge: London, pp. 198-208.

Wilson, H, Davies, JS and Weatherhead, S (2016). 'Trainee therapists' experiences of supervision during training: a meta-synthesis', *Clinical Psychology and Psychotherapy, 23* (4), pp. 340-351.

Reviews

Introducing Cognitive Analytic Therapy: Principles and practice of a relational approach to mental health (2nd Ed.) (2020)
A. Ryle and I.B. Kerr Chichester: Wiley (pp.358)

FRANK MARGISON

Ian Kerr had the rewarding but profound task of working with Tony Ryle on their core text on CAT for this new edition with the intention of revising and updating their original version (Ryle & Kerr, 2002). As all readers of this journal will know, Tony Ryle died in 2016 and Kerr continued the work on the new edition with an understandable delay to regroup. Ryle had always worked with colleagues on his major presentations of CAT. This can be seen in the contributions of Amanda Poynton and Bee Brockman as well as very close editorial engagement from Glenys Parry in his first key book *Cognitive-Analytic Therapy: Participation in Change (A new integration in brief psychotherapy)* (Ryle, 1990). That early book spelled out in detail the model of CAT and was in many ways the predecessor of both editions of 'Introducing Cognitive Analytic Therapy' (Ryle & Kerr, 2002, 2020: shortened to 'Introducing CAT' for brevity in this review).

What does the second edition of Understanding CAT contain?
The book can be divided into three main themes, plus a resources section: The first theme (Chapters 1-4) contains an introduction to CAT and the development of the self, where Chapters 1 and 2 give a brief account of CAT and how the main features of its current practice evolved, with an example of a therapy in chapter 2. Chapters 3 and 4 consider the normal and then the abnormal

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development of the self and introduce Vygotsky and Bakhtin's concepts which now form part of the underlying theory of CAT.

The second theme (covering Chapters 5 to 8) is how CAT is practised and developed: Chapter 5 covering the selection and assessment of clients / patients leading on to reformulation and mapping in chapter 6. The course of therapy and how to consolidate change is summarised in chapter 7 and this includes how to recognise and deal with re-enactments and how to bring a therapy to ending that promotes further change. Chapter 8 addresses an 'ideal model' of therapist interventions embedded in the CCAT competence measure and its relationship to the supervision of therapists.

Applications of CAT in various settings and contexts is covered in the third theme: A wide variety of patient groups and settings is described in Chapter 9 and treating complex presentations and so-called personality disorders in Chapter 10. The concept of the so-called 'difficult' patient and approaches to this problem, leading to 'contextual reformulation' and its use in reflective practice form the main themes of the final chapter (11).

These sections are all developed and expanded from the First Edition, so there is good continuity with what has gone before, whilst the book is also richer for the many additions.

There is then an extended section covering key resources for practice such as the Psychotherapy File, CAT competences, Personality Structure Questionnaire assessing stability of the self, and the basics of repertory grids.

Mapping these chapters against the contents of the First Edition there is a high level of similarity of the basic structure of both editions. However, there are some important aspects that have been updated. For example, the section on contextual reformulation is greatly expanded (Ryle & Kerr, 2020, pp. 269-281) with a rich array of examples and a reworking of the main diagrammatic example to show the evolution of *contextual understanding*. The current emphasis is on seeing the 'difficult patient' as a series of complex re-enactments between staff members engaging with different aspects of a fragmented self-structure, and looking at the whole as a complex system.

Scope of review

I have considered the second edition in its own right, but this review is also a way of reflecting more generally on progress for the CAT model.

All psychotherapy models, like religions, face an existential crisis when the founder is no longer here, and this review considers the health of 'CAT' through the lens of the second issue of 'Introducing CAT'. Acknowledging this, in his preface to the second edition, Kerr acknowledges that this book marks the end of an era:

> 'However, I hope that it may still represent an important "staging post" in the development and evolution of CAT in that it represents the last position and views of its creator.'
> (p xii: from Preface to 2nd Edition, op cit, 2020)

This review is an opportunity to 'take stock' as CAT moves into a new era with all the risks that involves. Kerr comments on what he has taken on:

> '. . . we all stand "on the shoulders of giants" and of many others, and depend on their very various contributions. In a very real, and dialogical, sense there is no such thing as completely original or independent work.'
> (p. xiv, Preface, op cit, 2020)

He is confirming what we all know – that CAT is a shared endeavour, as much in its mode of development as in the therapy itself. This edition comes at a key point in the development of CAT having been in existence now for about forty years. I was privileged to see presentations and discussion of the very early synthesis that led to CAT by Ryle and colleagues from Guys' and Thomas's medical school at early meetings of the Society for Psychotherapy Research (UK) in Ravenscar, North Yorkshire. The publication of this book marks the evolution of those early ideas into a rich and thriving approach to psychotherapy after forty years of development.

Having a charismatic figure like Ryle as the founding figure of a therapy can bring its own problems in the transition between the initial generation and those that follow. This book gives us an opportunity to check how well CAT has prepared for making that crucial step.

In my mind, Ryle and colleagues giving those early talks represented the prototype and CAT 1.0 was Tony Ryle's 1990 book. We can perhaps see Ryle & Kerr 2002 as CAT 2.0 and the current book as CAT 3.0 – a new iteration building on the past but also taking stock and consistent with earlier iterations.

This review looks at how mature the CAT model is at this point. But, how do we recognise maturity in a model of therapy?

I suggest we consider the maturity of CAT in terms of six fundamental questions, each with a rider to help us reflect:

- Is the model coherent in itself and is it underpinned by a coherent body of theory?

  - Has the theory base continued to expand alongside the growth of training?

- Can the model be defined and differentiated from other approaches?

  - As part of that definition, can we assess whether the approach is being used in a competent way that is consistent with the theory?

- Has the approach been tested adequately across a range of conditions?

  - Are new areas of applicability being continuously developed?

- Are there tried and tested ways of teaching the model to a new generation?

  - Are new ways of developing therapy skills welcome?

- Are new approaches to practice welcomed, tested, and assimilated

  - Do these new developments link back seamlessly to existing knowledge?

- Finally, are there any warning signs of the field splintering into disparate factions?

  - Is there a new generation drawn to the model and generating new research questions, or are subgroups fighting for the right to be the true heirs of Ryle?

Ryle and Kerr's (2020) book provides us with a great vantage point to address all of these questions, but at times I have looked beyond the book to other contemporary work to review the development of CAT more generally.

Is the model coherent in itself and is it underpinned by a coherent and expanding body of theory?

The first chapters of Introducing Cognitive Analytic Therapy' address these key question of the theoretical coherence of CAT. On the very first page we are given a brief history of CAT in that it is drawn from cognitive and psychoanalytic roots and more recently the works of Vygotsky and Bakhtin, but the essence of CAT is:

> '. . . a predominantly relational understanding of the origins of patient problems and symptoms and an explicitly empathic, pro-active, and compassionate therapeutic stance, with an active focus on issues arising within the therapeutic relationship.'
> (Ryle & Kerr, 2020 p1)

These fundamental relational and humane values exemplify the whole of the book.

