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of Cognitive Analytic Therapy
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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, Finland, Greece, Ireland, Italy, New Zealand, Poland, 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.

International Journal
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and Relational Mental Health

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Copies of the journal are available online or in print according to the reader's preference.

The journal is freely available worldwide online in pdf format, both as the journal as a whole and article by article. There is a donations button who value access to the journal in this way and who want to support the work of the journal and the International Cognitive Analytic Therapy Association which is a federation of national associations in eight different countries.

For those readers who value the more detailed textual engagement of print copies, or who would like copies for their organisation or service, these are available for this volume and previous ones by order from:
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As well as the four volumes of this journal other CAT books are listed and available.

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Editorial

WE are delighted to present the fourth issue of the *International Journal of Cognitive Analytic Therapy and Relat–ional Mental Health*. We have now moved to an open access, online medium for the journal (though print copies are available for those who would prefer to read a paper copy). All four issues are now on the International CAT website www.internationalcat.org/journals

This issue has, unfortunately, been delayed by various unavoidable circumstances, most notably the still-ongoing, world-wide Covid pandemic over the past eighteen months. This has been, and continues to be, devastating in many ways for many people world-wide, and especially for those belonging to less privileged groups or countries. For this reason we are very pleased to carry, firstly, a reflective guest editorial on this topic by our new member of the editorial group, Hilary Brown, whom we also welcome 'on board'. We all felt strongly it was important to attempt, from a CAT-informed perspective, to make some deeper sense of the consequences and effects, both material and psychological, of the pandemic. Hilary's editorial addresses, amongst other things, the current and future urgent therapeutic challenge facing mental health practitioners and services in helping those many struggling with resultant serious mental health problems but also, importantly, the socio-political issues worldwide that have contributed to the severity of this pandemic in most places, and the, all too often, poor state of health services trying to respond to it. From a CAT-informed perspective we would all wish to address and stress not only the prevalence of mental health problems and the challenge of how to respond to them, but also their broader socio-political context and determinants.

Beyond this, we are pleased to offer again a wide range of high-quality articles, characterised in general by a 'real world' concern with and focus on assisting colleagues (including trainees), staff teams and services with the inherent relational and systemic difficulties encountered in trying to help various client/patient presentations in a range of differing settings. We note also in general throughout these articles a high degree of personal commitment and involvement on the part of practitioners and researchers, and of critical, creative self-reflection on this. This 'involvement' could be described in terms of extended''reciprocal role' enactments in various, often stressful, front-line settings. We note such approaches offer a further, deeper approach to thinking about the nature of mental health problems and about offering treatments, in comparison to the more 'decontextualised' reporting of outcomes of 'delivery' of supposedly standardised psychological treatments frequently encountered in the literature (see also Margison in this issue and below).

The current issue contains, in running order, articles on staff experiences of the helpful use of CAT reformulations in a challenging, 'learning disability' service

(Priddy *et al*.), on a rigorous, early intervention, replication study from the Netherlands for adolescents with 'BPD' (still a controversial but important topic) (Hessels *et al*.), a thoughtfully self-reflective paper on the challenges of endings (a key focus in CAT-based treatments) (Byron), a creative and challenging piece on the potential importance of awareness of and training in 'embodied therapeutic presence' for practitioners working especially with internalised psychological trauma (Sheard), a paper on the potentially important, but difficult to evaluate, contribution of 'personal reformulations' for clinical psychology trainees (Hamilton *et al*.), and, finally, a paper on the helpful contribution of reflective practice, aided by the 'map and talk' framework, in working with staff and systemic issues in an in-patient adolescent service (Mulhall).

This issue also offers an extended and deeply-thoughtful 'book review' by Frank Margison on the thorny issue of 'evidence' in mental health treatment and research, and how it is obtained, with particular reference to CAT, but far from confined to it. The review is prompted by a recent special issue on CAT of *Psychology, Psychotherapy Research: Theory and Practice,* but also reflects on a revised edition of *The Great Psychotherapy Debate* by world authority Bruce Wampold with Zac Imel a few years ago. We were especially pleased to have Frank do this given his previous editorial on the same topic some 20 years ago in an earlier incarnation of the same journal, which he here also helpfully revisits. In our view this major review raises very considerable and still unresolved issues, especially with regard to current dominant paradigms of research in mental health, and psychotherapy in particular, that have some very important implications. For these reasons, we hope it will have an importance and readership well beyond the confines of this journal. We also offer a book review by one of the editorial group (SP) prompted by an encounter with a troubling book by Mary Trump, niece of the last US President. This raises some disturbing thoughts about the current socio-political world we inhabit, key to mental health broadly conceived, including the question of how, socio-culturally, support for such a President can arise.

We hope that the forward-looking hopefulness implicit in these various pieces and in CAT-informed approaches generally may be both provocative and inspiring to our readership, despite possibly some of the more sobering and possibly gloomy reflections also evoked. We note again that the journal welcomes correspondence on possibly contentious and/or debatable topics that may have been touched upon in this, or indeed previous issues. We hope too that this issue will, as mentioned above, possibly stimulate readers to contribute some financial support via our website to help maintain the journal which is sustained by a labour of love by all contributors, peer reviewers and the editorial team! We thank the members of the ICATA board for their ongoing support of the journal. And we thank the many colleagues who have contributed anonymously to the work of reviewing contributions to the journal. We continue to welcome submissions and will be aiming as usual, global events permitting, to produce our next issue by the end of 2022.

Ian B Kerr, Steve Potter, Hilary Brown, Louise McCutcheon (as Chair of ICATA)

CAT around the world
What's on

ICATA special interest group

CAT in relation to the Climate and Ecological Emergency

This group has had two webinar meetings in 2021including one scheduled for November 30th and plans meetings through 2022.
https://www.internationalcat.org/event

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26th Annual ACAT Conference 2022

(postponed from 2021)

26th to 28th May 2022
Venue: Grand Hotel, Gosforth Park, Newcastle, UK
'Connections, Conflicts and CAT'

We are formed in our relationships, by our landscape and its culture. At the same time our individuality results in different ways of seeing and acting in the world leading to both conflicts and connections. CAT's focus on the dialogical and relational aspects of our lives promotes integration of these different parts, healing, valuing and giving voice to them.

This conference aims to provide a space to consider the factors that can influence all of us both at a micro brain level and a macro social level, central to us individually, in our clinical practice and in the broader work place.

#ACATconf22
For booking please visit https://www.acat.me.uk/event/1060/
For queries please email alison.marfell@acat.me.uk

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ANZACAT Conference

20th August 2022
'Relating to change and uncertainty'
Melbourne, Australia

https://anzacat.org.au

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ICATA International Conference

15–17th June 2023
Helsinki, Finland
https://www.internationalcat.org

Learning from the Pandemic

HILARY BROWN

Preface

I am writing this as a white woman, in my early 70s, who has been living in the UK throughout the pandemic. My views have been shaped by this experience, and may be quite specific to it. The UK arrived at the pandemic after a decade of political turbulence that led to the country leaving the European Union. We have a centrally coordinated National Health Service which is free at the point of need. Other countries will have faced the pandemic with different kinds of health systems and/or available resources but I hope what I have written will resonate with therapists from other countries and that we can start a dialogue about how best to support those who have been most affected.

Introduction

At Starehole Bay in South Devon there is a submerged shipwreck. It is a place I have visited throughout my life, but I have only seen it with my own eyes once because, to be visible, it requires an alignment of unusual circumstances – a very low tide, a stunningly clear sky and the sun at a particular angle. In ordinary times you don't notice it and it only takes ripples on the surface, or debris from a storm to obscure the upturned hull from view. The pandemic threw up a similar once in a generation alignment, one that elided in the UK with the divisiveness and xenophobia of Brexit and worldwide with the slow-burning panic of climate change. It laid bare the broken timbers of our own society, exposing its inequality, its injustices, and its cruelties for all to see. Usually, these aspects of how we live are made invisible by distortions, lies, smoke or mirrors. When they surface in episodes of violence or tragedy they are quickly pushed back under the surface – procedures whereby the more powerful get to render the less powerful invisible and construe their difficult circumstances as personal failings.

The daily death toll and rising case numbers soon highlighted those

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The author would like to dedicate this editorial to her late colleague Naison Msebele, who died from Covid at the beginning of the pandemic.

groups who were physically and economically the most vulnerable, those who were the most exposed, those who were the least rewarded and those 'key workers' who were to become the most relied upon. Small ripples of generosity surfaced in the early days, but these soon dissipated and now, while it is by no means all over, it seems as if this period, while painful to live through, has offered up important lessons. As Beckett (2021) remarked: 'A pandemic is a political event. It exposes who is vulnerable and who can afford to escape, who is prioritised for treatment and who is neglected. The politics of a pandemic are both large-scale and intensely personal.' In other words, the pandemic was a relational event, upending the networks within which we all live but also making inequalities explicit in the reciprocal roles that were enacted between individuals, communities and helping agencies.

CAT began its life as a radically social model of psychotherapy and one in which poverty and disadvantage were not allowed to be a barrier to receiving a service. It was paced and spaced so that it could be provided in public health settings within a limited time frame, and in a spirit of collaboration, without falling back on the more mystical all-knowing interpretations of orthodox psychoanalysis. Over time, and under pressure to produce measurable outcomes, this commitment to equality has been diluted, and CAT in the 2020s is at risk of being seen as just another therapy that is 'delivered' or 'done to' people seeking help for their distress or their sense of dispossession.

Many people within the CAT community have been trying to reset this imbalance by including within our formulations of what hurts, those structural disadvantages that seep into a person's soul. We have been seeking practice that rehabilitates social injustice as a proper explanation of mental ill-health and as a legitimate focus for shared understanding with our patients. The pandemic has made this adjustment even more necessary.

When a person grows up with insufficient or insecure income, it undermines the stability and connectedness of their relational lives. Poverty has even been shown to affect the developing brain of an infant at a neurological level leaving its indelible stamp on their progress through life (Rocheleau 2019). But international data at population level, compiled by Wilkinson and Picket (2011) demonstrated that it is not only the level of absolute poverty in a country that creates social 'problems' but the scale of *inequality*. Their analysis suggests that this is because it undermines social bonds and cuts across solidarity. Inequality is therefore closely correlated with addictions, suicides, early pregnancy,

depression, violence, divorce, stalled longevity, infant mortality, and other societal difficulties. The data proves, once and for all, that structural issues percolate down to cause individual stress and distress. A CAT understanding of this data might be to postulate that inequality fundamentally destabilises reciprocal roles making them more 'asymmetric' than truly reciprocal (Emilion and Brown 2017; and Brown 2019).

The pandemic provided further evidence, if it was needed, of the extent to which more unequal societies fare worse. Writing from the experience of the UK, years of austerity in relation to public services since the financial crash of 2008 had led to extremes of inequality within and between regions. Poverty then came to be implicated as a cause of increased mortality and morbidity in line with these existing inequalties. Pre-existing conditions were evident in the demographics of the early mortality statistics, as the virus took lives that had already in part been compromised. The final turn of the screw is that the pandemic has left an disparate legacy in human and economic terms that is creating even further tears in the social fabric and placing a still heavier weight of disruption and dislocation on the shoulders of the already disadvantaged. Our government put mandatory restrictions in place that were too little and too late, and they weakened their effect by accompanying official public health information with mixed messages as influential people close to power flouted rules and appeared unmasked in public. This hesitancy and ambiguity played a significant part in our country's higher numbers of infections and deaths to date than those in comparative countries.

Black and minority ethnic communities were disproportionately affected by a juxtaposition of biological vulnerability and long-term discrimination in the labour market, by the increased likelihood that people from these communities would be working in public-facing, economically insecure employment, and by the fact that they were often living in more crowded housing and in more densely populated and poorly served neighbourhoods. The international outcry that erupted in the face of the appalling racist murder of George Floyd, resonated with the voices of many who already felt that they had been unjustly left behind including those who had been hit disproportionately hard by the virus and further impoverished by its economic impact. People were also suffering from many bereavements washing over them in waves, many of which are laced with anger and 'if-onlys'. This sense of an overdue reckoning also emerged in relation to incidents of violence against women. When Sara Everard, Sabina Nessa, Nicole Smallman and Bibaa Henry were killed going about their ordinary lives, it was as if there had been what we call in CAT a 'bottling up' procedure that the pandemic

forced into the open. People protested despite the risk of infection, and they protested against the backdrop of burning forests and flooded streets.

In the UK, it is unlikely that anyone would have escaped the pandemic's ramifications. For some this will have meant painful separations and bereavements. Some found themselves better off with incomes held steady and reduced outgoings, while others have been plunged into poverty, debt, and homelessness. Some found the retreat into relative isolation calming, while others experienced it as alienating. For anyone living with a violent partner or family member the risks and pressures increased. What is clear is that many will not return to 'normal' at home, in their workplaces, their politics, or their sense of themselves. In CAT terms, reciprocal roles have become so changed and so charged that the procedures that previously worked no longer cut through. In this editorial I want to think about what we can learn as relational therapists about naming inequalities and acknowledging the impact of so many overturned reference points.

Absolute and Relative Poverty

My recent writing has focussed on making visible the underlying 'distal' causes of mental distress in terms of inequality, racism and poverty, arguing that as therapists we often render these pressures on individuals invisible, loading their personal and familial narratives with, what are often, societal problems. I have argued that reciprocal roles can rarely be seen outside the prevailing social hierarchies and that traps, snags and dilemmas are often hard wired into the conditions of a person's external life not only encoded in their internal dialogue. A person's diminishing options may lead them to seek ever more desperate ways of getting what they need from indifferent others, including from public agencies.

Absolute poverty

As we have seen, poverty may be absolute as in not having enough to meet one's basic needs, or it may be relative as in not having as much as others around you. In the UK the Joseph Rowntree Foundation (2020), which campaigns around these issues, reports that an adult with an income below £70 a week or couples with 2 children who have less than £140 are effectively destitute. The UK government, recognising that the basic level of welfare benefits (Universal Credit) was insufficient, raised

it by £20 per week at the start of the pandemic but then in the autumn of this year the supplement was withdrawn. Some changes were made to the adjustments for people in work, but despite advocacy from all sides of the political divide those who do not or cannot work were knowingly left without enough to manage. Many of the people who do not work are carers for disabled family members or disabled themselves; they have no way of generating sufficient income to get by. It is worth noting that children presenting to mental health services at this point in the pandemic are more than twice as likely to live in a household that has debts or that has fallen behind with key payments. The Royal College of Psychiatrists (2017) had published information before the pandemic showing that one in two adults with debts has a mental health problem and that one in four people with a mental health problem are also in debt. It is not appropriate for therapists to focus on personalised narratives when these circular links between poverty and mental ill-health have been staring us in the face throughout the pandemic.