There are distinct phases in the development of CAT and all of these are well-represented in both editions of 'Introducing CAT". Also, there is research to show that the core reformulation used within the evolving model of CAT can be shown to be accurate at least as measured by comparison with another model such as the Core Conflictual Relationship Theme (CCRT: Luborsky & Crits-Christoph, 1989) and the SASB-CMP (Structural Analysis of Social Behaviour-Cyclic Maladaptive Pattern: Benjamin, 1987). So, the book succeeds well in its primary task of conveying how CAT conceptualises difficulties and how these can be represented succinctly in clinical work.

Can the model be defined and differentiated from other approaches and be practised competently?

CAT exemplifies an approach to therapy that supports reflective practice (see Ryle & Kerr, 2020, pp 279-81). To be a reflective practitioner it is important to know not only *what* you are saying but also *why*. Also, to conduct meaningful research on the effects of CAT we need to be able to recognise that something actually is CAT therapy against some agreed definition. This recent book traces the development of the tools for reflective practice.

Having produced a plethora of tools, Ryle commented (1990, p208-9) that this is more than a 'tick box' exercise. In discussing how change is internalised he comments that

> '. . . in real life, thinking is embedded in a total living process. . .'

and comments CAT. . .

> '. . . aims to enhance subjective competence through the development of precise, appropriately aimed reformulations, which hold the patient to the task of addressing his actual important problems and which explicitly build up the patient's skills in, and practice of, self-reflection.'

This is in the context of understanding the change process for client / patient, but it states a principle embedded in the learning of CAT and how it changes the therapist.

In the first edition of Introducing CAT therapists were encouraged to be self-reflective and to use tools to review what they were doing, but the methods were less clearly defined at that time and the focus was on internalising the model through supervision.

> 'Supervisors are working in the supervisee's zone of proximal development (ZPD) in their transmission of the methods and values of the model. . .'
>
> (Ryle & Kerr, 2002, p128).

However, by the second edition, there is a much fuller exposition of how therapists internalise CAT. The early steps included simple tools like the Therapist Intervention Coding [TIC] method developed by Ryle (see Ryle, 1997). This is discussed as an early way of reflecting on practice to provide feedback to clinicians. It existed in three forms – first as a self-reflexive tool for self-supervision; secondly, for supervisors providing training; and, thirdly, for outside observers, for example in a research study. Although, as discussed below, the CCAT has largely superseded the TIC it is worth revisiting as an early example from more than 25 years ago of a very practical approach to assimilating complex concepts.

In the second edition there is a more explicit acknowledgement of the need for therapists to evaluate whether they are actually practising CAT as measured against some objective standards. In the chapter 'The CAT model of Therapist Activity and of Supervision' Ryle and Kerr, (2020, pp 141-159) acknowledge the work of Parry, Bennett and colleagues and the CCAT [Competence in Cognitive Analytic Therapy measure] (Bennett & Parry, 2004). This has been a significant change in the development of CAT: Ryle had been working on measures of competence in repairing alliance ruptures (Bennett et al, 2006) which led to the development of the CCAT, for years before the first edition of *Introducing CAT* came out, but the implications from task analysis for how we learn CAT had not featured so prominently until the most recent edition (Ryle & Kerr, 2020, pp 146-8).

The focus on both adherence and competence demonstrates that these concepts are now embedded in the mature model of CAT when previously they had been seen as the province mainly of researchers. Most training centres for the development of CAT therapists now build in learning from self-reflection assisted by measures like the CCAT, and detailed reflection based on audio and video recordings. Possibly I should own a bias towards this approach to learning (Margison, 1991), but in the context of this review it is vital to have clear descriptions of competent practice otherwise the field will inevitably fragment into personal idiosyncrasies masquerading as revised versions of the model.

Has the approach been tested across a range of conditions and are new applications being developed?

The research output for CAT is increasing steadily, but the situation has not changed greatly from the analysis from Calvert and Kellett's review in 2014.

> 'Cognitive analytic therapy is a popular and promising intervention for complex presentations. However, the evidence base currently lacks wider credibility due to having largely bypassed the rigours of the controlled phase of the hourglass model of psychotherapy evaluation. There is a particular need for further CAT outcome research with common mental health problems.'
>
> (Calvert & Kellett, 2014, p.253)

The research base for CAT has been consolidated further since the publication of *Introducing Cognitive Analytic Therapy*, (2nd Edition) by the publication of a special issue of *Psychology and Psychotherapy: Theory Research and Practice* (Taylor and Hartley, 2021) which demonstrates the range of research strategies being used to understand the impact of CAT ,

I commented about the special issue (Margison, 2021):

> '[In] practice, research is an integral part of an evolving approach. Research questions are prompted by real dilemmas in the therapy room, and in turn, CAT as a model of therapy transmutes almost imperceptibly into a new version. Those of us working in psychotherapy around forty years ago hearing the first iterations of CAT would hardly recognise the model as currently described – the core values are unchanged, but the tools, length of therapy, range of formats and clients seen have changed hugely.
>
> 'Research is always shooting at a moving target with therapies

evolving over time, and CAT focuses on reformulation rather than fixed diagnostic categories. The special issue shows both the health of CAT research but also some of the limitations of research being carried out on a relatively small scale. If we look ahead another twenty years from now we may see further development of this hybrid model of small-scale research supporting and enriched by larger projects.' (Margison, 2021, pp. 163-4)

Taylor and Hartley (2021, p. 1) comment in their Editorial:

> 'A notable characteristic of CAT research to date is that it has largely consisted of practice-based evidence (PBE), small-scale evaluations taking place in real-world clinical practice, often led by clinicians.
>
> 'This focus is perhaps reflective of CAT's origins as a pragmatic model developed primarily through clinical practice. Research of this nature comes with advantages and disadvantages. The small samples limit the generalizability of the results, and the lack of randomization and control or comparison groups limits the ability to attribute outcomes to the therapy itself. Nonetheless, such small-scale clinical work is important.
>
> 'Case series and small-scale pilot trials represent an essential step in determining the acceptability and safety of novel interventions, and the feasibility of larger-scale evaluations.'

Ryle & Kerr, (2020, p285-6) comment that CAT was from its outset embedded in a culture of evaluation:

> 'CAT arose out of the attempt to evaluate the validity and effectiveness of existing psychotherapy models and has aimed to maintain this as a fundamental component of its own self-evaluation. . .
>
> 'We would see this position of critical self-reflection and evaluation as being central to the CAT model in terms of both theory building and clinical practice.'

The approach of both Ryle and Kerr's books is still at the centre of gravity of CAT development and ethos: Research and self-scrutiny are both recognised as essential components of a therapy offered as part of public services. But, Ryle & Kerr do not follow the need for large scale RCTs slavishly and are sceptical about the distortions produced by large-scale funding structures for research.

When is CAT used?