Thus therapists in public health settings will often be seeing people who are necessarily preoccupied with their day-to-day survival while other people with mental health problems will be unable to attend therapy at all because they do not have enough for transport or childcare. Forgetting this undermines our service initiatives just as forgetting the pervasive messages poor people are being given about how little they are valued, has the potential to undermine the integrity of our clinical input.

Relative poverty

Wilkinson and Pickett's (2011 *op cit*) work *The Spirit Level* used international data to make explicit the damaging impact of inequalities on a whole range of mental health and wellbeing indices at population level. Their work focussed on inequality more than on absolute poverty, on status rather than on need. Their analysis cemented in place a layer of explanation about why people suffer, not only because they are unable to meet their basic needs but because this relative poverty imbues so many reciprocal roles encountered in everyday life with a sense of injustice and envy. These skewed roles lean towards one pole that is exploitative or withholding and another that is desperate and needy. The pandemic made visible these default settings, the low pay of key workers, the insecurity of their housing, the split between those who could retreat to work from their homes and those whose jobs disappeared overnight, and the lack of respect shown to benefit claimants.

The geography of inequality

Others have explored the geography of poverty (Ballas, Dorling and Hennig 2017), examining the regional inequalities that had prompted the supposed 'levelling up' agenda on which the current UK government was elected. In July 2021 the Health Foundation reported: 'The chances of dying from Covid-19 were nearly four times higher for adults of working age in England's poorest areas than for those in the wealthiest places.' They attributed this to years of austerity, cuts in public services and stagnant wages. Ballas *et al* (*op cit*) stated that 'cuts to public services had "frayed the nation's health" and contributed to the UK's disproportionately high Covid death toll compared with similar countries.' The lockdowns shone a harsh light on these disparities with their differential regulations for the different regions and countries of the UK. For example a recent report on the post pandemic needs of Manchester compiled by Sir Michael Marmot (2020) stated: 'the coronavirus death rate in Greater Manchester was 25% higher than the England average during the year to March, leading to "jaw-dropping" falls in life expectancy and widening social and health inequalities across the region.' These forms of inequality predated the pandemic, but they made it worse, and they were in turn made worse by it.

Bottled up injustices

So, it became clear in the first lockdown, that we were not 'all in this together' and as time went on this perception grew more stark. People in white collar jobs were able to withdraw into their own homes to continue working while 'key' workers continued in public-facing jobs, health care, transport, food delivery, retailing, teaching and social care, where they were disproportionately exposed to the virus. The government's first official report *Coronavirus: Lessons learned to date*, while lacking the heft of an official independent inquiry, laid out useful information and concluded that the initial handling of the pandemic had been a public health failure.

It had also become evident that communities of colour were facing the vagaries of the virus from structurally disadvantaged positions and that this was resulting in disproportionate exposure to the virus and excess deaths. At first it was thought that structural inequalities accounted for all of the increased exposure and risk to BAME patients, but subsequent research suggests that subtle genetic differences exist especially for those with South Asian heritage that may render some people more vulnerable to respiratory stress. So, it is likely that the causes

of this 'disparity' were both structural and biological, in that 'existing social, economic and health inequalities were exacerbated by the pandemic and combined with possible biological factors contributed to unequal outcomes including unacceptably high death rates amongst people from Black, Asian and Minority Ethnic communities (*op cit* para 16). The report also specifically acknowledged the failure to address the needs of people with learning disabilities and autism, that had included applying blanket 'do not resuscitate' notices in contravention of their human rights.

For a brief moment, it had seemed that the contribution of key workers was being really acknowledged and this was publicly expressed through weekly applause and rainbows but when the crisis abated, they were soon put back 'in their place'. In CAT we might frame this as idealisation and projected heroism that gave way to dismissal and abuse of the kind we might represent in a split egg diagram. Clinicians who had been left without adequate personal protective equipment (PPE) were then blamed for high rates of sickness and difficulty in meeting demand, for example GPs have recently been excoriated for not providing enough face-to-face consultations. Government sources began to challenge expectations that NHS workers would receive significant wage increases as soon as the crisis was seen to be somewhat under control. Individuals and organisations have since tried to reassert the values that had emerged during the early part of the pandemic with the hope that at least some of the public solidarity that had been witnessed on those Thursday evenings might remain when the rainbows had finally been peeled off the windows, but to little avail.

Instead, it is clear that while the rich were getting richer, the poor were getting poorer. More than a third of British workers lost their jobs in 2020 according to the Office of National Statistics. Compared with other European countries, the UK fared worse and (although we share a similar median wage) the poor are poorer. Income inequality is stretched at both ends of the range but hugely to the detriment of poorer people. Citing a report from the Policy Institute (2021), Bell compared the UK to both Germany and France where:

> 'The rich here have incomes 17% higher than their equivalents in France. . . [but] our poorest households have to survive on incomes a staggering 20% lower than those across the Channel (£14,700 v £18,500). That means higher poverty, lower living standards and no margin when things go wrong, such as a pandemic hitting.'

These levels of inequality corrode trust and solidarity. The early rhetoric about being 'all in this together' was never going to be sustainable: in CAT terms it represented the fantasy of perfect care that could rapidly descend back into neglect and deprivation. Early in the first lockdown (April 9th, 2020) the journalist Emily Maitliss, fronting BBC *Newsnight*, challenged the 'trite and misleading' language that was being used to suggest that people could survive if they were 'fighters' or that the illness would be a 'great leveller' affecting rich and poor alike. She noted that it was the key workers who were being disproportionately affected and that they tended to be in the lowest paid groups. She heralded the people who had died in that first wave, not as 'soldiers' but as ordinary people just doing their jobs with 'bravery and kindness'. Healthcare workers continue to bear the scars of anguised decisions and tragic deaths.

And the pandemic did not breed social cohesion, instead it has exacerbated the discord. It has also amplified generational conflict with the more vulnerable older population seeking higher levels of restriction because of their health status and the younger people resisting this because of their economic jeopardy. The organisation Hope not Hate has recently circulated a research study showing that, of 336 local councils, COVID is believed to have fostered such 'community tension' that risks inspiring far right activity in 52. (Clarke 2021).

The UK situation paralleled class and racial dynamics emerging in the US. Case and Deaton (2020) describe, how in the decades leading up to the pandemic, large companies had outsourced more menial jobs to separate companies that offered less secure and valued employment creating 'different worlds' (*op cit* p166):

> 'There is the world of the more educated, and a world of the less educated; no one in the latter has hope of joining the former. . . the outsourced workers are no longer part of the main company, they do not identify with it, and are no longer invited to the holiday party.'

. . . or, as it was manifest during the lockdowns, the ubiquitous Zoom quizzes. Against this backdrop of status anxiety, they described how white workers specifically came to 'see black progress as an unfair usurpation of their opportunities rather than as a weakening of the privileged racial position they held.' These *privileged to devalued* reciprocal roles on both sides of the Atlantic undermined local and national policy making. Without solidarity it is difficult to enforce mask mandates, bring about compliance with social distancing, get widespread adherence to

lockdowns, encourage people to be vaccinated, vote through adequate benefit levels, let alone get richer countries to donate aid and vaccines to poorer regions of the world.

There are also some important questions, if not yet answers, about the way that conspiracy theories have tapped into these fractures, undermining public health messaging and eroding trust in expert knowledge and the scientific process. Vaccinations have proven efficacy. Despite the fact that there is a drop-off in immunity over time, the US Center for Disease Control and Prevention (CDC) issued figures recently showing that cases for unvaccinated citizens are running at six times the level of people who are fully vaccinated and that deaths are 12 times as high, despite which considerable numbers of people refuse to be vaccinated and do not trust the scientists who have made this level of protection possible.

Mental health impacts

These early evaluations of the economic impact of the pandemic have been accompanied by studies that are beginning to delineate the additional mental health needs that are being presented to public service agencies. An international team writing in *The Lancet* (Davis 2021) estimate that there have been 76 million extra cases of anxiety and 53 million of depression worldwide, most affecting women and young people. In the UK, referrals for a first suspected episode of psychosis rose by 29% between April 2019 and April 2021 according to NHS figures (Pidd 2021). A Cardiff University study (2021) showed that 10-11 year olds, ate fewer vegetables, took less exercise and experienced worsening emotional difficulties in 2021 when compared with 2019 (Adams 2021). These studies suggest a hugely increased volume and severity of mental health presentations.

Clients of different ages will present specific cohort effects reflective of their developmental stage. We may be seeing young people who have missed out on critical periods when lasting friendships would have been formed (Dunbar 2021) or partners met, or we could be working with new parents who have not been able to set up the networks that would have provided them with future babysitters and cat feeders. The pandemic will be like the rings on trees and the dents will follow people through life. CAT's sensitivity to our clients' incremental developmental may help us to see what has been missed when significant milestones have been cancelled or hard-won independence reversed as a result of lockdowns

and economic instability.

In the coming years our practice and our research will need to quantify and understand these impacts. The studies in this journal describe good practice in relation to the mental health needs of young people and people with learning disabilities Before Covid (BC) but we will need to rigorously explore the increased demand for services and the right mix of interventions that can support them as they go forward, building resilience for themselves, their peer groups and for their communities. The papers here describe interventions that worked in relatively conventional mental health settings, but can we use them as a baseline for the development of innovative and far-ranging interventions in schools, antenatal clinics and inpatient facilities but also online and on air?

As we have seen, people with learning disabilities were also disproportionately disadvantaged by the pandemic and many of the protective structures around them proved insufficient to protect their basic human rights. Disabled people are often at pains to refute the fact that they are uniquely vulnerable but, as a group, they already had poorer health outcomes and compromised longevity and the pandemic has exacerbated this situation. As a group they illustrate a social model of vulnerability, one in which a particular group has a primary vulnerability because of health differences or disproportionate exposure, but then finds itself being discriminated against when trying to access services or being treated less favourably by helping agencies, which creates a secondary vulnerability. This is then made worse if that group finds it harder to garner resources for recovery in the aftermath of illness for example if they disproportionately lose their jobs, are made homeless or find themselves with insufficient income or in debt, all of which constitute an additional tertiary layer of vulnerability. So, people with disabilities have been *made* more vulnerable in ways that other citizens were not.

Anyone living with friends or family members whose behaviour was threatening, volatile or abusive also found it difficult to keep safe during the lockdowns. UK Women's Aid (2021) put out a statement saying: 'While Covid 19 did not cause domestic abuse, only abusers are responsible for their actions, it has led to the escalation of existing abuse and closed down routes to safety for women to escape.' One fifth of those seeking to leave unsafe situations could not do so due to lack of housing and refuge places. The pandemic clearly did not cause abuse but made it worse, we can only hope that this elicits more understanding of the plight of victims and a call for resources to be ear-marked for this sector, as countries recover. We not only need to 'build back better', as one

political slogan says, but build back safer.

At the other end of the age range, older people will have retired without gold watches, or been widowed without the comfort of friends or the rituals of a funeral. Grieving for loved ones who had to die alone added an extra layer of anguish. Each culture has its own rituals that surround bereaved people and keep them afloat through their darkest hours and the pandemic robbed us of these structures. People in care homes were deprived of visitors over long periods in ways that must have been bewildering for many and desperate for their relatives.

The UK's Office for National Statistics has produced figures suggesting that access to all mental health services has decreased during the pandemic with barriers emerging at referral and treatment stages. Referrals for talking therapies dropped from 150,000 per annum in 2019 across the country to 60,000 by April 2021. NHS figures show that most people referred were able to see a therapist, albeit online, within 18 weeks and that patients participating in group therapies were officially allowed to leave home during lockdown to attend their sessions. But despite this, adults starting therapy dropped by a third during the first lockdown. In my own practice most clients welcomed the chance to work online, and it has given some of them more choices as they no longer need to be tied to their local area and/or to make expensive child-care arrangements. But some have found that they do not have adequate privacy at home or cannot relax especially if they are living in a stressful environment or relationship. These delays mean that the person sitting across the room from you is likely to have waited to be seen and to have had to manage crises in their mental health with no one to turn to.

Silver Linings?

Resetting levels of 'busy-ness'

It seems perverse to look for silver linings in this dark period, but as with other kinds of adversity it has highlighted issues that can inform our theory and practice as relational therapists. The pandemic and its lockdowns have provided some people with respite from relentless engagement and sensory input. The role of temperament in shaping personality has never been discounted in CAT, although pre-pandemic we might sometimes have paid too little attention to those with introversion or a proneness to social anxiety. Not all clients found lockdown difficult, because for some it provided an acceptable reason for slowing down from previously frenetic working patterns or social

contact. As CAT therapists we tend to work from the premise that all our patients are driven to be social while, for a minority, constant exposure and activity creates stress and anxiety. Some of our patients may be more motivated to avoid being overwhelmed and to bat away difficult thoughts or interactions than to be always busy and engaged. The lockdown, for them, provided a safe space to reassess their levels of social interaction. Procedures designed to limit exposure and to avoid conflict may need to be made more explicit in our reformulations. Despite the ubiquity of social media, at times the pandemic returned our communities to a dependence on the local and the neighbourly and to a gentler way of relating.

Respecting people who live with chronic illness

Another unexpected development has been that the emergence of 'Long Covid' has made visible the way that post viral illnesses operate thereby exploding the myth that conditions marked by chronic fatigue, pain and brain fog are 'made up' or unworthy of attention. As Douhat observed:

> '. . . unlike other such conditions, which tend to creep up on society, long-haul Covid arrived suddenly, creating a large pool of sufferers in a short period of time and afflicting frontline medical workers and younger patients in large numbers. This created a sense of immediacy and urgency absent from other chronic-illness debates and a constituency for research and treatment among a population – doctors, especially – that's often sceptical of difficult patients and mystery illnesses.' (Douhat 2021)

This lent timely support to patients living with chronic illness who have been campaigning against the current orthodoxy of treating these disorders of the immune system with CBT and graded exercise.