Both of the editions (Ryle & Kerr, 2002, 2020) are wide-reaching and eclectic in the range of conditions addressed. In the first edition, just under a third of the book (op cit. 2002, pp 131-201) addresses the conditions where CAT has been developed. The authors briefly describe how CAT can be modified for a whole range of conditions including depression, anxiety, PTSD, OCD, somatisation, deliberate self-harm, medical conditions (such as asthma and insulin-dependent diabetes), and substance misuse. There are also introductions to topics of early-stage dementia, gender identity issues, and unresolved mourning, plus a section on psychosis. The latter explored how a dialogical approach to voices may be fruitful and go beyond the then current models based on CBT. In one particular aspect the first edition was ahead of many in the field discussing complex PTSD, its relation to long-term trauma, and how it overlaps with the concept of borderline personality.

This strand is further developed in the context of current uncertainty as to the status of complex PTSD (Ryle & Kerr, 2020, pp 176-7). The advice given is consistent with a three-phase model reminiscent of Herman's suggestions:

> 'Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life'.
> (Herman, 1998, see also Howell, 2020)

Ryle and Kerr (2020 p177-8) express it slightly differently but the underlying approach to complex PTSD can be seamlessly incorporated into the practice of CAT by incorporating strategies from other therapies:

> 'The extent to which these [other treatments] can and should be helpfully embedded or 'nested' within relationally based approaches such as CAT to improve outcomes and engagement remains to be formally demonstrated, although clinical experience suggests a secure relational framework is very likely to be helpful and indeed necessary.' (op cit. p.178)

Other developments not covered in depth in the book include some of the following examples.

Work with trauma has been central to the development of CAT in other contexts, for example following early sexual abuse (Pollock, 2001). Lloyd & Clayton, (2014) had previously extended the reach of CAT by describing innovative approaches for individuals with learning disability

and their families, and examined why the lack of engagement makes it difficult to work with severe autistic spectrum problems (Lloyd and Potter, 2014). They brought together innovative approaches to developing tools for those with limited verbal language and developed the idea of working in complex institutions such as forensic settings – a theme developed earlier by Pollock and colleagues (2006). At the same time, CAT has been used with older and younger individuals. Chanen and colleagues have developed integrated approaches using CAT for adolescents with early features of emotional dysregulation (Chanen et al, 2014, Chanen et al. 2015), whilst Hepple & Sutton, 2004) have described how CAT can be used with older people and their families.

Challenging presentations

The diagnostic approach is critiqued, but then used as scaffolding for a long chapter as described above, covering diverse conditions (op cit. 2020, pp. 161-223). This is followed by a separate chapter dealing with especially complex and challenging presentations (op cit, 225-264). This works as an effective way of applying principles generally and then looking at a more complex level where the challenge for the therapist is much more intense. The section on challenging presentations (Ryle & Kerr, 2020, Chapter 10, pp225-263) is complex but clearly grounded in clinical experience. My lingering concern with this chapter is that it still reifies the concept of borderline and narcissistic personality disorders, when the markers of dissociated self-states belong equally well in the section on trauma (op cit, pp. 176-185). Other challenges include working with co-existing physical disorders, (for example, Fosbury et al, 1997; Ryle & Kerr, 2020, p.187)

Both of these chapters will be well-received by practitioners looking for guidance on how to work across a wide range of multiple and complex disorders. But, as discussed above it was necessarily based on the work of pioneering clinicians rather than a distillation of extensive outcome research and practice so these descriptions are still part of an emerging picture, where diagnostic categories are of limited help.

Limitations

It is unreasonable to expect a single book to cover the whole range of human conditions in depth, but it is important to acknowledge that there are inevitable limitations. There is a summary from Robert Watson on 'affirmative practice' working with differently gendered individuals (op cit. 2020, pp. 210-212). This is a welcome addition, but as it is such a salient issue currently a deeper discussion on gender identity and dysphoria specifically would have been welcome.

Some current topics receive very brief discussion – for example, there is only a very brief section on perinatal mental health although this is potentially an area where CAT's understanding of early attachment issues may be particularly relevant.

> 'The CAT model was subsequently influenced by insights from developmental psychology stressing the actively intersubjective nature of the infant.'
>
> (Hamilton et al, 2021 and see Trevarthen, 2017).

I am not aware of CAT studies where the reformulation covers the parent and infant dyad, rather than the mother as an individual (albeit in the context of having a child and possibly a partner). Perhaps CAT as a way of exploring delayed bonding is an idea whose time has come.

Another area at the developing edge of therapeutic work is in neurodivergent states such as Autistic Spectrum Conditions [ASC], but the only mention of this area of work occurs in the discussion of neurobiology in the section of 'permeability of the self' (op cit, p36-7). The authors speculate about the role of 'mirror neurons' which are thought to mediate intersubjectivity (see Ammaniti & Gallese, 2014), but to do justice to the developing field of neuropsychoanalysis in CAT would probably need a whole volume. There have been attempts to work across the learning disability spectrum, but Lloyd and Potter (2014) draw attention to the difficulties faced when working with individuals at the severe end of autistic spectrum conditions. As such a common presentation to clinicians, more examples of work with individuals with neurodivergence would have complemented this section well.

Are there tried and tested ways of training new therapists and can new approaches to teaching further extend these?

Both editions pay some attention to the development of CAT therapists through training, and Chapter 8 of the second edition (op cit, 2020, pp. 141-159) provides a good grounding in the model of training underpinning the development of CAT therapists. As discussed earlier in the context of competence and the CCAT (see Parry et al, 2021), there is increasing emphasis on ensuring that therapists are true to the model they say they are offering.

Are new approaches to training being developed?
There are approaches using Dialogical Sequence Analysis as a way of training individuals to see repeated cycles and links with the Assimilation model (Leiman & Stiles, 2001) but these have not been fully incorporated into training across centres and there is little exploration of these methods in the book.

There have also been developments in the use of role-play, film and video to enhance skills, for example the suite of training films developed by Catalyse (2023), or the films developed within ICATA to model how to map self-states (ICATA, 2023). Personal Reformulations are now used as an additional training experience with the learner experiencing a reformulation based on their own life story over 4 sessions, for individuals not able to access a full CAT therapy experience.

These approaches are not explored in *Introducing CAT*, 2nd edition, and the focus in the book has been on developing self-assessment with the CCAT and developments within relational Cognitive Analytic supervision (Bennett & Parry, 1998, Pickvance & Parry, 2017). One of the great achievements within the CAT model has been the enormous growth in training and possibly a theme ripe for development is to re-examine what aspects of supervision and modern approaches to learning would benefit from revision for the next generation.

Is there a risk of splintering into factions?
There is fortunately little factionalism within the CAT world, as yet – at least not in the sense that new leaders are pulling away from the main model as described by Ryle and his colleagues over the last four decades. This reflects well on Ryle's own ability to synthesise and integrate within the developing model (see Denman, 2002).

Denman describes Tony Ryle recounting how he designed the Procedural Sequence Model [later re-named PSORM: Procedural Sequence Object Relations Model] as an explicit attempt to provide an explanation for the finding announced in the 'Dodo bird paper' (Luborsky, et al, 1975) that all therapies were equal in efficacy. (Denman, 2002, p. 88). Ryle suggested that different therapies addressed different aspects of the sequence – whether appraisal as in cognitive therapy, action as in behavioural therapy, or aim as in psychodynamic therapy.

With such a broad theoretical underpinning Ryle to some extent future-proofed CAT as its theoretical base was wide enough to accept many fellow travellers. It may have been possible in the past to say this person has a psychodynamic-flavour of CAT, or this one is a CBT-style CAT therapist but these tribes are much less in evidence as CAT becomes mature as a model in its own right.

Critique

Over-complexity
All of the above positives remain true but there are still be some criticisms that should be considered. For example, Denman (2002, p. 88), whilst positive about the integrative aspects, pointed out gaps such as the weakness in linking with attachment theory although that has been partly remedied later by Jellema (2002), and subsequently others. On the one hand attachment theory is a different model to that of CAT, but its importance needs to be acknowledged. These gaps combined with openness to links with other approaches demonstrates an ability to assimilate and engage with other models seamlessly within the integrative nature of CAT.

However, such an ability to integrate other concepts comes at a price. Is the model now too complicated and has it lost its original simplicity to its detriment? We can see this dilemma graphically when we compare the simplicity of a basic mapping of snags, traps and dilemmas (see Ryle & Kerr, 2020, p. 106) compared with the complexity of the model of self (op cit, p. 57) where the self is as a complex construct embedded within several forces. Also, we can compare the simple basic model with the very high level of complexity seen in a contextual SDR (see for example, op cit. pp 235-6). There is no clear answer to how much complexity should be put into a diagrammatic reformulation, but the trend over time has been to assume that complexity increases the fine-grained nature of the formulation. In practice, with shifting self-states it is possible to identify 'where we are on the map', so putting the immediate experience into a wider context. But on the principle of Occam's razor, we should not multiply entities beyond necessity (Leff, 1975, pp 6-13) and make the map unnecessarily complex without clear reason.

The simple 8-session model with a distillation of Target Problem Procedures with Traps, Snags, and Dilemmas still exists, but there is a potential risk that this simplicity may become subsumed under greater and greater complexity. Ultimately it is an empirical question about the relative advantages and disadvantages of complexity of formulation. Potter (2020) exemplifies recent attempts to rethink mapping within CAT seeing

it as a multimodal approach that tries to capture rapidly the essence of what is happening at a first meeting, and this reminds us that mapping is a process rather than the carefully-refined end-product.

Limitations of scope

No single book can cover every aspect of CAT, but one of the refreshing aspects of CAT is its ability to embrace non-linear ways of thinking, whether in art, drama or poetry and as a statement of where CAT is embodied it surely includes those aspects of practice. The book does not do justice to this range of different ways of working and the 'poetics of experience' (Mair, 1989). Hughes (2013) develops the theme of arts-based therapy in her discussion of the integration of CAT with arts-based therapies, but that aspect of CAT is not prominent in *Introducing CAT* 2nd edition, and therapist creativity is encouraged but not fully developed in this book.

Socio-political perspective

It is equally true to say that the book focuses on difficulties experienced by individuals, albeit in a rich social context. But, there is little of the explication of Ryle's socio-political work evident directly in this volume. Fortunately, we can see the inspiration arising from that aspect in specialist texts for example (Lloyd & Pollard, 2018) which extends the political aspects of CAT in the spirit of Ryle

Is the book an easy read?

The first edition was well-received but also a demanding read. This edition has more space (358 compared to 265 pages), so there is more space for clinical examples. Still, at first glance some readers may hesitate at the start of entering into the theoretical and clinical detail of a book on this scale. Even the pictures are complicated! But, it is a book to savour and dip into from time to time, or to look for particular guidance. If you already know CAT, perhaps start in the section on contextual reformulation (in Chapter 11, pp 265-281) and then the Afterword for inspiration (op cit, pp 283-286). Contextual reformulation is a challenging topic but brings a new perspective to the practice of CAT. If you are fairly new to CAT perhaps start with the clinical wisdom in the pages on recognising enactments (op cit. pp 132-139) or connect with sections on CAT for specific conditions (op cit, for example, pp171-194). Those who persevere and take their time will be well-rewarded with a full sense of a model of psychotherapy in all its versatility, maturity, breadth and depth, but even those who have been involved with CAT over decades will take time to assimilate the amount of information that Ryle and Kerr have provided.

Conclusions

This book demonstrates a maturing and coherent model of psychotherapy. CAT has not stood still: This review shows that there is evolution and changing emphasis. However, can we learn from the trajectory of other therapies and identify the risks as this approach to psychotherapy matures?

Despite many books written on CAT, this book stands alone as the distillation of Ryle's views. Confusingly, there is also the *Oxford Handbook of Cognitive Analytic Therapy* (Brummer, et al (eds), 2022). This may eventually evolve into a comparable state of the art handbook, but it is being published chapter by chapter, initially on-line, and only two chapters are yet available to read. However, the advance notification covers several gaps in the Ryle & Kerr book by considering the contribution of arts therapies and of perinatal care amongst other topics.

Kerr has done a wonderful job of making 'the centre hold' (Yeats, 1994) after Tony Ryle's death. The book strains at times to hold in all the fresh ideas that invigorate CAT but it fulfils its main task of being an authoritative exposition of the model. The risk of making CAT top-heavy has been successfully negotiated, and we have a lot to thank both authors for. Ryle's voice is still clearly there, and his ongoing influence is enormous, and Kerr has succeeded in holding together a developing CAT psychotherapy world view. □

References

Ammaniti M, Gallese V. (2014) *The birth of intersubjectivity: Psychodynamics, neurobiology, and the self*. New York: WW Norton & Company; (Chapter 1)

Benjamin, L. S. (1987). Use of the SASB dimensional model to develop treatment plans for personality disorders, I: Narcissism. *Journal of Personality Disorders*, I, 43-70

Bennett, D., & Parry, G. (2004). A measure of psychotherapeutic competence derived from cognitive analytic therapy. *Psychotherapy Research,* 14(2), 176–192

Bennett, D, Parry, G (1998) The Accuracy of Reformulation in Cognitive Analytic Therapy: A Validation Study, *Psychotherapy Research*, 8(1), 84-103

Bennett, D, Parry, GD, Ryle, A (2006) Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy* 79(3) 395-418

Brummer, L, Cavieres, M, Tan R (eds), (2022) *The Oxford Handbook of Cognitive Analytic Therapy* (online edn, Oxford Academic, https://doi.org/10.1093/oxfordhb/9780198866572.001.0001, Accessed 21 Apr. 2023

Calvert, R. and Kellett, S. (2014), Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychol Psychother Theory Res Pract*, 87: 253-277

Catalyse (2023) https://catalyse.uk.com [Accessed 24/04/23]

Chanen, A., Jackson, H., Cotton, S.M. et al. (2015) Comparing three forms of early intervention for youth with borderline personality disorder (the MOBY study): study protocol for a randomised controlled trial. *Trials* 16, 476