People living with post viral illnesses have been very clear for some time now that exercise regimes do not work because exertion today means exhaustion tomorrow. They have asked that treatment decisions pay far more attention to the lived experience of those speaking out about their conditions both individually and collectively. There is no doubt that these conditions do not fit neatly with current practice in health services or the benefits system where the vagaries of the symptoms and their seeming lack of an identified aetiology have in the past led to people living with these chronic conditions being falsely labelled as lazy, unreliable and unworthy.

When the British Psychological Society (BPS 2021) rather hastily put

out a paper urging psychological screening to *prevent* what has come to be known as Long Covid, there was an instant challenge from those who had been campaigning around these issues (see Kenward 2021) and it was taken down. The new statement put out by the BPS challenges the assumption that 'if nothing shows up in (standard and limited) tests, 'there's nothing (physically) wrong'. It is indeed 'all in your head' (BPS *op cit).* Long Covid's *modus operandi* cast serious doubt on this state of affairs. The sheer numbers – with 2 million Britons and 1 in 7 children identified as having Long Covid symptoms in October 2021, and its multiple constellations of symptoms including parasomnia, joint pain and chronic fatigue, have presented an overdue lesson in how a novel virus can cause long term illness with the obvious corollary that other viruses might also operate in this way. As the author of this section of the bulletin stated 'when the attitude held is that there is a psychological predictor, a psychological interpretation, of people with chronic illness, the patient experience is silenced and undermined. Given all this there is hope.' (BPS 2021). The evidence from so many people affected by long lasting Covid symptoms backs up their accounts. Therapists as well as other health care professionals, insurers and welfare assessors (Kenward 2020) who have in the past treated people suffering chronic fatigue with disbelief or disdain will need to reset their commitment to listening to, and learning from, their clients.

Concluding Remarks

The distress caused by the pandemic will show up in many guises. People living in poverty across all communities have suffered doubly in that they were more affected by the illness itself but then also more disrupted by the economic dislocation that has followed from it. Communities will be struggling with the increasing racial, class and intergenerational tensions that have unfolded from this. Colleagues, whether researchers seeking answers or therapists facing questions, will need to work together to shape a research agenda that is fit for the future. The papers in this edition provide excellent examples of innovative practice in what we might come to see as the pre-Covid world but the pandemic will leave a trail of distress which needs to be dscribed and understood. Therapists will need to work collaboratively to identify each person's specific experiences and heartaches. Together we will need to assess the very particular relational disruption that has taken place for different cohorts and communities.

The UK government has recently started to refer to health *inequalities* as health *disparities* as if the differences exposed by the pandemic were neutral and voluntary which is not, of course, the case. Many organisations paper over inequality in similar ways as if this were kind rather than dishonest. The UK body representing CAT therapists, for example, has a committee that is working on an agenda to increase the participation of therapists from minority communities but decided to name this a Diversity and Equality Committee when the real issue is not that diversity comes bundled up with equality but that it is linked to, and made toxic by, *in*equality. As therapists we often falter when it comes to naming unequal and unjust circumstances even though these are often brought to therapy and activated in the therapeutic relationship.

When inequality and injustice are hidden from view they are kept out of the stories we tell each other and ourselves about who we are as individuals and as a nation. This leaves us hunting for scapegoats or clinging to unreliable solutions: it leaves us vulnerable to deceptive narratives and open to being duped. It leaves us open to drinking disinfectant instead of getting vaccinated. When key parts of the narrative are edited out, we cannot account for our own distress, and then as therapists our work involves helping our clients to discriminate between what is, and what is not, in their control and deciding anew where responsibility lies. Like the shipwreck that appeared once in the late autumn sun, the pandemic focused a harsh light on widening inequalities and the relational fractures they engender. As a society we all saw this and now we all know it is there. We must hold onto that knowledge as we process these years of loss and separation because, both as therapists and citizens, we cannot afford to turn away. □

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‘We’re able to see the smoke’:

Exploring staff experiences of remote cognitive analytic team formulation within a residential learning disability service

SASHA PRIDDY, JO VARELA, JAMES RANDALL

Abstract: Team formulation is increasingly used within health services across the UK to facilitate reflective practice within teams. This research sought to understand staff experiences of team formulation using a cognitive analytic therapy (CAT) model within a residential learning disability (LD) service. The evaluation was conducted in two phases, using a mixed methods approach. In phase one, participants (n=6) were invited to attend a series of team formulation sessions for clients with whom they were directly working. A total of 11 CAT-TF sessions were held, across three clients. Participants completed two evaluative questionnaires following the last formulation session (n=12); there was a 100% response rate on both measures. Phase one analysis informed the development of semi-structured focus group questions (phase two), to further explore participants’ (n=4) experiences.

Results across both phases indicated that participants felt CAT-TF sessions facilitated their understanding of the client and of the relational processes within services. This understanding was reported to aid the development of relationships between staff and clients. Remote delivery was experienced positively, with participants suggesting this enabled accessibility and openness within the sessions. These findings indicate there is benefit in practitioners offering CAT as a core model when delivering team formulation groups – particularly with a view to offering these services to organisations which do not have mental health specialists embedded within their teams. The findings of this research

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aid further development of a CAT-TF structure, particularly within LD services, to support reflective capacity within teams. CAT-TF can be delivered effectively through remote technologies and offered numerous advantages in terms of resource efficiency, accessibility and ethics (e.g. increasing access for staff; allowing greater service-user engagement; providing an means to embed psychological thinking without exhausting resources). In order to be true to CAT, CAT-TF needs to be collaborative in approach – with informed consent and the service-user voice underpinning its delivery.

Keywords: team formulation, cognitive analytic therapy, CAT, consultation, reflective practice, learning disabilities, mental health, remote therapy

Introduction

Under the Transforming Care initiative within the UK, there has been a significant shift towards helping people with learning disabilities (LD) to live within the community; in 'homes not hospitals' (Houlden, 2015). This move towards supporting people to return home from hospital units, arose from significant human rights abuses perpetrated by those within 'caring' roles (e.g. Winterbourne view; see Flynn, & Citarella, 2013). In order to meet the care and support needs of people with LD in the community and reduce the risk of any further admissions, care-worker input is often provided to facilitate daily living. Where additional mental health needs are also present, this is often supported through the provision of 'in-reach' from community health teams – whereby specialist services advise, consult and supervise care-worker input.

For staff and professionals fulfilling these roles within LD services, the perceptions that they hold of their client can significantly impact upon the client's experience of services and the quality of their care provision (Russell, 2019). Indeed, people with LD have talked of staff seeing them as 'a different person' once they transitioned back to living at home within their community, rather than being seen as a 'bad' person in hospital (Head, Ellis Caird, Rhodes, & Parkinson, 2018). Having returned home, it was important for these people 'feel safe' and 'happy' in their homes and they viewed staff as having a key role in helping them to feel this way (ibid.). From this, it can be seen that the foundation to effective community health care is to ensure staff are sufficiently trained and supervised to understand and dynamically manage relational and

behavioural difficulties in-line with evidence based clinical models. Within these contexts, psychological consultation has been suggested to benefit staff and clients, through facilitating a consistent team approach across the network (Kerr, Dent-Brown & Parry, 2007).

However, evidence suggests frontline staff working with this client group often feel under-supported and ill-equipped in working with the interplay of psychological, social and physical needs they are presented with (Bromley & Emerson, 1995; Hastings, 1995). Staff burnout and reduced team morale have been found to be influenced by staff feeling unskilled and unsupported in working with such complexity, in addition to the impact of the work itself (Robertson *et al*., 2005; Mills & Rose, 2011). In the face of these challenging environments, Varela and Franks (2019) suggest staff often experience threat-based responses, that eventually become cemented into practice; especially where low levels of support are available. Within these circumstances, staff are likely to fall out of dialogue with clients, as the reciprocal process of communication, and therefore any attempt to understand the client becomes lost (Varela & Franks, 2019).

To provide staff teams with the tools to develop their understanding of clients and provide a coherent team approach, there has been an increasing interest in psychologically informed working with staff groups; such as team formulation and consultation. Team formulation involves a process of collaborative sense-making underpinned by psychological theory, to inform the understanding and approach of staff groups working with a client (Johnstone & Dallos, 2014). The Division of Clinical Psychology (DCP, 2011) propose numerous potential benefits to team formulation, including facilitating consistent interventions, encouraging collaborative working, gathering key information succinctly, generating new ways of thinking, processing staff counter-transference, and increasing staff reflectiveness and empathy. Research suggests whilst the range of models used to provide a framework for team formulation is diverse, CAT is one of the most frequently adopted models; second to the use of cognitive behavioural therapy (Ghag, Kellett & Ackroyd, 2019).

CAT is considered a fundamentally relational model for understanding individuals' experiences, through recognising how internalised relational experiences, termed 'reciprocal roles', come to influence how we engage with the world, other people and with ourselves (Ryle & Kerr, 2020). Although CAT was originally designed as time-limited individual therapy, the application of CAT with teams has become increasingly recognised; for example, the 'Map and Talk' approach (Potter, 2010). The use of CAT

with services has been suggested to enable staff to express and make sense of their reactions to the client, sustain empathy, and maintain a therapeutic approach (Carradice, 2017). Thus, it can be seen that CAT appears to offer a potentially suitable model for working relationally with staff within LD services.

Aims

The service evaluation sought to explore the acceptability of CAT-TF for staff working within a residential LD service that supported people with complex presenting needs and risks, with the view to prevent hospital admission. This research also sought to explore the staff members' experiences of using the groups. Specifically, commissioners of the service also wanted to ascertain whether the project appeared valued by staff and whether its delivery via remote technologies was acceptable. This informed the following aims for the evaluation:

- Explore the acceptability of team formulation for staff;
- Explore staff experiences of the group, including what was considered helpful or unhelpful within the meetings;
- Explore the impact of remotely delivering CAT-TF on staff experiences.

Service context

The service evaluation was conducted within a residential service for clients presenting with significant mental health needs alongside a LD diagnosis. The residential home would often support people who were at risk of hospital admission (with the view to reduce this risk), to mitigate placement breakdown and offer temporary respite, and for periods of assessment in advance of developing a community support package. The residential staff included support workers (n =10) and residential managers (n=4); with additional support provided by external agencies based on client need. This research was conducted during the COVID-19 global pandemic (March 2020 – September 2020), where the UK saw two national 'lockdowns' but residential services continued throughout. In this context, CAT-TF was offered through remote technologies, rather than on site and in person. This provided an additional opportunity to explore the potential benefits or drawbacks of remote delivery.

Team formulation process

For team formulation to take place, informed consent was obtained from the client. To enable this, an easy-read document about CAT-TF and a consent form were developed (Priddy & Varela, in prep.). For each client, three-to-four team formulation sessions were held on a bi-weekly basis; lasting 90 minutes each. Clients were invited to attend their formulation meetings; all clients chose to attend at least one session. Formulation meetings were informed by clinical experience, consultation with the residential home and the steps proposed by Carradice and Bennett (2012). These steps, adapted from Carradice and Bennett (2012), were used to facilitate an effective formulation space (Table 1). All sessions were facilitated by a trainee clinical psychologist, with supervision from a qualified CAT practitioner.

Methods

Design

A mixed methods design was implemented, which occurred in two

Table 1: CAT-TF in a residential LD context – steps adapted from Carradice and Bennett (2012)

Step	Tasks
1. Preparation	● Referral screening ● Seeking consent from service-user (using accessible/easy-read information) ● Preparing the team: process & practical group set up
2. Letting people talk	● Developing empathy and a context to talk freely ● Ensuring that the client's voice is heard and adapting ● Validating relational struggles ● Co-regulation (allowing movement from expressing emotion to reflecting on emotion)
3. Sharing of relational experiences & sharing knowledge of self	● Focussing on how the struggle is embedded in relational dynamics, not necessarily individuals ● Enabling and supporting relational talk ● Drawing out reflections on the self and the selves as relational ● Connecting the selves to the patterns ● Reformulation of team 'stuckness'

4. Funnelling using CAT theory and awareness of ZPD	● Giving observations a name (eg 'that sounds like a dilemma . . .') and supporting elaboration (eg 'because if they do this, or if they do that, what occurs in either situation?' ● Guided questionig to suport identification of target problem procedures, traps, dilemmas, snags, reciprocal roles ● Noticing the relational patterns in the room; using transference and counter-transference, to enrich understandings ● Drawing out the moment, providing examples and scaffolding to extend awareness
5. CAT Mapping	● Drawing out a CAT map together as collaboratively as possible (eg everyone has a pen, or using 'share screen'/ whiteboard features) ● Working to establish and use language and/or images that are co-created by the client and the team to create the CAT map
6. Seeking consensus and further understanding	● Reviewing the CAT map together – what makes most sense and is in-line with the group's expereience ● Taking the map away to revise and return to the group for further review
7. Inviting recognition	● Embedding the invitation of the observing eye ● Tasking the team to actively recognise patterns within the moment ● Collaboratively designing out-of-session ways to recognise and monitor patterns
8. Planning the exits	● Supporrting the development of therapeutic care-plans, rooted in relational ways of understanding/responding ● Developing relational and collaborative ways of managing risk

phases. A validating quantitative data model (Creswell, 2019) was used, whereby quantitative questionnaire findings were validated using content analysis of qualitative questionnaire data (phase one). Findings from phase one informed the second phase of the evaluation, in which a focus group was conducted to further explore participants' experiences of the sessions.

Participants

Inclusion criteria required staff to have attended at least one team formulation meeting and a 2-hour introductory CAT training session. All staff members who met the inclusion criteria participated in phase one (n=6). Participants included three residential workers, a social worker, a team manager and a psychologist; all of whom were white British. Three participants were male, three were female.

Four of the phase one participants also participated in phase two; two participants could not attend due to other commitments. Participants in phase two included three residential workers and one social worker; two participants were male, two were female.

Ethical considerations

Approval was granted from the Research and Development department within the NHS Trust that the project was completed. Participants were informed their data would be anonymised and they could withdraw their data at any time; up until data analysis commenced.

Measures and materials

Consultation Outcomes Scale (COS)

The COS is a 7-item questionnaire which explores participants' perceptions of the 'outcomes' of formulation and consultation meetings (Fredman, Papadopoulou & Worwood, 2018); for example, 'the consultations have helped improve my relationship with clients'. Each item is rated using a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). For each item, a qualitative response is requested, to enable explanation of the rating.