Chanen, A.M., McCutcheon, L., Kerr, I.B. (2014). HYPE: A Cognitive Analytic Therapy-Based Prevention and Early Intervention Programme for Borderline Personality Disorder. In: Sharp, C., Tackett, J. (eds) *Handbook of Borderline Personality Disorder in Children and Adolescents*. Springer, New York, NY

Denman, C. (2002) Integrative developments on cognitive analytic therapy. In J, Holmes and A Bateman (Eds.) *Integration in Psychotherapy: Models and methods*. Oxford: OUP pp. 87-106

Fosbury, JA, Bosley, CM, Ryle, A (1997) A trial of cognitive analytic therapy in poorly controlled Type 1 patients, *Diabetes Care*, 20, 959-964

Hamilton, J, Saxon, D, Best, E, (2021) A randomized, controlled pilot study of cognitive analytic therapy for stressed pregnant women with underlying anxiety and depression in a routine health service setting. *Clin Psychol Psychother*. 28: 394–408

Herman, J (1998) Recovery from Psychological Trauma. *Psychiatry and Clinical Neurosciences* 52, (S1) S98-S103

Hepple, J, Sutton, L (2004) *Cognitive Analytic Therapy in Later Life: New Perspectives on old age* London: Routledge

Howell, E. (2020) *Trauma and dissociation informed psychotherapy: Relational healing and the therapeutic connection*. New York: WW Norton & Company

Hughes, R (2013) Integrating Art Psychotherapy and Cognitive Analytic Therapy (CAT) *Reformulation*, Summer 2013, p.44-49.

ICATA (2023) https://www.internationalcat.org/resource [Accessed 24/04/23]

Jellema, A. (2002) 'Dismissing and Preoccupied Insecure Attachment and Procedures in CAT: Some Implications for CAT Practice', *Clinical Psychology and Psychotherapy*, 9, 225-241

Leff, G (1975) *William of Ockham : the metamorphosis of scholastic discourse*. Chapter 1. Intuitive and abstractive knowledge. Manchester: Manchester University Press p 6-13

Lloyd, J. and Clayton, P. (2014) 'Cognitive Analytic Therapy for People with Intellectual Disabilities and their Carers', In *Cognitive Analytic Therapy for People with Intellectual Disabilities and their Carers*, London: Jessica Kingsley

Lloyd, J Pollard, R (2018) *Cognitive Analytic Therapy and the Politics of Mental Healt*h London: Routledge

Lloyd, J. and Potter, S. (2014) 'Heroic or Stoic: Why Do We Try So Hard, Or Give Up So Easily, in Helping with Severe Autism', In: P. Clayton, & J. Lloyd (Eds.) *CAT with people with intellectual disabilities and their carers*, P. Clayton, P. & J. Lloyd. London: Jessica Kingsley pp. 153-167

Luborsky, L, Singer, B, Luborsky, L. (1975) Comparative studies of psychotherapies: Is it true that 'everybody has won and all must have prizes'? *Arch Gen Psychiatry* 37, 471-481

Luborsky, L, Crits-Christoph P. (1989). A relationship pattern measure: The CCRT. *Psychiatry*, 52, 250-259

Mair, M (1989) *Between Psychology and Psychotherapy: The poetics of experience*. London: Routledge. pp 59-69

Margison, F (1991) Learning to listen: teaching and supervising basic psychotherapeutic skills. In J Holmes (Ed.) *Textbook of Psychotherapy in Psychiatric Practice.* London: Churchill Livingstone, pp. 165-185

Margison, F (2021) Psychotherapy research and CAT (review) *Int. J Cognitive Analytic Therapy and Relational Mental Health*, 4, 151-159

Parry, GD, Bennett, D, Roth, A, Kellett, S (2021) Developing a competence framework for cognitive analytic therapy *Psychology and Psychotherapy: Theory, Research and Practice*. 94, 151–170

Pickvance, D, Parry, G (2017) Clinical and Ethical Challenges in Relational Supervision. In D. Pickvance, (Ed.) *Cognitive Analytic Supervision: A Relational Approach*. London: Routledge

Pollock, P. (2001) *Cognitive Analytic Therapy for Adult Survivors of Childhood Abuse: Approaches to Treatment and Case Management* Chichester: Wiley

Pollock, P.H., Stowell-Smith, M. (eds.) (2006) *Cognitive Analytic Therapy for Offenders: A New Approach to Forensic Psychotherapy* London: Routledge

Potter, S. (2020) *Therapy with a Map: A cognitive analytic approach to helping relationships,* Shoreham-by-sea, West Sussex: Pavilion

Taylor, PJ and Hartley, S (2021): Special Issue: Cognitive Analytic Therapy: Research Developments and Insights. Psychology Psychotherapy Theory Research and Practice, Vol. 94: (S1) pp i-iv, 1-170

Trevarthen, C. (2017). The affectionate intersubjective intelligence of the infant and its innate motives for relational mental health. *International Journal of CAT and Relational Mental Health,* 1, 11– 53

Yeats, WB (1994) The Second Coming. In: *The Collected Poems of WB Yeats*, Ware, Hertfordshire: Wordsworth Editions

La Thérapie Cognitive Analytique CAT, Marie-Anne Bernardy-Arbuz, self-published, undated (2023)

Annie Nehmad

Marie-Anne is the only qualified CAT therapist in France, and she is keen to disseminate the model. Instead of translating the Ryle & Kerr introduction to CAT, as people in some other countries have done, she has written her own book, addressed to current and future trainees, and in fact to the interested lay reader.

This is a considerable achievement, and the result is very good.

The book is in three parts.

The first is a clear and engaging introduction to CAT's history, applicability, key concepts, and practice. She draws on Ryle & Kerr, and also on the writings of Rachel Pollard, Steve Potter, Liz McCormick, Corbridge et al, and others.

The second part includes accounts of actual therapies, including a young woman with a 'Borderline' diagnosis (which allows a discussion of enactments and recruitments), a teenager, and the mother of a 15-year-old on the autistic spectrum (Marie-Anne works with children, adolescents and their parents). It also includes imaginary therapies, with contemporary versions of Hansel and Gretel, and Ebenezer Scrooge. There is also a Reformulation letter to Cinderella (translated from Alison Jenaway's 2010 article).

Marie-Anne shows how she integrates other approaches into her CAT therapies, such as Moreno's Psychodrama, and Family Sculpting. She also describes the use of CAT-informed diagrams within long-term therapies with adolescents.

I was particularly impressed by the lengthy account of the 16 session CAT of 'Dorothée'. This takes up 64 pages, allowing a lot of detail, and also, in a different font, explanatory comments by Marie-Anne. This very detailed account felt to me like just what a beginner would want to read before

(or while) embarking on their first case.

The third part of the book is about the power of writing in therapy. In earlier parts of the book she has spoken about Reformulation, Goodbye Letter, No-Send Letters and Diagrams. Here she adds the importance of shared phrases in writing, whether to help 'unblock' a therapy by writing down the 'blocking' phrase/belief, thus changing the client's relationship to it; or 'protective phrases' ('I am now a grown-up and I am safe'), as a way of grounding the person in the present, helping to prevent, or deal with, dissociation.

Throughout the book there are suggested exercises for readers (both lay people and psychotherapists), e.g.

> Consider your reciprocal role with your favourite (and/or hated) schoolteachers?
>
> What did you consider significant about this session?
>
> Write a Reformulation and Diagram for Snow White, perhaps focusing on her relationship with her mother-in-law.

These exercises provide food for thought and would be helpful for study groups, with or without a tutor/supervisor.

This is an excellent book, which I wish all my new supervisees could have access to.

Were there any disappointments for me? Yes, and I would like to offer these comments as suggestions for the second edition.

Marie-Anne repeatedly refers to the Reformulation Letter as happening in the fourth session. This could make CAT seem rather rigid, almost manualised. In fact, CAT is practised flexibly. There can be good reasons for delaying the reformulation, such as needing to build a therapeutic relationship with scared or mistrustful patients.

Some concepts and tools, such as timelines, are very useful, but they are presented as if they are an inextricable part of CAT – and could come across to readers as if they were invented by CAT.

The Window of Tolerance is referred to several times, without a real explanation of its meaning and significance, and without referencing Dan Siegel, who originated it.

Though there are several references to Ryle's 1997 book, CAT and Borderline Personality Disorder[1], and his 1997 article, 'The structure and development of borderline personality disorder: a proposed model', *British Journal of Psychiatry2*, Marie-Anne does not address the concepts of Level 1, Level 2 and Level 3 procedures, nor the importance, especially with fragmented clients, of working at Level 2 (ability to choose appropriately from one's repertoire of procedures) and Level 3 (reflective capacity). I consider these one of Ryle's most important contributions. There again, one can hardly criticise his disciples for such an oversight, since Ryle himself lost interest in these ideas after 1997 (they didn't make it into the first edition of the Ryle & Kerr book in 2002)

The book would greatly benefit from a glossary, or even a glossary/index (a glossary which says, after the definition, See also page X).

Message to all CAT supervisors (to be included in next ACAT mailing): find out which of your supervisees is fluent in French, and recommend this book! □

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[1] Ryle, A (1997b) Cognitive Analytic Therapy and Borderline Personality Disorder, Chichester: Wiley, pp 34-38.

[2] Ryle, A. (1997a) 'The structure and development of borderline personality disorder: a proposed model', British Journal of Psychiatry, 170: 82-87

Cognitive Analytic Therapy: Theory and Clinical Practice
Iannis Vlachos

Rita Toli

This is the first Greek book discussing the theoretical framework and clinical use of Cognitive Analytic Therapy (CAT). Its timing coincides with CAT's increasing expansion around Greece, with training courses taking place in different areas of the country on an annual basis. The book is written in simple and understandable language, accessible to mental health professionals or lay people, who are interested in different models of psychotherapy and do not have expertise in psychiatry or psychology.

Firstly, the book introduces the reader to the main twentieth century psychotherapy models and their understanding of the psychotherapist's part in the therapeutic process and how it's changed in recent years. It also offers an overview of how the relationship between the therapist and the client is perceived by the different models. The importance of these two factors is addressed through a CAT stance. Subsequently, the writer could not but refer to Tony Ryle's background and the socioeconomic circumstances which he had in mind when he developed the idea of CAT and its theoretical framework. It was Ryle, who trained the writer, Iannis Vlachos, in the use of CAT at Guy's Hospital, London. This might have contributed to Iannis' warm style in his presenting CAT's essence and applications across various mental health difficulties.

The book goes on to talk about the procedural sequence model and other fundamental CAT concepts, including reciprocal roles and different maladaptive patterns, which are key in contributing to unhealthy relationships. An important asset of the book is that it offers readers, who are not well-familiarised with the model, an insight into the clinical use of CAT through the detailed outline of the model's different stages and the tools available. Additionally, the author makes a specific reference to some well-known aspects of therapy, such as the therapeutic alliance, transference and termination, explaining how these are perceived and managed within the process of CAT. A detailed step-by-step diagrammatic reformulation follows, illustrating how the client's problems and core feelings are maintained. The wealth of the clinical examples helps understand the different ways in which procedural patterns contribute to problematic relationships and situations.

In the last section, the reader finds an extended reference to the application of CAT with borderline personality disorder and some preliminary reflection on special topics including the use of CAT with children and adolescents as well as incorporating art in CAT. The book finishes with the discussion of well-known theories, which form the theoretical basis of CAT.

One could argue that this book consists of a concise overview of the theoretical bare bones of CAT and a practical guide for its use across different problems and populations. It comes as a helpful tool for the increasing number of therapists in Greece, who have recently been introduced to CAT, and those who wish to learn more about the model. However, a topic which has not been considered and would add to the value of this book is the challenges faced by Greek therapists, when attempting to offer CAT in their practice. The current socioeconomic reality of Greece which has followed a severe economic crisis and a pandemic has significantly affected health services and comprise a very different context to the British NHS, where CAT was first envisaged and developed. □

Rita Toli is a Clinical Psychologist and CAT therapist

Wild Therapy - Rewilding our inner and outer worlds (2nd Edition)
Nick Trotton, PCCS Books, 2021. First Edition (2011)

Nick Barnes

Nick Trotton, through his book is looking to make a radical departure within the world of psychotherapy. He is challenging us to explore how we might rewild ourselves and our practice, not only to support those that might present to us with profound distress but also to ensure we all may find ways of managing and coping with the existential threats upon us within the age of the Anthropocene. As he states in the opening line of his first edition

> 'Therapy is by nature wild: but a lot of it, at the moment, is rather tame. This book is intended to help shift the balance.'

Wild Therapy starts with an exploration of the polarisation of wildness and domestication which has run throughout human history and culture. This polarisation has been held within a structure of binary oppositions, such as male-female or light-dark, which often contribute to significant hierarchies and power imbalances evident in societies today and that have given rise to the need for movements such as #blacklivesmatter or #metoo.

The thinking within this book looks not only to encourage us to explore a more eco-psychotherapy and eco-psychological perspective, but rather to contextualise the reasons why there are such deep inequalities and marked social injustices throughout societies. Trotton conceptualises this as our alienation from the natural world around us – referred to by him as the other-than-human and more-than-human, giving us permission to dislocate ourselves further from nature.

Even starting with an exploration of what we mean by the word, Wild, Trotton notes there are 36 different meanings within the Oxford English Dictionary, which then also encourages a plurality of opposites, moving from wild-tame to wild-civilised, wild-peaceful, wild-constrained, and so on. Many of us (perhaps also within the world of psychotherapy) could easily be drawn into these oppositions. The idea of wild carries with it as sense of danger, and possibly excitement, but encourages a response of caution. What Trotton asks us to consider is the possibility that

> 'there is both a fear and longing contained within the idea of running wild.'