Consultation Partnership Scale (CPS)

The CPS explores individuals' experiences of 'partnership' within team formulation meetings, across five items (Fredman, Papadopoulou &

Worwood, 2018), namely: 'relationships within the consultation and network', 'goals and topics', 'approach or method', 'group experience' and 'overall experience'. Items are rated on a 5-point Likert scale, anchored by individual statements relating to positive or negative endorsement of the item; higher scores indicate agreement and lower scores indicate disagreement.

Semi-structured interview schedule

Four semi-structured interview questions were developed, based on the findings of phase one and consultation with the commissioners:

1) In what ways, if any, did team formulation change your understanding and practice?

2) Was there anything within the CAT framework that made it easier to apply your understanding to your practice?

3) What are your perceptions of how the clients responded to team formulation and the use of CAT?

4) Was there anything that happened during the process of team formulation that you found particularly helpful or unhelpful?

Procedure

Informed consent was sought from staff prior to each session using an information sheet and consent form. Following completion of the formulation process for each client, participants completed the COS and CPS measures. These were returned anonymously to the researcher, to reduce risk of bias. Six months after the introduction of the formulation meetings, staff who consented to participating in phase two were invited to attend a two-hour focus group, to further explore their experiences of the sessions. The focus group was recorded using an encrypted device, before being transcribed by the lead researcher and stored securely, according to NHS Trust guidance. For an overview of the service evaluation procedure, see Figure 1.

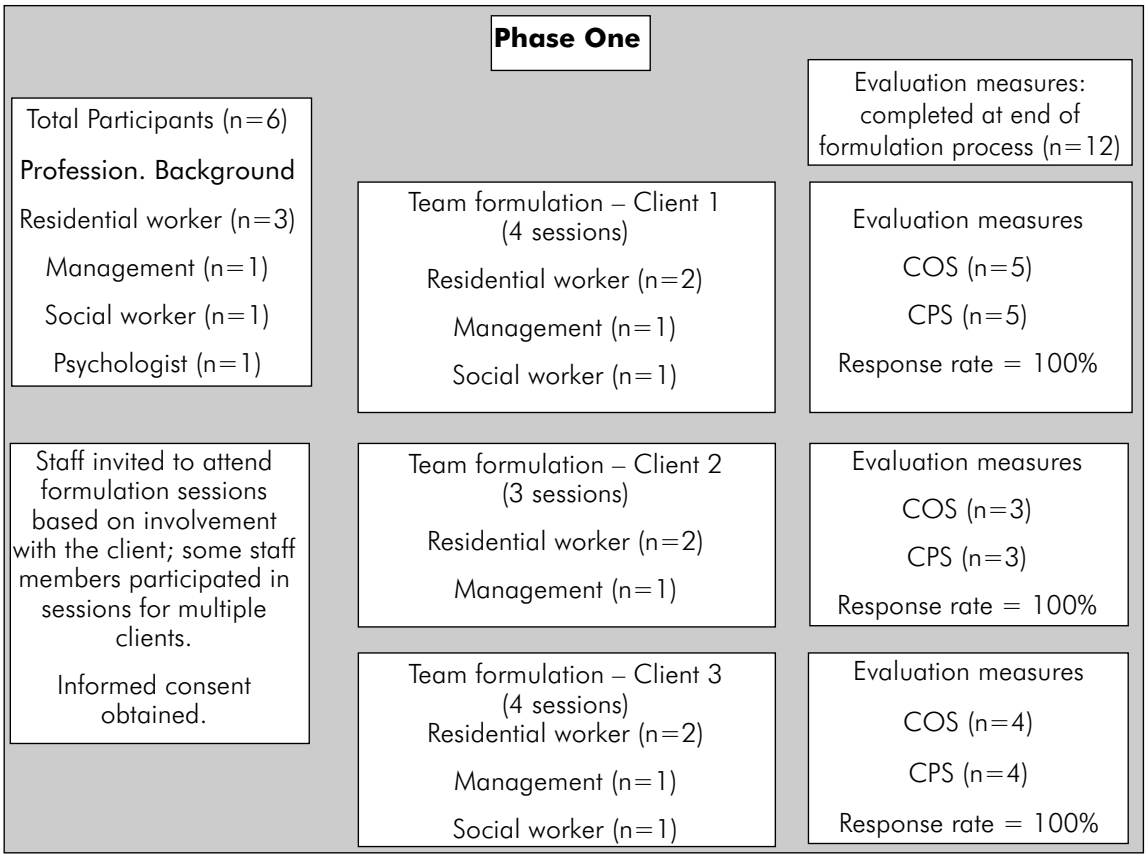


Figure 1. Project overview

Analysis

Quantitative Analysis

Based on the aims of the project and due to the small sample size, descriptive analysis was used on the quantitative data collected on the COS and CPS measures.

Qualitative Analysis

Qualitative data from phase one and two was analysed using content analysis, which involves systematic investigation of written verbal or visual information through identifying, coding and categorising patterns within the data (Elo & Kynäs, 2008; Patton, 1990). To complete the analysis, the researcher followed Schreier's (2012) content analysis model, which involved the following process:

1) *Conceptualising.* The researcher repeatedly examined the data, to note patterns of similarity and difference, and identify concepts that appeared relevant.

2) *Defining categories.* Similar concepts were grouped into categories; according to their shared features.

3) *Developing categories.* The researcher introduced a structure to the coding frame through deciding upon main categories and subcategories.

Reliability procedures were implemented using Hill, Thompson and Williams (1997, as cited in Priester *et al*., 2008) consensual qualitative research model. An independent clinical psychologist, who was not part of the research team, second coded the data. Coders discussed discrepancies until they reached agreement on categorising 95% of the items. This process was repeated two weeks later, until coders reached consensus on all themes and subthemes.

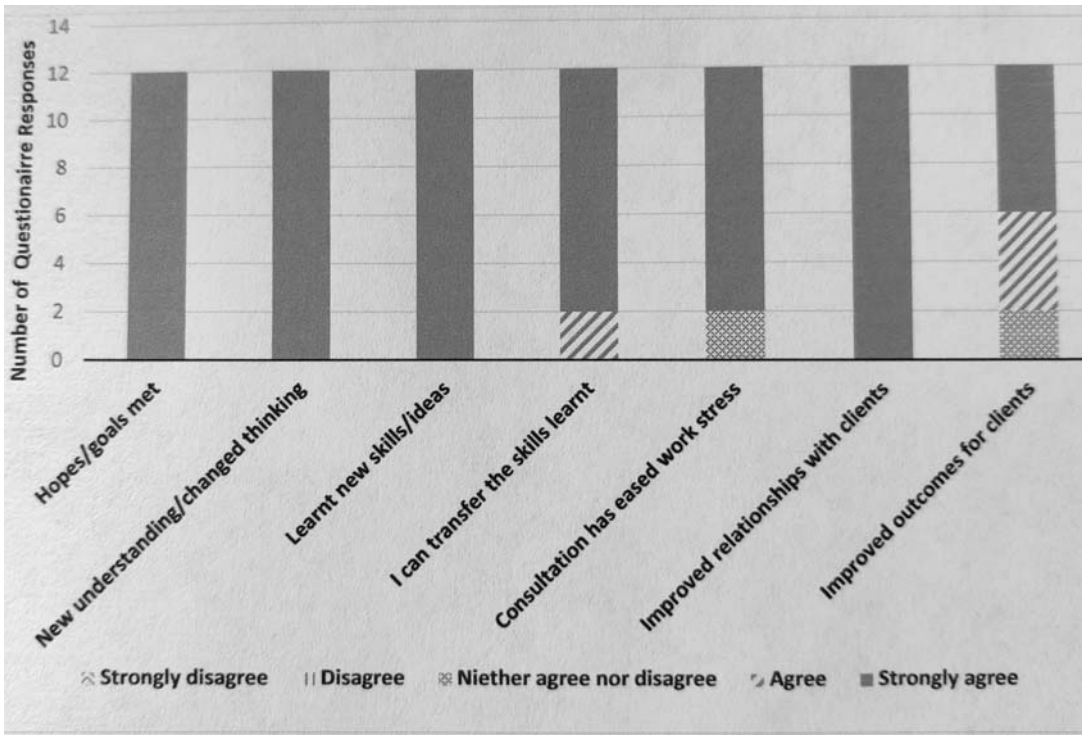
Results

Quantitative Results

Twelve questionnaires were available for analysis. Based on the small sample size, raw data has been presented; as opposed to percentages. Responses on the COS scale illustrate that participants strongly agreed with four items on the measure (Figure 2). These items included: 'my hopes and goals for the consultation were met', 'the consultation has

given me new understanding/changed my thinking to help address the issues brought', 'the consultation had helped me learn new skills/ideas to address the issues brought', and 'the consultation has improved my relationship with clients'.

Figure 2. Quantitative COS data



In response to the 'I can transfer the skills I've learnt' item, two respondents indicated 'agree', whilst 10 indicated 'strongly agree'. On the item 'team formulation had reduced work-related stress and/or increased my confidence', two respondents indicated 'neither agree nor disagree', 10 responses 'strongly agreed' with this statement. On the final item, 'the consultation will lead to improved outcomes' for the client, there were six responses for 'strongly agree', four for 'agree', and two for 'neither agreed nor disagree'.

Data from the CPS measure indicated positive experiences of partnership across all five domains (i.e. participants provided a score of 5 across all items).

Table 2 Summary of qualitative findings for phase one

Theme	Subtheme
Outcomes for client: this theme related to participants reflections on how team formulation had impacted the client (either directly or indirectly	Improving care provision: this subtheme contained comments from staff relating to how clients would be positively impacted up by the team formulation process
	Building relationships: two participants described a positive influence of team formulation on improving therapeutic relationships
Outcomes for staff: this theme contained four subthemes, which reflected different outcomes of team formulation for staff in relation to their personal and professional development	Increased confidence: Three participants reported increased confidence in themselves or their practice as a result of attending the team formulation
	Changing practice: Two participants provided reflections which detailed ways in which the team formulation would inform their practice
	New understanding: this was the most frequently reported subtheme, with participants reflecting a sense of new understanding of the client based on their participant in team formulation
	Transferable skills: Four participants contributed to this subtheme, indicating that the skills they felt they had developed were transferable to other areas of their work
Facilitator role: this theme reflected comments relating to the characteristics of the facilitator role that were experienced as helpful	No subthemes

Qualitative results

Questionnaire data

The content analysis indicated the presence of three themes, for which a brief summary is provided:

1) Outcomes for staff: participants reported increased feelings of confidence, greater understanding of clients, changes to their practice and the development of transferable skills.

2) Outcomes for clients: team formulation was perceived as facilitating improvements in the care offered to clients and enhancing client-staff relationships.

3) Facilitator role: this theme reflected the perceived role of the facilitator and helpful aspects of their approach; such as introducing ideas using psychological theory.

Examples	Frequency
'I think the consultation enabled a positive outcome for the client by giving direction for the care team, providing consistency, improving emotional well-being, ensuring the client's needs are being met, encourage development of C2's skills when care planning, and supporting the client to achieve their outcomes.'	3
'The consultation has helped improve our relationship with them, we know more about their background. We will continue to learn and build on our skills.'	2
'This has improved overall confidence in working with the client, as I can now have confidence in support planning and my advice to support staff, as this is underpinned by psychological theory.'	3
'We are now able to create an evidence-based care plan which will support the client's emotional well-being.'	2
'I now have a better understanding of what C2 is trying to communicate, and how they are communicating this to us.'	12
'Skills I learnt in these sessions are invaluable. Thinking about reciprocal roles is transferable to all clients.'	4
'The facilitator offered ideas and put together a really useful flow chart of behaviours and explored current responses and exit strategies for times of heightened anxiety.'	3

These themes informed the semi-structured interview schedule for phase two, alongside the quantitative findings. All themes, subthemes, and the frequency they occurred within the data is presented in Table 2.

Focus group data

Content analysis of the focus group data yielded five overarching themes: 1) new insights and understanding, 2) the tools of CAT, 3) growing relationships, 4) creating safe and (remotely) accessible spaces, and 5) recognising patterns and unhelpful responses. All major themes and subthemes are listed in Table 3. Samples of the data have been included, to maintain the richness of the data (Elo & Kyngäs, 2008).

Table 3
Phase two content analysis: main themes, subthemes and frequencies

Themes	Subthemes	Frequency
New insights & understandings	Understanding client	10
	Understanding self	4
	New understanding changes practice	5
	Subtotal	19 (30.16% of total)
The tools of CAT	Using the map	8
	The map provides a plan	5
	Understanding complex ideas	3
	Subtotal	16 (25.4% of total)
Growing relationships	Relationship enables dialogue	4
	Understanding builds relationships	3
	Developing cohesion	4
	Subtotal	11 (17.46% of total)
Creating safe & (remotely) accessible spaces	The benefits of remote sessions	5
	Creating a safe space to share knowledge	4
	Subtotal	9 (14.29% of total)

Theme 1: New insights and understanding

Within this theme, participants described team formulation as developing their understanding of clients, themselves and the team; which, in turn, facilitated changes in their practice.

Understanding the client

The process of team formulation was experienced as an opportunity to understand the client 'beyond the surface':

> 'You can just understand them so much more. . . and you realise there is a reason behind every action that they do. . . just because we don't know everything, there's still got to be a reason somewhere.'

> 'It's like our understanding goes beyond the surface now, we're actually seeing what's going on.'

Participants noted that this understanding was enabled through new insights into the client's historical experiences:

> 'I just think it's such a holistic approach, looking at his past, his current presentation, and why we see these things. . .'

Understanding the self

Participants also reported that engaging in self-formulation using CAT allowed them to consider the relational interplay between them and the client:

> 'Because I have my own CAT map in my head now, I can understand why I respond in certain ways [to clients].'

This understanding extended to reflecting upon themselves within the context of the team:

> 'It's made us think about how we work, and we all take on specific roles. . . I almost feel like 'dad' at times in the building. . . we take on roles of brother, sister, mates and stuff, and I think that's something that we've learnt. . . we can transfer the CAT stuff on to each other, and look at each other as a team.'

Your understanding changes your practice

For all of the participants, comments were made relating to how their new understanding had changed their practice:

> 'Understanding the way he's working, made me realise I can support him better. . . knowing that information, it's like having a separate bag of tools that you can pull out to use with somebody.'