What has been missing from how we define wild, is the possibility of complexity. Wild has often been located within a simplified and elemental construct, that has not yet connected with or drawn upon the opportunities offered through civilisation. Trotton would argue that now wilderness – something beyond the boundary – has become so scarce:

> 'wild is more likely to signify the irreplaceable richness and depth of the climax forest, threatened by the crude slash of the bulldozers and the geometric grid of cities.'

Many climate activists position their arguments for climate justice within the context of a growth in extraction and consumerism that has its origins within the rise of capitalism, and consolidation through the western scientific revolution and enlightenment. Trotton completely accepts how the global and societal inequalities are sustained by the obsession with growth-based economics, but also asks us to explore the origins of the demarcation between domestication and wildness through an interpretation of the neolithic revolution that resulted in the defining of our parameters – the placing or othering of the wild spaces beyond the boundary of civilisation or beyond our control.

The reason why this then becomes of paramount importance to us, as therapists, and those interested in relational mental health, is that we are now being asked to think about and consider the boundaries – in our practice, in our communities, for our societies and for our globe – of how we might explore the possibility to re-connect to find an exit, or at least a way of coping, within this current climate and ecological crisis.

It is highly significant that the

subtitle of this book has changed from its first edition to the second. Initially presented as the Wild Therapy: Undomesticating Our Inner and Outer Worlds, the second edition has the newer subtitle, Rewilding our Inner and Outer Worlds. Rewilding has become one of 'the' words of our time, with the incumbent risks of being rapidly aligned with greenwashing ventures across the globe. Likewise, within settings such as the Highlands of Scotland, rewilding sits within the political context, where local communities see themselves, yet again, being displaced and alienated from their land, as 'green lairds' are accused of buying up estates to enable markets to offer carbon offsetting as a way to displace responsibility for climate inaction.

But Trotton encourages us to recognise the potential and possibilities inherent in re-positioning ourselves in our relationship with the other-than-human and more-than-human. If we embrace the definitions offered by Scotland, The Big Picture – 'Rewilding is an evolving process of nature recovery that leads to restored ecosystem health, function and completeness'[1] – and position this within the context of our relationships with ourselves, with each other and the world around us, then seeking ecosystem health, function and completeness is a meaningful, reachable and relevant goal.

This book is hugely important for all who are seeking change – therapeutically and or societally. Colleagues within the Cognitive Analytic Therapy world are drawn to the model by its awareness of how we are socially defined, and a desire to seek ways of enabling others to explore and empower change, overcoming profound social inequalities. But it has also become increasingly evident that access to Green Space and opportunities to engage in green / blue spaces are not only hugely important for our individual wellbeing and development, but also have a demonstrable impact on addressing and overcoming inequalities – they are equigenic[2]. The rallying cry of Psychologists for Social Change [3] has long been, 'Equality is the best therapy' – and this is one of the books that can offer a how, as we strive towards achieving that equality. To overcome the alienation and displacement that drives so much emotional and mental distress, as well as profound physical hardship, we all need to consider how we might rewild ourselves, and find a way to reconnect – within, between and around.

My only sadness in reading this book was that Trotton had not trained as a Cognitive Analytic Therapist. Throughout this book he talks about the need to prioritise relationships and to recognise the reciprocity that exists in our relations with each other as well as with the natural world around. Through a description of reciprocal roles, I believe it would be easier to articulate how we don't necessarily hold on to such polarised and oppositional positions and stances. Rather, we can find ourselves moving between both. There may be times when we hold a place that could be alienating. Or moments of connecting and enabling. Whichever way we seek to articulate the possibility that we might move between domestication and wildness, it is clear that it will be through a relational awareness that we might better facilitate our engagement with rewilding and allow ourselves the chance to connect with wildness – to allow ourselves to feel wild. Afterall, as Thoreau stated in 1862,

> 'In Wildness is the preservation of the world.'[4]

For those who may wish to explore this work, the ideas of wild therapy, and the developments of Wild CAT and how to develop CAT skills for working in the outdoors. then please contact wildcatstherapy@gmail.com ☐

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(1) Scotland: The Big Picture https://www.scotlandbigpicture.com/our-take-on-rewilding

(2) Mellor, C et al (2022) Seeding hope: restoring nature to restore ourselves. Nature restoration as an essential mental health intervention. I*nternational Review of Psychiattry* 2022, VOL. 34, No. 5, 541–545. https://doi.org/10.1080/09540261.2022.2092391

(3) Psychologists for Social Change - https://www.psychchange.org/

(4) Thoreau, H.D (1862). Walking, Part II. www.walden.org/wp=content/uploads/2016/03/Walking-1.pdf(p665)

Troublesome Words

STEVE POTTER
introducing a regular feature

Introduction

In editing five issues of the journal over as many years I have learnt from and struggled with what Bill Bryson (2007) in his personal dictionary of the same name calls **troublesome words**. They are troublesome in the CAT lexicon in good ways if they take us to the threshold of new understanding or troublesome in bad ways if they divert or foreclose the search for meaning. Readers may have their own troublesome words and contributions to future issues on this topic are welcome. Here are few to start with.

Relational?

This is one of those adjectival words that needs endless bracketing in CAT. In one very general sense everything human is relational. The word developed a modern currency in psychotherapy with Stephen Mitchell (1999, 2000) calling out the relational turn in psychoanalysis with the combination, in his case of British Object Relations approaches with the Interpersonal legacy (of Sullivan, Fromm and Thompson at the William Alanson White Institute in New York) attachment theory and feminist theory (see for example, *The Space Between Us* by Ruthellen Josselson 1995). Mitchell died in 2000 but his legacy and those of others lives on in the work of the International Association for Relational Psychoanalysis and Psychotherapy. To quote from their forthcoming 2023 conference (https://iarpp.net/events-hub-page/) Relational Psychoanalysis as framed by Mitchell and others above is:

> 'Further nourished by significant contributions from anthropology, sociology, philosophy, political science, infant research, attachment

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studies, gender studies and the neurosciences, among others, Relational Psychoanalysis continues to develop in exciting ways. As we confront the intrinsic impact of the socio-political on our psychic lives, how we think, and work clinically has shifted to encompass the significant and inevitable meeting and recognizing the "other" both externally and internally.'

I think CAT would sign up to all of the above but add something by courtesy of Leiman and Bakhtin which for simplicity's sake I will call simultaneity. We are simultaneously in and out of awareness of relational dimensions within, between, around and beyond us. The relationality of interpersonal encounters are simultaneously woven with social narratives of gender, generation and class, sexuality and ethnicity. Our internal worlds are simultaneously formed in mind and body (Vygotsky style) by external family relations, school and neighbourhood dynamics. In contemporary language we other as we are othered. The dynamics of 'othering' and 'worlding' (see Spivak'https://jan.ucc.nau.edu/~sj6/Spivak%20CanTheSubalternSpeak.pdf) or in CAT terms the oppressive and undermining creation of narrative power to position and be positioned is also explored by the literature on intersectionality (as defined by Kimberlé Crenshaw https://www.youtube.com/watch?v=ViDtnfQ9FHc).