Theme 2: The tools of CAT

Elements of CAT were perceived as offering an accessible framework for understanding 'sophisticated' ideas.

Using the map

Participants reported benefits of using a visual diagram (i.e. a sequential diagrammatic reformulation) to encapsulate the formulation and recognised this as aiding the recognition process:

> 'I think the client can understand their patterns better through the map. . . especially [client]. . . she really understood the little circles that she could go in, she'd say to us, 'oh, well I'm here. . . I need to find the exit to get out of that circle', so she genuinely took it on. . . because she was telling us where she was.'

Two participants spoke about the map providing a mechanism to hold the formulation over time:

> 'I think it's good that we have it down on paper, so that when they move on, they don't have to go through everything again. . . it's just there, and we can carry on working in that way.'

Understanding complex ideas

Participants described experiencing the CAT model as providing an accessible framework for understanding complex ideas:

> 'As a format, I think it's lovely. . . because it looks at past, present, and allows us to push them into their future and change. . . in what feels like very simplistic way. . . but is actually a very sophisticated model of analysis and psychological intervention.'

Theme 3: Growing relationships

Participants perceived their new understanding as enabling staff-client relationships to grow, which was suggested to facilitate dialogue within the relationship.

Understanding builds relationships

This subtheme reflected participants' perceptions of how their understanding of clients led to developments within the therapeutic relationship:

> 'The knock-on effect of doing this, and understanding more about him means that the relationship has grown, it's amazing. . . it's been beautiful to walk on this journey.'

This was described as a two-way process, whereby understanding the client facilitated participants' professional development, to allow staff to facilitate personal development for the client:

> 'With some of the residents we really didn't connect with them, but now we've got really good relationships, and I think part of that is a knock-on effect from this process, because we think bigger. . . around how have they got to be where they are, what's gone on for them. . . it allows you to develop. . . and that develops them. . . which is really nice, because it's a two-way process.'

Building the relationships enables dialogue

This subtheme captured participants' subsequent experiences of dialogue with clients based on their improved relationship:

'I saw [client] and [staff]'s relationship grow. . . because [they] opened up, talked about her experience, which let you guys in even more.'

'He must feel comfortable around me now, he's able to say how he feels. . . it made me feel quite proud'

Relationships with the team

Participants spoke about feeling stronger as a team based on the skills they had developed throughout the process:

'Skills that we've got now have helped make the team stronger, and they are able to support in a better way.'

In turn, the development of skills and strategies were described as enabling a more cohesive staff approach:

'It's given us lots of strategies that we can be consistent with. . . and I think with this client group, consistency is really important.'

'It's given us direction as a team, which is a really beautiful thing. . .'

Participants felt that engaging in a CAT-based training generated a new outlook for the team and reported a desire for more of these opportunities:

'It gave the whole team a different outlook and a different view. . . so I wish we could've done more of that sharing as a group remotely.'

Theme 4: Creating safe and (remotely) accessible spaces

This theme related to participants' experiences of engaging in team formulation via video-call platforms and being able to establish a safe space.

The impact of engaging remotely

Participants reported benefits of engaging in the sessions via video call, for both themselves and the clients, despite initial reservations:

'[client] is so scared of meeting new people. . . and actually. . . it's worked really well. . . because I thought, 'how is this gonna work?'

> . . . and I honestly thought. . . 'how can we do psychology type meetings over the internet?'. . . and it's worked amazingly.'

Some participants felt clients appeared to find it easier to 'open up' over video call:

> 'Being behind a screen probably allowed her to open up and little bit more than she would've done in person. . . it's a safe space, she knows where she is. . . I think having the screen maybe gave them more confidence to open up.'

Remote engagement was seen as increasing the accessibility of the team; which could be helpful, whilst also making work feel more stressful:

> 'I think we've all been more accessible. . . which makes the job more stressful. . . but it's also really helpful, because you're just at the end of a video-call.'

Creating a safe space to share knowledge

Participants described the meetings as a safe space where curiosity, uncertainty and knowledge could be shared:

> 'I feel like we could all be really honest, in saying in the sessions, 'I don't know, can someone help me?' It did feel like a safe space. . . where we could say we don't know the answers, but we can figure it out together.'

Theme 5: Recognising client patterns and staff responses

Within this theme, participants described being able to actively recognise enactments.

Recognising patterns in the client

Within this subtheme, staff described recognising enactments of reciprocal roles or problematic patterns from the CAT map:

> 'When they say 'I'm going to go get stoned, and you won't like me then' . . . I was able to be like, ah okay, that's your past experience, that's your parent speaking. . . and then they turn into 'child' [client], the victim bit, and being able to identify that is really useful.'

The ability to recognise enactments was seen as providing staff with the opportunity to intervene earlier, before situations escalated:

> 'We used to just all get in there and just firefight, and now, we don't firefight, because actually, we're able to see the smoke. . . so we can intervene quicker'

Recognising unhelpful responses

Within this subtheme, participants contributed comments which related to reflecting on their actions and how these impact upon relational dynamics:

> 'I think sometimes I try and rescue, and now I realise that can ignite the fire even more.'

Some participants extended these reflections beyond themselves, to recognise unhelpful responses within the team and initiate conversations about revising relational patterns.

Discussion

Delivering CAT-TF to residential services is an appropriate, effective and resource efficient way of ensuring that people with LD have access to staff who are able to deliver care informed by theoretical and evidence-based models of care, as an alternative to hospital admission. This research evidences that its delivery is both acceptable and feasible, and indicates that those participating experience CAT-TF positively and as helpful for their practice. In particular, team formulation sessions enabled staff to develop their understanding of clients, themselves and the team. In turn, this facilitated the positive development of relationships between the staff team and clients. This process is encapsulated in the below figure for illustrative purposes. CAT-TF appears to be a well-matched service offer to meet the relational needs of people with LD who have moved out of hospital or face other significant transitions (as voiced within Head *et al*., 2018).

This research also sought to explore the potentially helpful and unhelpful elements of team formulation for staff. The findings indicated numerous valued aspects of this approach, particularly the benefits of the CAT 'map'; which appeared to be appreciated for its ability to increase

accessibility to relational understandings, and provide a single document to 'hold' the developed understanding both figuratively and literally. Overall, these findings suggest that the 'tools' of CAT add helpful components to team formulation.

This research also provided the opportunity to consider the impact of remote delivery (i.e. through video-call platforms). Remote delivery of CAT-TF appeared to increase accessibility and flexibility, with more staff attending than had been anecdotally observed within similar projects – this included staff members who attended despite not necessarily being 'on shift' or attending whilst being based elsewhere (though no comparison data was collected). The formal evaluation indicated that staff did not feel inhibited by using remote technology to engage in sessions, with some staff describing the use of video-call technology as having a positive impact on accessibility and 'openness' within sessions. As such, there are clear benefits from remote delivery of CAT-TF.

Clinical and research implications

Based on this research, there are a number of clinical and research implications:

1. CAT-TF is acceptable/feasible, and appears to facilitate relationally-informed, ethical and safe practice within residential services.

> CAT-TF appears to facilitate understanding, dialogue, and relational aspects of care for staff and clients who do not have specialist mental health training within residential settings. Although there is a need for further research, this research clearly demonstrates it is experienced as acceptable and useful by staff. As such, this research provides a good evaluative basis for further commissioning for such groups.

2. CAT-TF offers a user-friendly approach to facilitate reflective practice, with useful steps and stages.

> It is recommended that the formulation framework outlined by Carradice and Bennett (2012) or adaptations, such as our described process, continue to be used; as this provides necessary 'steps' to reach a visual CAT formulation.

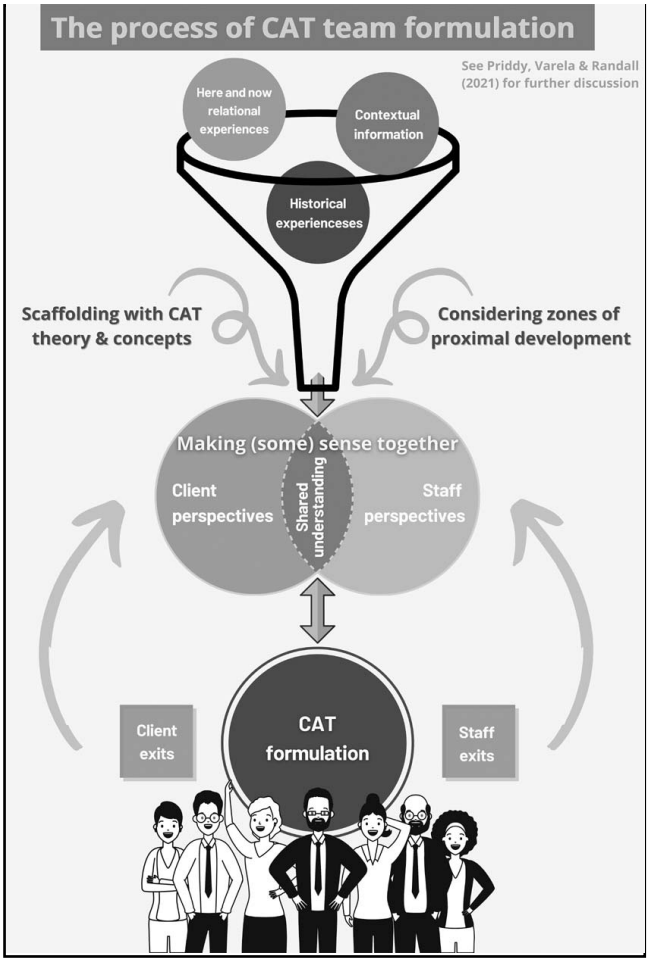
3. Remote delivery of CAT-TF is acceptable, feasible and advantageous.

> The use of remote technologies to facilitate CAT-TF was considered acceptable by participants and appeared to facilitate regular and

fuller attendance. Remote delivery did not appear to negatively impact the experience and quality of these sessions for staff. Therefore, the use of video call platforms is recommended where appropriate.

4. Informed consent from service-users is a fundamental milestone in delivering CAT-TF and speaks to the ethos of collaboration at the heart of CAT.

To the authors' knowledge, no other easy-read team formulation and consent forms have been produced for CAT-TF (and possibly for Team Formulation more widely). Easy-read materials are vital if CAT-TF is to embody CAT principles and values, such as collaboration. Therefore, this study uniquely contributes to the betterment of CAT-TF processes when working within the context of learning disabilities and residential care through setting the precedents for this. We are preparing a manuscript in order to make these materials available for wider user (Priddy & Valera, *in prep*.). Please contact the lead author for a copy in the meantime.



Conclusion

We believe that CAT is uniquely placed to cater to the multi-faceted constraints of individualised thinking; freeing up teams to take the relational seriously, and thus help unstick themselves from unhelpful repetition and re-enactments. CAT-TF is an acceptable, feasible, and resource efficient process for supporting psychologically informed

thinking and formulation informed decision making within contexts that support people with complex health and relational needs. Further research to explore client outcomes and experiences of CAT-TF is needed to further inform the implementation of CAT-TF within services. □

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A CAT-based early intervention for Borderline Personality Disorder: A Pilot Study

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Abstract

Objectives: Clinical interventions for borderline personality disorder (BPD) traditionally focused on established and chronic forms of the disorder. Increasing evidence indicates the reliability, validity, and clinical importance of the diagnosis of BPD in adolescence. This underscores a more developmental perspective to the disorder and sets the stage for prevention and early intervention. However, much is still unclear about the clinical practice of early intervention. This study aims to (a) explore a sample within an early intervention program, (b) explore how the different treatment modalities within this program were used, and (c) provide a preliminary test of general difficulties and psychosocial functioning change within young people participating in early intervention.

Design: The current paper describes a pilot study of the program 'Helping Young People Early' (HYPE) in the Netherlands. HYPE is an early intervention program for BPD in youth based on cognitive analytic therapy (CAT), developed in Melbourne, Australia.

Methods: For the current pilot study, data were used from 22 adolescents (M_{age} = 17.3, SD_{age} = 2.3). Subjects were offered HYPE treatment, comprising time-limited individual CAT, CAT-informed family therapy and

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psychosocial coaching integrated within the general psychiatric care. The sample and use of the specific treatment modalities were explored. Changes in experienced difficulties and psychosocial functioning were examined at six-month follow up.

Results: Individuals within the HYPE program showed (sub)threshold levels of BPD and received on average 15 sessions of individual CAT therapy, in addition to family therapy, psychosocial coaching and generic psychiatric care over a six-month period. After a six-month follow-up a trend was found suggesting a decrease of difficulties, emotional problems and self-harm. Prosocial behaviour seemed unchanged.

Conclusions: This pilot study offers a helpful characterisation of the patient sample within an early intervention program and the use of different treatment modules in this program. Preliminary findings suggest a decrease in experienced difficulties within adolescents participating in the HYPE program. This study supports the argument for early intervention studies in general. It then arguably also justifies and implies the need in this European setting for further extended studies of previous ones undertaken in an Australian setting. Further studies are required to study effectiveness of early intervention on a larger scale.

Keywords: borderline personality disorder; adolescents; early intervention; cognitive analytic therapy

IN the last decades, borderline personality disorder (BPD) is being considered a lifespan developmental disorder more and more (Chanen & Kaess, 2012). Theories of the aetiology of BPD include complex transactions between biological vulnerabilities of the child and the family environment (Chanen & Kaess, 2012). The data supporting this developmental view are convincing, as BPD has been found to be continuous in different developmental periods and similarities in terms of phenomenology, structure, stability, validity, and morbidity are found for adolescents and adults (Chanen & Thompson, 2014; Newton-Howes, Clark, & Chanen, 2015). A growing body of research shows that BPD can be assessed in adolescents in a reliable and valid manner (Chanen *et al*., 2004; Chanen, Jovev, & Jackson, 2007; Miller, Muehlenkamp, & Jackson, 2008; Westen, Shedler, Durrett, Glass, & Martens, 2003) and different national guidelines acknowledge that diagnosing BPD is justified in adolescents (Fonagy *et al*., 2015; National Health and Medical Research Council, 2012).