In all this, with a CAT map I can walk my fingers and develop a conversation that in alternate breaths refers to the interpersonal, the social, the 'infant' developmental, the cultural context, systems of power over roles, world views and language and so on. All of it troublesome in a good way if we have the tools to hold it in mind. The CAT thesis is that mapping conversationally together builds or restores reflective capacity, and this is a mutual shared experience of relational awareness. I say this with the legacy from Tony Ryle in mind. He was pragmatic and economical with theory and the most notable tool of CAT – the reciprocal role procedures – were mapped out as what Ryle called 'necessary simplifications' which were (and are in my view) freely adaptable to scaffold all the different dimensions of relating touched upon above. CAT is not a psychological model, a sociological model, a humanistic, a feminist or existential, or neuro and narrative model. It can irreducibly and simultaneously be all of these thanks to the necessary simplifications and versatile scaffolding of reciprocal role procedures.

Model and models?

CAT is a model although Ryle informally resisted this description preferring at times the idea of it being an understanding. It makes conversational sense to talk of a CAT model of anorexia, or depression, or addiction but it might be better put as 'using the CAT model' to understand and work with such and such a condition. Within CAT there is not a model of narcissism, borderline, anorexic or depression. Maps, templates, diagrams and reformulations using the CAT approach would do.

A CAT Lens?

The phrase is offered quite often as in putting on a different lens will see things differently. It chimes somewhat with the observing eye (though this is a rich and troublesome idea in its own right) but the idea of the eye on the corner of the diagram or added in the process of mapping is to invite zooming in and out and taking the larger and wider perspective or even an authorial I (for more see Alison Jenaway on the Observing Eye in CAT https://www.engage.acat.org.uk/observing-eye-in-cat/) The observing eye graphic probably should always be mediated in a multi-sensory way with a listening ear or a speaking voice graphic.

A specific reciprocal role or a trap, snag or dilemma might fit the idea of a lens (looking at life through my *nice guy* lens) but CAT as an integration of several concepts, tools and methods is more than a lens. It is indeed more than a camera. It is a multi-sensory, multi-media scaffolding for creating a language and frameworks for working together to relieve distress and build understanding. The idea of the lens risks relativising the approach and conjures the image of a therapist with a set of lens to put on the camera of his or her therapy. Then the limited use of the idea of a lens might work comparatively. Looking through an EMDR Lens compared to a CAT might work as a shorthand. But then another problem arises in positioning the therapist or clinician as an outsider to what in CAT we might conceive as a collaborative endeavour.

Intervention?

This striking medical or military term does not sit easily with the collaborative (doing with rather than done to or done for) spirit of CAT therapy. CAT is a shared, conversational and collaborative educational

experience. The idea of intervention makes some sense from the viewpoint of a general weighing up different lines of attack or a commissioner choosing between different kinds of treatment. In both cases detachment and a cool head is needed to weigh up the choice between interventions. In psychotherapy intervention is a troublesome word in a bad way if it slips into meaning something that is provided and delivered independent of human agency and emotional context. The idea of intervention should not become the dominant narrative to the therapy. CAT mediates and moderates a therapy relationship, and we don't at any point ask how was your intervention today.

Patient, client or service user?

Different professions and different settings have different preferences in naming the person taking part in psychotherapy with them. It makes sense to refer to patients if the setting is clearly medical and some CAT therapists very much prefer the compassion and care in the idea of patient and their role in addressing the suffering and providing a healing experience (see also the preface to Ryle & Kerr 2020). It makes sense to refer to clients where there is a contract, and the client is making a choice of therapist and therapy. The etymology online dictionary https://www.etymonline.com/word/client says a client is. . .

> 'one who lives under the patronage of another', from Anglo-French clyent (c. 1300), from Latin clientem (nominative cliens) 'follower, retainer' (related to clinare 'to incline, bend'), from PIE *klient-, a suffixed (active participle) form of root *klei- 'to lean'.

The reciprocal role pointed to here is one of chosen dependency or leaning in and following. Perhaps in the CAT spirit we should think of *'clienting to cliented'* and a reciprocal role dynamic that might swap between the provider of therapy and the receiver.

The phrase service user draws out the multi-disciplinary context of the overlap between psychotherapy and mental health care but perhaps has connotations of 'arm's length' detachment and autonomy. All three words are potentially troublesome in the context of a collaborative educational approach. Is it that there is not a good word for the active co-creative participants in a therapeutic conversation. Perhaps participant would do the job?

Cognitive analytic therapy?

Is there a mischievous mix of troublesome words in the very title of our approach to therapy. There is Ryle's hope in the title of a common language across psychoanalysis and behaviour therapies using the tools of cognitive psychology. Also in the title is a healthy provocation that schools should talk to each other and be surprised at the similarities in what they do when their mysteries are stripped away? The name is fixed for all time or at least until good integrative and relational practice becomes the common sense of psychotherapy. There is also possibly some quick thinking in the original choosing of the name. According to Annalee Curran (the first chairperson of ACAT in the UK) when talk began from others of calling his work *Rylian Therapy,* Tony Ryle quickly came up with the pragmatic title of Cognitive Analytic Therapy. It was the way of thinking in the model that mattered to him not the kudos. Some twenty plus years ago I asked Tony Ryle what, now in hindsight, would he call CAT? He paused for a minute and said, partly in jest, Vygotskian Object Relations Therapy (VORT). He wondered for a minute more and then corrected himself. What about Vygotskian Object Relations Social Therapy (VORST). But CAT is CAT for all that.

Bryson, B. (2007) *The Penguin Dictionary of Troublesome Words*. London: Penguin

Josselson, R. (1995) *The Space Between Us*. London: SAGE Publications.

Mitchell, S., Aron, L. (1999) *Relational Psychoanalysis: The Emergence of a Tradition*. Hillsdale, NJ: Analytic Press.

Mitchell, S. (2000) *Relationality: From Attachment to Intersubjectivity.* Hillsdale, NJ: Analytic Press.

Potter, S. (2017) *Reciprocal Roles: The mother of all ideas* https://www.mapandtalk.com/downloads

Ryle, A. (1975) *Frames and cages.* Sussex University Press

Ryle, A. (1975) 'Self-to-self and self-to-other' *New Psychiatry* April, 12-13

Contributions for short descriptions of troublesome words for future issues please email to journalicata@gmail.com

We offer our thanks to the contributors and to the diligent and persistent peer reviewers who have so thoroughly, carefully and anonymously reviewed all the contributions to this issue.

International Journal of Cognitive Analytic Therapy and Relational Mental Health

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Smith, Adam (1776): *An Inquiry Into the Nature and Causes of the Wealth of Nations*, London: Ward, Lock, Bowden & Co.

Spainhower, Kirsten (2011): 'Twin Labs: Silicon Valley and BRAC', *Journal of Social Business*, Vol. 1, No. 3, October, Pp61-64.

Yunus, M, Moingeon, B and Lehmann-Ortega, L (2010): 'Building Social Business Models: Lessons from the Grameen Experience', *Long Range Planning*, Vol. 43 (2-3 April), Pp308-325.

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