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) describes BPD as a severe mental disorder characterised by a pervasive pattern of impulsivity, emotional instability, interpersonal dysfunction, and disturbed self-image. Despite widespread use in research and treatment settings, the concept of BPD based on the criteria of DSM-IV and DSM-5, has never been universally accepted in the field. This lack of acceptance can be understood from limitations, such as excessive comorbidity, within-disorder heterogeneity, and diagnostic instability (e.g., Widiger & Trull, 2007) and has led to redefining BPD using traits, as well as the introduction of an alternative model of personality disorders with dimensional elements in DSM-5. Different theoretical and psychotherapeutic models have defined a theory-specific understanding of BPD, with a central role of the internalization of negative or adverse early interpersonal experiences as a framework for later psychosocial functioning. This is also a central key within the procedural sequence object relations model as used in Cognitive Analytic Therapy (Ryle, 1985). This more psychotherapeutic understanding of BPD adds to a life span developmental view on the disorder.

Within a lifespan developmental view of BPD, adolescence and young adulthood are crucial developmental phases. BPD usually emerges during adolescence (Sharp, 2016) and is defined by high comorbidity and poor outcomes (Chanen & McCutcheon, 2013; Ha *et al*., 2014). Prevalence rates of BPD in adolescents seem similar to those found in adult populations, 1–3% in community-dwelling samples, 11% in outpatient samples, and 33–49% in clinical inpatient samples (Johnson *et al*., 2008). It also shows a rise in prevalence from puberty and a steady decline with each decade from young adulthood onwards (Chanen & McCutcheon, 2013). Therefore, BPD is an important disorder to focus on in treatment especially in young people.

Traditionally, clinical interventions for BPD have focused on individuals with established and/or chronic forms of the disorder. However, studies have shown both in adults (Zimmerman *et al*., 2013) as well as in outpatient youth that subthreshold BPD features are already associated with greater psychosocial co-morbidity, such as more DSM-IV mental disorders, poorer social and occupational functioning, being more likely to be referred for treatment for suicidality and/or disruptive behaviour, compared with outpatient youth with no BPD features (Thompson *et al*., 2018). This underpins the clinical significance of subthreshold BPD features in youth and, therefore the need for early

intervention, aimed to strengthen the developmental pathways regarding psychosocial functioning and psychopathology.

Particularly during adolescence, (subthreshold) BPD may interfere with the process of gradually assuming more adult roles and responsibilities typical for the adolescent years. Longitudinal studies in adults with BPD consistently demonstrate that BPD features naturally attenuate over time, whereas impairments in social and vocational functioning persist, even decades after the diagnostic features of BPD are no longer clinically evident (Chanen *et al*., 2020). Longitudinal data also show that elevated levels of BPD features at a mean age of 14 years predict poorer functioning over the subsequent 20 years of follow up, in social functioning, life satisfaction, academic and occupational attainment, less partner involvement, and fewer attained adult developmental milestones (Winograd, Cohen & Chen, 2008). This could imply that BPD features during adolescence have the potential to disrupt the transition to adulthood, derailing the acquisition of essential skills (Chanen *et al*., 2020).

Both inside and outside the family, social interactions are important for the development of personality in young people. Problems in social functioning are considered a key problem in BPD as well as in personality pathology in general (Hopwood, Wright, Ansell, & Pincus, 2013). Paris (2014) stated that social relations of individuals with personality pathology are a key element for understanding the course of disorders. Moreover, Chanen and Kaess (2012) stated that in contrast to the relatively unstable nature of the diagnosis BPD, both in adolescents and in adults, problems in social functioning are relatively stable and may have long-lasting consequences for the individual's functioning. Therefore, early intervention needs to be targeting specifically social functioning in young people with subthreshold BPD.

Early Intervention based on Cognitive Analytic Therapy

Early intervention focuses on early diagnosis and treatment for BPD and subthreshold borderline personality pathology (Chanen, Sharp, & Hoffman, 2017). The program Helping Young People Early (HYPE) is an early intervention program for BPD in youth (12 to 25 years of age) based on cognitive analytic therapy (CAT) as developed by Ryle (Ryle & Kerr, 2002). The HYPE program was developed by Chanen and McCutcheon in Orygen, the National Center of Excellence of Youth Mental Health in Melbourne, Australia (Chanen *et al*., 2009). In the Netherlands,

the HYPE program has started in 2016, with training and support from the founders of the original HYPE program. The HYPE program employs an integrated, team-based treatment model with multiple elements, all based on cognitive analytic therapy (CAT). The current paper describes a pilot study of the HYPE program in a mental health institution in the Netherlands. The elements of the intervention are summarized in Table 1.

Table 1 Elements of Early Intervention in the HYPE Program

- Assessment of BPD and comorbid psychopathology
- Individual cognitive analytic therapy (CAT)
- Family intervention based on CAT
- Psychosocial coaching
- General psychiatric care, with specific assessment and treatment of co-occurring psychiatric syndromes (comorbidity), including the use of pharmacotherapy
- When indicated: Crisis care, with clear model of brief and goal-directed inpatient care
- Individual and group supervision of staff
- A quality assurance program

Cognitive analytic therapy. CAT is the core of the HYPE treatment model, as CAT is used in the different treatment elements and is used as a framework within the team meetings. CAT is a time-limited psychotherapy that has been developed in the United Kingdom (Ryle & Kerr, 2002). CAT is developed as an integration of theoretical elements of psychoanalytic object relations theory and cognitive psychology, as a model in which the self is seen as being characterised by an internalized repertoire of relationship patterns, acquired throughout early and subsequent relational experiences. The CAT model provides a radical social and relational understanding of the person with BPD. In this view the self is formed through a process of development during which an infant with its genetic predispositions interacts reciprocally with care-

givers in a given culture and time, and psychologically forms and internalizes a repertoire of relational patterns embodying action, thinking, feeling and meaning (Ryle & Kerr, 2002). When this relational development is suboptimal (as for example in the development of BPD), and early caregiving interactions are not supporting or even damaging, these relationship patterns when internalized will be re-enacted inappropriately and/or inflexibly (Chanen *et al*., 2009). As described in the CAT Multiple Self-States Model three aspects of impaired psychological functioning can be described in BPD; (1) early and extreme relational patterns, usually derived from relationships with caretakers are internalized and persist in determining self-management and relationships with others; (2) partial dissociation, reflecting in a fragmented and discontinuous experience of self, which can be observable in for example discontinuities in memories, behaviours and affects as switches and shifts between disparate and contrasting self-states and; (3) impaired and interrupted self-reflection, which leads to experiences and emotions experienced as confusing, disturbing or meaningless (Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001, Ryle & Kerr, 2002).

CAT aims at developing a joint (patient-therapist) understanding of the individual's problematic relational patterns and the thoughts, feelings, and behavioural responses that result from these patterns ('reformulation'). This reformulation provides the framework for the patient to practice recognizing these relational patterns, and finally revise them in more helpful patterns. In addition, this relational focus provides a framework, not only for the patient, but also for the family as well as for the therapist and the team, that is helpful in reflecting when relational patterns are enacted in daily life or the therapeutic relationship. Therapists make use of diagrams (diagrammatic reformulation) and writing (reformulation letter) in the process of joint and explicit reformulation (Ryle & Kerr, 2002). Termination is an important issue within CAT, as within the time-limited nature of CAT, separation is evident from the beginning. In CAT these issues are recorded in a 'goodbye letter' from the therapist, which is read and discussed in the last session. Patients are invited to write a goodbye letter as well, to promote an exchange of good-bye letters and reflections upon the ending of therapy.

As CAT targets interpersonal and intrapsychic processes common to personality disorders and as its integrative approach also encompasses co-occurring mental state disorders which are the norm in individuals with personality disorders, CAT has been particularly applied in the treatment of personality disorders (Mulder & Chanen, 2012). Because

of the practical and collaborative style of CAT, this psychotherapy seems to match the needs of young people quite naturally, as it is an active and practical form of therapy, and psychological mindedness is considered a goal of, rather than a prerequisite for therapy.

Despite the widespread adoption of CAT in the UK and other countries, the evidence of its effectiveness to date remains limited. The evidence is predominated by small-scale practice-based studies, showing encouraging results at post-therapy assessments, illustrating low dropout rates and substantial improvements in adults (Calvert & Kellet, 2014; Halam *et al*., 2020; Ryle & Golynkina, 2000). The number of randomized clinical trials is limited, although the results call for more research as they illustrate a reduction of symptoms and improvement in interpersonal functioning, as compared with treatment as usual (Clarke, Thomas, & James, 2013) or to manualised good clinical care in adolescents with BPD features (Chanen *et al*., 2008). Calvert and Kellet (2014) conclude that although the accumulating evidence for CAT in personality disorders suggest that CAT has a major contribution in front line clinical services, the challenge is now to benchmark the effectiveness of CAT via large-scale service evaluations and clinical audits.

Although the developments in the field of mental health care support a developmental view of psychopathology and BPD, early intervention programs are novel. As the diagnosis and treatment of BPD are often delayed (Laurenssen *et al*., 2013), the risk is that only young people who already have chronic and severe forms of the disorder are referred to specialized programs in mental health care. In addition, the CAT model was a break in traditional conventional belief that treatment of BPD needs to be intense and prolonged, which lead to reluctance in applying the CAT model (Ryle, 2004). However, CAT has particular advantages for early intervention for BPD, as its integrative approach enables encompassing co-occurring problems, which are the norm in this patient group, within the overall treatment (Chanen, McCutcheon, & Kerr, 2014), and the time-limited and practical nature of the treatment model matches the psychosocial needs of young people in a flexible way.

Therefore, it is important to study the effects of an early CAT-based intervention. A crucial first step in research on early intervention is to better understand which young people are treated in early intervention programs. From the perspective of clinical staging this could be a diverse group of young people, due to the broad inclusion criteria and the high level of co-occurring psychopathology. Furthermore, due to the reluctance in clinicians to assess BPD features, this could imply that only

older adolescents or adolescents with threshold BPD are referred to early intervention programs. In addition in it is important to explore which interventions are offered specifically within an early intervention program.

Current study

Taken together, in order to study the feasibility of a randomized controlled trial of early intervention, we need to understand more about which patients early intervention targets and about the treatment modules within an early intervention program. Therefore, in this study we aim to (a) explore a sample within an early intervention program, (b) explore how the different treatment modalities within the HYPE program were used, and (c) provide a preliminary test of how experienced difficulties and psychosocial functioning change within adolescents participating in the HYPE program, by studying pre- and post-treatment measurement of the general difficulties, such as emotional symptoms and prosocial behaviour.

Method

Participants and Procedure

This study is part of an ongoing clinical cohort study within HYPE (Helping Young People Early), an outpatient program for early intervention of BPD in an organization for mental health care in the Netherlands. Patients aged 12-to-25 years old were referred to specialized mental health care, mostly by their general practitioner. Patients were referred for assessment and treatment of borderline personality pathology and different co-occurring psychiatric problems, such as anxiety disorders, mood disorders and eating disorders. Participants seeking help who after clinical assessment met three or more criteria of BPD, based on DSM-5 (American Psychiatric Association, 2013) were recruited consecutively into the HYPE cohort study. This means that the inclusion criteria for the HYPE program are quite broad, as we expect that young people probably will have co-occurring psychiatric problems that need to be targeted as well during the treatment. Exclusion criteria for the program are an acute psychotic episode and eating problems or substance abuse that require medical attention. The measures for the study were part of the structured clinical assessment at entry to HYPE. Informed consent was obtained from patients (and caregivers when the patient was under 16 years of age), and patients agreed that the data could be used anonymously for

research purposes. As such, all patients entering HYPE were including in the current study as well. The study was approved by the Utrecht University Faculty of Social and Behavioural Sciences Ethics Committee and the Institutional Research Board. Patients were offered HYPE treatment, comprising time-limited CAT, both in individual therapy as well as in the family intervention. In addition, CAT-informed psychosocial coaching was integrated within the general psychiatric care.

Measures

Borderline Personality Disorder was operationalized with the Borderline scale of the SCID-II screening questionnaire (SCID-II PQ-BPD; Gibbon, Spitzer, Williams, Benjamin, & First, 1997; Chanen *et al*., 2008). The SCID-II PQ-BPD is a screening self-report questionnaire that consists of fifteen items in a yes/no response format. Items correspond to the nine DSM-IV BPD criteria. Each DSM-IV criterion has one question, except for criterion three (identity disturbance; four questions), five (recurrent suicidal behaviour; two questions) and eight (inappropriate anger; three questions). A BPD-score was calculated by counting the number of the affirmative answered items. Different studies showed that the SCID-II PQ-BPD was reliable in outpatient youth (a = .88; Chanen *et al*., 2008; a = .85; Alebeek *et al*., 2015) but found different cut-off scores to obtain the best value of sensitivity and specificity predicting 5 or more criteria of BPD according to DSM-5. Chanen *et al*. (2008) found a cut-off score of 12, while results in a comparable Dutch clinical sample of young people indicated a cut-off score of 6 with the best sensitivity and specificity (Alebeek *et al*., 2015). Research indicates that in outpatient youth, the SCID-II PQ-BPD has satisfactory psychometric qualities (Chanen *et al*., 2008). That is, the instrument has a moderate sensitivity, high specificity and moderate to high predictive value. Compared to other screening questionnaires for BPD, the aforementioned study showed that the SCID-II PQ-BPD had the highest overall diagnostic accuracy, test-retest reliability and internal consistency.

Prosocial behaviour, general difficulties and co-occurring difficulties. The Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) was used to measure prosocial behaviour and general difficulties. The SDQ is a 25-item behaviour screening questionnaire asking to what extent both positive and negative psychological attributes of the child were true in the past six months, using a 3-point scale (0 = 'not true', 1 = 'somewhat true', 2 = 'certainly true').'The questionnaire contains five subscales, each consisting of five items: prosocial behaviour,

hyperactivity-inattention, emotional problems, conduct problems and peer problems. In this study, we used a self-report version of the SDQ. The scale prosocial behaviour was used to measure prosocial behaviour and items from the four other subscales were added to compute a ìtotal difficultiesî score, indicating the overall level of problem behaviour. The SDQ has satisfactory internal consistency, test-retest stability and parent-youth agreement in Dutch adolescents and is an indicator for psychopathology such as attention problems and anxiety (Muris, Meesters, & van den Berg, 2003). The prosocial behaviour scale of the SDQ is found to be negatively related to psychopathology (Muris *et al*., 2003). For additional exploration of specifically self-harming behaviour, problems in alcohol-use, and problems in drug use, the subscales of the Dutch extended version of the SDQ (SPsy; Van Oort, Van 't Land, & De Ruiter, 2007) were used. The additional scales self-destructive behaviour and problems in drug use were found to have acceptable psychometrics, while the reliability of the scale problems in alcohol use were insufficient (Zwaanswijk, 2016).

Data analysis

In order to explore the sample, questionnaires and demographic data were analysed. To explore how the different treatment modalities within the HYPE program were used, contacts with patients as registered in patient records were categorized based on HYPE treatment variables (e.g., CAT session, phone contact). Additionally, although participants that dropped out of the study were not included in the study of outcome measures, the patient records and questionnaire data of the seven individuals who did not attend the second measurement point within six months ('study dropouts') were similarly analysed to explore possible differences in treatment pathways. A preliminary test was conducted to explore changes over time in total experienced difficulties, prosocial behaviour and co-occurring difficulties (i.e., emotional problems, self-harming behaviour and problems in drug and alcohol use). This was done by conducting paired-samples t-tests and computing test-retest correlations to examine stability of mean scores across measurement points.

Results

Aim a: exploring a sample within an early intervention program

During this trial period of 6 months, 29 individuals who gave permission

for the study had treatment in the HYPE program during the whole six months. Seven of the 29 individuals (24.1%) did not attend the second measurement point within six months, while 22 individuals (75.9%) participated in the first and second measurement point of the HYPE cohort study. Only these 22 participants were included in the study.

The sample in this report consisted of 22 female individuals (*Mage* = 17.27 years old at the first measurement point, *SDage* = 2.31, range = 13-21 years). Participants were college students (45.5%) or secondary students (40.9%), had a full-time or part-time job (4.5%), or had no job or did not go to school (9.1%). The minority of participants used no medication at the start of the treatment (*n* =4, 18.2%). Of the participants who did use medication, one individual used a stimulant, two individuals used a sleep-inducing drug, and one individual used a selective serotonin reuptake inhibitor (SSRI), an anti-epileptic and a sleep-inducing drug. At the second measurement point, more individuals used medication (*n* = 9, 40.9%), mostly (a combination of) stimulants (44.4%), a sleep-inducing drug (44.4%) or an atypical antipsychotic (44.4%). Some individuals used an SSRI (22.2%), an anti-epileptic (11.1%) or a benzodiazepine (11.1%). At the first measurement point, the average score on the SCID-II PQ-BPD was 12.00 (*SD* = 2.59, range = 8-15). This average score is indicative of the presence of five or more BPD criteria (Alebeek *et al*., 2015; Chanen *et al*., 2008).

Aim b: exploring how the different treatment modalities within the HYPE program were used

Mean scores and standard deviations of the various HYPE treatment elements are shown in Table 2. In addition to the average 15 sessions of individual CAT, participants received family intervention, sessions of generic psychiatric care and psychosocial coaching, adding up to on average 33 sessions of treatment within the HYPE program. Given the small sample and the large variation in the amount of sessions, reporting the median of the total HYPE sessions is more informative, which is 29.50. Within the individual CAT with 90.9% of patients, reformulation letters were discussed, 54.5% of goodbye letters written by the therapist and 40.9% of goodbye letters written by the patient were discussed. During their treatment patients had on average 11 phone contacts with one of their therapists. No patients dropped out of treatment; three patients had a negotiated early ending of treatment. One patient had an inpatient admission of one night.

Table 2 Descriptives of HYPE Treatment Variables

HYPE treatment sample (n = 22)				
	M	SD	Median	Range
Number of individual CAT sessions	15.36	3.08	16.00	5-21
	N	%		
Reformulation letter discussed	20	90.9%		
Goodbye letter discussed	12	54.5%		
Goodbye letter patient discussed	9	40.9%		
	M	SD	Median	Range
Number of sessions family intervention	7.27	6.64	5.00	1-28
Number of generic psychiatric care sessions	5.27	4.12	4.50	2-21
Number of psychosocial coaching sessions	4.91	6.60	2.50	0-27
Amount of phone contact	11.05	7.79	9.50	2-36
Number of no shows	1.55	2.60	1.00	0-12
Number of cancelled sessions	4.27	3.17	4.00	0-13
Number of total HYPE sessions	32.82	16.04	29.50	13-97
Number of follow-up sessions	2.00	1.69	2.00	0-5
	N	%		
Dropout	0	0.0%		
Negotiated early ending	3	13.6%		
Inpatient admissions	1	4.5% (1 night)		
Study dropouts (n = 7)				
	M	SD	Median	Range
Number of individual CAT sessions	8.57	5.53	11.00	2-16 /
	N	%		
Reformulation letter discussed	4	57.1%		
Goodbye letter discussed	3	42.9%		
Goodbye letter patient discussed	2	28.6%		
	M	SD	Median	Range
Number of sessions family intervention	4.14	2.19	3.00	3-9
Number of generic psychiatric care sessions	3.86	1.68	3.00	2-7
Number of psychosocial coaching sessions	2.00	1.73	2.00	0-4
Amount of phone contact	12.86	5.61	15.00	4-19
Number of no shows	3.86	3.98	3.00	0-10
Number of cancelled sessions	4.00	1.73	4.00	2-6
Number of total HYPE sessions	20.43	5.59	21.00	13-28
	N	%		
Dropout	1	14.3%		
Negotiated early ending	3	42.9%		
Inpatient admissions	0	0.0%		

Table 3 Means, Standard Deviations and Ranges of Pre- and Posttreatment Total Difficulties, Prosocial Behaviour, Emotional Problems, Self-harming Behaviour and Problems in Alcohol and Drug Use (n = 22)

	Pre-treatment (Wave 1)			Posttreatment (Wave 2)		
	M	SD	Range	M	SD	Range
Total difficulties	20.50	4.33	11-28	18.73	4.69	9-26
Prosocial behaviour	8.41	1.74	3-10	8.73	1.58	5-10
Emotional problems	7.73	1.80	4-10	6.91	2.27	2-10
Self-harming behaviour	2.59	1.05	0-4	2.09	1.05	0-4
Problems in alcohol use	0.64	0.95	0-4	0.50	0.96	0-4
Problems in drug use	0.14	0.47	0-2	0.32	1.04	0-4

Aim c: providing a preliminary test of pre- and posttreatment measurement of general difficulties, and prosocial behaviour

Mean scores and standard deviations of pre- and posttreatment of total difficulties, prosocial behaviour and co-occurring difficulties are shown in Table 3. The group mean score of total difficulties is lower at the second wave than at the first wave (Mean$f$ = 0.23; 95% CI = 0.40-3.15 on a 0-40 scale; t(21) = 2.68, p < .05, 95% CI [0.40, 3.15]). Rank-order stability of total difficulties was high (test-retest correlation = .77). Group mean scores of prosocial behaviour did not significantly change between the two measurement points (Mean▲ = 1.77; 95% CI = -0.71-0.08, on a 0-10 scale; t(21) = -1.67, p = .11). Rank-order stability of prosocial behaviour was high (test-retest correlation = 0.86). The group mean score of emotional problems is slightly higher at the first wave than at the second wave (Mean▲ = 0.82; 95% CI = 0.01-1.62 on a 0-10 scale; t(21) = 2.11, p < 0.05). The relative ordering of individuals on emotional problems was modestly stable over time (test-retest correlation = 0.62). The group mean score of self-harming behaviour is somewhat lower at the second wave than at the first wave (Mean▲ = 0.50; 95% CI = 0.05-0.95 on a 0-4 scale; t(21) = 2.318, p < 0.05). Rank-order stability of self-harming behaviour was fairly high (test-retest correlation = 0.70). The group mean scores of problems in alcohol use are nearly the same across measurement points (Mean▲ = 0.14; 95% CI = -0.36-0.64 on a 0-6 scale; t(21) = 0.568, p = 0.576). The relative ordering of individuals on alcohol use was fairly unstable over time (test-retest correlation = 0.31). Finally, mean scores of problems in drug use also appeared to be nearly the same across measurement points (Mean▲ = -0.18; 95% CI = -0.44-0.08

on a 0-6 scale; $t(7.397) = 0.932$, $p = 0.381$). Rank-order stability of drug use was very high (test-retest correlation = 0.98). Given the small sample size, reluctance is needed in interpretation of the results of the statistical tests.

Additionally, to describe possible differences between individuals who participated in the first and second measurement and individuals who did not attend the second measurement point ('study dropouts'), the means and standard deviations of HYPE treatment elements, BPD features, prosocial behaviour, and total difficulties of the latter group are presented in Table 2 and 4. No statistical test was conducted to test for significant differences, given the small sample size.

Table 4 Means, Standard Deviations and Ranges of BPD Features, Total Difficulties and Prosocial Behaviour for Study Dropouts (n=7)

	M	SD	Range	Mean ▲ compared to study sample
BPD score SCID II PQ wave 1	10.43	2.88	6-15	1.48
Total difficulties wave 1	20.29	3.99	13-24	0.21
Prosocial behaviour wave 1	8.14	1.77	5-10	0.27
Emotional problems wave 1	7.29	3.25	1-10	0.44
Self-harming behaviour wave 1	2.86	0.90	2-4	-0.27
Problems in alcohol use wave 1	0.14	0.38	0-1	0.49
Problems in drug use wave 1	0.43	0.79	0-2	-0.29

Discussion

Within a lifespan developmental perspective on BPD, highlighting the clinical significance of subthreshold BPD, the need for early intervention becomes increasingly clear. In order to study feasibility of a future randomized controlled study on early intervention in the Netherlands, the purpose of this pilot study was (a) to better understand the sample characteristics within an early intervention program, (b) to understand how the different treatment modalities within the HYPE program were used, and (c) to provide a preliminary test of how experienced difficulties and psychosocial functioning change within adolescents participating in the HYPE program.

First, in exploring the sample we can conclude that despite the

reluctance in the clinical field (Laurenssen *et al*., 2013), young people with (sub)threshold BPD were actually being treated in a specialized early intervention program for BPD. This is an important finding, as delay in diagnosis and treatment has long been considered the norm in treatment of BPD, while early intervention seems effective at improving functioning and prognosis (Chanen, Sharp, & Hoffman, 2017). However, we do not have data on the number of young people who were not referred or who refused referral to the HYPE program, so no conclusions can be drawn on the level of willingness versus reluctance in clinicians to refer young people with subthreshold BPD to early intervention.

Second, in exploring the use of the different treatment modules of HYPE, descriptives showed that, in addition to, on average 15 sessions of individual CAT, young patients in the HYPE program also received family intervention, sessions of generic psychiatric care and psychosocial coaching, adding up to on average 29 sessions of treatment within the HYPE program. No participants dropped out of treatment. This is a remarkable finding as BPD in adults generally is associated with substantial fluctuations in completion rates in treatment, fluctuating from 33-37% in any psychological treatment to 75% in psychotherapeutic interventions that have been shown to be effective in treating BPD (Barnicot, Katsakou, Marougka, & Priebe, 2011). Specifically in intervention studies of self-harming adolescents, who are considered at risk for already having or developing BPD (Kaess, Brunner, & Chanen, 2014), poor adherence to follow-up is a major obstacle in providing treatment. Ougrin, Ng, and Low (2008) found a robust improvement of adherence after a CAT-based therapeutic assessment, suggesting the need of an integrative therapeutic model over a single therapeutic method as in engaging young people a variety of therapeutic tools may be needed.

Third, in comparing pre-treatment-posttreatment preliminary findings suggest a decrease in experienced general difficulties, emotional problems and self-harming behaviour. In prosocial behaviour, problems in alcohol use and problems in drug use, no significant were found at six-month follow-up. Prosocial behaviour was already in the normal range at the pre-treatment measurement and remained unchanged. This could imply that the items of the prosocial behaviour scale of the SDQ do not reflect the social difficulties young people with BPD meet. For both problems in alcohol use and problems in drug use, very low levels of problems were reported in this sample. As the criteria of BPD wax and wane over time (Temes & Zanarini, 2018), we did not use BPD criteria as an outcome variable in this study but focused on general and emotional

difficulties and prosocial behaviour. Given the small sample size no conclusions can be drawn from these findings.

In this preliminary testing of how experienced difficulties and psychosocial functioning changed within adolescents participating in the HYPE program 7 participants dropped out of the study, as they did not attend the second measurement at six-month follow-up. This group is worthwhile considering, as they showed less use of treatment modules compared to the participants that completed the study, as shown in less CAT sessions, a lower percentage of reformulation letters that were discussed, less family intervention and a higher number of telephone contact and no-show during treatment sessions and a higher percentage of negotiated early endings. In this group 1 participant dropped out of treatment as well, and the other six remained in treatment although they dropped out of the study. The contrast of dropping out of the study, but not out of treatment is worthwhile considering. It is assumed that treatment dropouts may be more likely to drop out of research assessments than treatment completers, research data may therefore become skewed towards outcomes for treatment completers even when an intention-to-treat analysis is used, limiting its generalizability. However, given the differences we observed in this study between both the participants who completed the six-month follow up measurement and the participants who did not, this might suggest that this group of patients, at an earlier stage had different needs for treatment compared to the group of completers of the study. Based on the results, it is not clear whether is because they have attained the aims for their treatment and experience better functioning, or that therapy has not met their needs. Although, they have had an negotiated ending, which could be interpreted as a collaborative decided ending which specific attention for the ending of therapy and some goodbye letters discussed, we cannot draw any conclusions on the reason for an early ending of treatment. However, considering the importance of endings in intervention for this specific population, in future research it should incorporate findings on (negotiated) early endings and dropout as well.

There are three important limitations to this pilot study. A first limitation is the small sample size. Therefore, our results should be regarded with caution and need to be replicated in future studies with more statistical power. A second limitation is the lack of a control/ comparison group, which means that changes in participants' experience of difficulties cannot be solely attributed to their early intervention. A third limitation was a lack of formal treatment-adherence monitoring.

Although all treatments were supervised and closely monitored within the HYPE team, no structured treatment-adherence monitoring was used. These studies should be addressed within future randomised controlled studies on early intervention.

Despite these limitations there are important implications from this study. A strong point is the reliance on a clinical sample of youth in the age when BPD typically emerges clinically, which allows the preliminary findings to be both generalizable and applicable to a vulnerable group of individuals with (emerging) borderline personality pathology. In addition, we were able to differentiate the different treatment modules within an early intervention program, which need to be studied further in investigating the specific outcomes of each treatment module within an early intervention program.

In conclusion, the present study provides a description of HYPE as an early intervention of BPD in the Netherlands. In further studies feasibility of the trial procedure and patient experience of the treatment should be investigated. Specifically, in future studies special attention should be paid to no-shows and an increase of phone contacts as possible signs of an earlier ending of therapy than originally agreed upon. It should be further investigated how this could be interpreted, for example in the light of improved functioning and despite of a time limited focus still aiming for longer-term therapies than matching the needs of the young person. The current findings suggest that it would be worthwhile to proceed to a randomised controlled trial. Such a trial should investigate the effectiveness of the early intervention program and the different treatment modules within this program. Specifically in a trial focused on early intervention, a risk for comparison with unstructured care needs to be anticipated for, as delay in the diagnosis of BPD in young people (Laurenssen, 2013), could result in offering unstructured treatment-as-usual in clinical practice. In randomized controlled trials for specialised treatments for BPD, well-organized comparator treatments are shown to be equally effective (Bateman, 2012). Therefore, a need for focus on structured intervention is important, carefully minding the risks for cross-contamination due to overlap between therapists' attitudes or techniques used and studying the value of structured early intervention for BPD as well as the mechanisms of change during early intervention. In addition, special attention should be paid to adherence both to treatment and to the study, in which the length of treatment should be carefully considered. This pilot study was a first exploration on early intervention in the Netherlands, offering a helpful characterisation of both the patient sample

and the treatment modules within early intervention. Preliminary findings in this study support the argument for early intervention studies in general. Moreover, our findings indicate the need for early intervention in the European setting and call for more extensive effectiveness studies aligning those conducted in Australia. □

ADDITIONAL INFORMATION

On behalf of all authors, the corresponding author states that there is no conflict of interest.

This study has been performed in accordance with the ethical standards of the involved institutes institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent was obtained from all individual participants included in the study.

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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'Falling off the edge of a cliff': Complex Endings and CAT

KATIE BYRON

Abstract:
A significant amount of clinical work within a Community Mental Health Team involves managing clients' fears about endings. These fears often present as therapy draws to a close or when there are discussions around discharge from the team. This article aims to describe some of the client, clinician and cultural factors that potentially make endings a source of angst for clients and professionals. This article will also discuss endings from a Cognitive Analytic Therapy perspective, exploring why endings are considered necessary within clinical work and outlining the definition of a 'good enough' ending. These issues will be considered alongside my own reflections of my professional experiences of working within Adult Mental Health and the impact that CAT practitioner training has had on my own approach to negotiating endings with service users.

Key words:
Ending, loss, separation, death, time-limited, discharge.

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Introduction

Separation[1] and loss are part of the human experience. Throughout our lives, we face a series of endings and new beginnings; we leave home, schools, jobs and relationships. Whilst intellectually it makes sense that 'nothing lasts forever', the emotional process of saying goodbye is generally unpleasant, challenging and at worst, incredibly painful.

The human struggle with endings is most obvious when we think about cultural attitudes towards death and dying and how death is considered a 'taboo' subject in society (Department of Health, 2008).

[1] The term ending, separation and loss will be used interchangeably throughout.

This article will consider endings specifically in the context of working in a Community Mental Health Team (CMHT) and my observations of the frequent problems encountered around endings with clients. Inspired by Potter's (2013) 'one third' rule, this article aims to outline some of the client, clinician and cultural factors that make endings difficult. It will also explore CAT's stance on why endings are a key component of client work and how the CAT framework has positively contributed to my clinical practice.

The title was inspired by a service user who described their experience of being discharged from my team as 'falling off the edge of a cliff'. It provides a powerful metaphor of the feelings evoked and the parallels with dying, which are considered throughout the article.

Clinical Context

I am currently working as a Clinical Psychologist in a CMHT with adults with moderate to severe mental health problems. As the only Psychologist in the service, I spend a considerable amount of time supporting the team with care planning of service users with complex presentations. I also hold a small caseload of clients, offering individual and group therapy.

Within my work, I promote recovery principles as an alternative to the dominant medical model that exists in the wider Trust. This means encouraging clients to define their own recovery, to build on their existing strengths and to support connections with their local communities. Shorter periods of care are offered, rather than the traditional medical model of seeing service users as 'mentally ill' and requiring 'care co-ordinators for life'.

Working in this way, there are plenty of opportunities to discuss endings with service users; either when talking about coming towards the end of therapy or the end of their time with the CMHT. It is within these conversations that the struggles with endings become most apparent. Clients generally become very distressed, and their problems often re-emerge, or their mental health deteriorates, in one form or another, as the end approaches. Some people leave the service, only to be re-referred within a short period of time. In my qualified life, these issues have been consistent across client populations and teams and the term 'dependency' is often used to describe clients who struggle the most.

My experience is that problems with endings are often attributed to

clients and their previous experiences of traumatic loss. However, my observation is that colleagues also seem to find endings hard. Some struggle to set limits and work towards discharge and consequently, there are some service users who have been open to the service for many years. Quite often this means the same interventions are revisited time and time again, with signs of progress only to be lost once the intervention ends. The process of discharging clients becomes quite prolonged.

In stark contrast, other team members approach endings by abruptly discharging clients from the service without recognising the significance of endings. I imagine this must feel to clients as if they are 'falling (or perhaps being pushed) off the edge of a cliff'.

These extreme responses from the team seem to re-enact problematic reciprocal roles ('Ideally Caring–Ideally Cared for' and 'Abandoning, Rejecting–Abandoned, Rejected'). The constant discussions around endings are quite draining for me and I feel myself getting frustrated at times with constantly trying to promote a 'third way' ('Setting Limits–Safe and Contained'). It is these experiences that have inspired me to answer the following questions.

Why are endings difficult?

Client Factors

In considering some of the challenges with endings, we need to revisit the start of our clients' lives.

Bowlby's (1980) attachment theory describes how infants are innately hardwired to attach to a caregiver (usually their mother) and subsequently become distressed whenever they are separated. Bowlby noticed that when babies are separated from their mother, they initially become distressed and make attempts to reconnect with her through 'protesting'. 'Protest' behaviours include crying, clinging and angry tantrums; all of which are considered part of normal, healthy development.

In circumstances when baby and mother are not reunited, these protest behaviours may temporarily subside, and the infant begins to grieve for the loss of their mother. At this 'despair' phase, the baby may appear withdrawn and cry inconsolably. Intermittently, the search for the mother may start again whenever the baby is reminded of the separation.

For longer periods of separation, Bowlby proposed that infants move into a 'detached' phase whereby they stop exhibiting normal attachment behaviours and become more self-reliant. This stage is considered a psychological defence whereby feelings of loss are simply repressed, rather than resolved. Just as early experiences of attachments become templates for future relationships, these early experiences of unresolved loss become templates for future losses. In CAT terms, an 'Abandoning–Abandoned' reciprocal role may be formed and a variety of limiting procedures attached to it.

The service users seen in secondary care often have had very disrupted early life experiences. For this reason, Bowlby's theory suggests that these individuals would become even more acutely distressed by endings, than those with 'good enough' attachments, because they have unresolved feelings around loss. One example of this may be clients who attract personality disorder diagnoses and present in crisis in response to real or perceived separations. Attachment theory would understand these increases in risk behaviours, as perhaps, alternative, adult versions of protest behaviours and attempts to reconnect with the caregiver (now represented by the CMHT or specific team members, such as care co-ordinators). In short, attachment theory sees distress around endings as a primitive response and a consequence of relationships being central to human survival.

Similarly, Klein (1947, as cited in Anderson, 1992) also recognised the importance of early experiences in how losses are managed in later life. She proposed that babies rely on primitive defences of splitting and projection to manage the fear associated with being dependent on an imperfect 'other'. During this developmental phase ('paranoid-schizoid position'), infants only relate to objects in extreme, fragmented ways as if objects are wholly good or wholly bad. Klein predicted that adults who remain stuck in this 'position' become extremely depressed in response to endings or separations because 'the good' is seen as completely lost.

It is only when the 'depressive position' is achieved that the infant has capacity to hold onto both the good and bad simultaneously. A sense of loss accompanies the realisation that the 'idealised other' is a fantasy, but this is seen as an integral part of development. For adults who achieve this realisation, grief is still felt in response to losses but is experienced as less overwhelming because both the good and the bad parts of 'the other' have been internalised.

This Kleinian theory offers explanations for the development in CAT terms of reciprocal roles such as 'Idealised, Perfectly Caring–Idealised, Perfectly Cared For' and 'Rejecting, Attacking–Rejected, Attacked'. These roles are common amongst clients seen within secondary care services, who often describe a wish for services to offer perfect, never-ending care. Klein would suggest that these clients remain stuck in the paranoid-schizoid position and consequently, endings are more painful and anxiety-provoking for them.

Another potential innate contributing factor to consider is death anxiety. A fear of dying is thought to underpin a number of psychological problems and distress (Menzies & Menzies, 2008; Yalom 2008). Mann (1973) argues that therapy endings and the time-limited nature of service input may unconsciously remind clients about their own mortality, and it is for this reason that clients resist endings. This is consistent with proposed universal stages of grief (Denial, Anger, Bargaining, Depression and Acceptance; Kübler-Ross, 1975) which suggest that even smaller losses will evoke the same feelings as more significant endings.

In summary, clients' responses to endings are shaped by both primitive responses to loss and their early experiences of separations from their caregivers.

Practitioner Factors

Given the relational nature of our work, it is also important to consider the role that professionals may play in struggles and enactments around endings.

Inevitably, clinicians bring their own experiences of endings and reciprocal roles to client work and these likely contributed to their decisions to enter the caring profession in the first place. Common reciprocal roles of such as 'Rescuing–Rescued', 'Protecting–Protected' and 'Perfectly Caring–Perfectly Cared for' are often self-identified by clinicians (Staunton *et al*, 2015; Coleby & Freshwater, 2019).

These findings are consistent with my own observations of some of my colleagues, who openly describe themselves as 'rescuers' or 'fixers'; a description that I would have previously used for myself before embarking on CAT practitioner training and one that I continue to watch out for within my own interactions. Within reflective practice discussions, I have tentatively explored some of these themes and I have come to understand that setting limits and working towards discharge feels

difficult because it is not seen as possible until a client is 100% better ('fixed' or 'rescued') and on board with the idea of moving on from the service. In this context it is the therapist, or team member, that is holding the client back.

In relation to this, problems with endings may also be influenced by the narcissistic needs of healthcare practitioners. 'Healthy narcissism' is considered a feature of human nature (Nehmad, 2017) and therefore it is likely that team members, including myself, fall along a spectrum ranging from 'healthy narcissism' to 'pathological narcissism'. The ability of service users to make us feel 'special' or 'admired' is one of the potentially rewarding aspects of the job (Chused, 2012). By unconsciously revelling in these feelings, the service user and the clinician develop a co-dependent relationship whereby the prospect of saying goodbye feels intolerable (Ryle & Kerr, 2020).

Through discussions with my fellow colleagues, I am aware that historically there was a culture in the team where care co-ordinators saw themselves as having 'special' relationships with their clients and fiercely defended the need for them to remain under the care of the service, whenever questions were raised about the progress of the work. Whilst most of these team members have moved on themselves, an air of 'specialness' remains in some of the relationships.

These issues of personal transference coming from the therapist amplifying and entangling with the client derived countertransference (when our feelings about a service user are a reflection of our own 'map') are to be noticed and discussed in supervision (Ryle, 1998). I am aware that the focus of supervision for non-therapy colleagues, such as nurses or occupational therapists, is quite different and therefore I suspect that these issues often go unnoticed. This means clinicians have fewer opportunities to reflect on the feelings evoked by clinical work and to consider how to negotiate some of the common pitfalls around endings.

Cultural Factors

Cultural dynamics have also been shown to influence our work with service users (Coleby & Freshwater, 2019; Kerr, 1999).

There has been some consideration of the unhealthy reciprocal roles that exist within the NHS and the politics underpinning healthcare. Welch (2012) proposed that management structures relate in 'Controlling, Demanding, Ignoring and Attacking' ways towards frontline staff who

respond by either compliantly striving, shamed into underperforming or being defensively dismissive. The consequence is staff operate from a threatened mindset whereby 'firefighting' becomes the norm and responses are reactive, as opposed to reflective. In losing the capacity and the time to be curious, the overall aim of the work gets lost and the importance of endings to our clients is more likely to be missed by the team. This means endings are either avoided or rushed through quickly with little opportunity to think about how this may be experienced by a service user.

This is further supported by Coleby & Freshwater (2019) who share their observations of the impact that fewer resources and growing demands have on CMHT staff. They have witnessed how wider systemic pressures can lead to practitioners relating in attacking or dismissive ways towards clients. This is in contrast to a historical pattern of CMHTs re-enacting 'perfect care' (when they had more time, smaller caseloads and more experienced/trained clinicians).

Within my own team, I have noticed fears about being 'attacked' (or blamed) whenever something goes wrong, such as when a client formally complains, or when there is a serious incident. For example, a service user taking their own life. These fears are often raised when the team is considering the pros and cons of discharging a service user and again this can lead to two extreme responses of either delaying or rushing discharges. My observation is professional anxiety and a sense of feeling unsafe within the wider system inevitably does influence decisions around endings and how endings are managed.

In relation to this, the consequences of austerity over the years have also impacted greatly on the communities in which our service users live. From my own experience, cuts to funding of day-care centres and social activities within the local area have caused problems for some of our service users. In the past, individuals seem to have gained a sense of belonging or connection from such groups and the benefits of these relationships largely contributed to a person's wellbeing, even when their mental health symptoms persisted. In recent years, the loss of these opportunities has badly affected service users. Loneliness is a real issue for many of our clients and for those clients who are extremely isolated, professionals may be the only human contacts they have in their lives. For these service users, the real sense of loss (when discharge is discussed) may be even greater and subsequently this may be additionally challenging for them. Professionals are also likely to find these endings harder and care co-ordinators often talk to me about feeling guilty about

discharging clients 'to nothing'. (This may be represented by a reciprocal role of 'No one, Nothing–Alone.) Ultimately, teams get pulled into offering interventions that fall outside the remit of the service because the wider communities have been stripped of potentially nurturing or supportive opportunities.

From a CAT perspective, why are endings necessary in our client work?

The time-limited nature of CAT was inspired by the work of James Mann (1973), who observed some of the challenges of offering long-term therapy to patients. Whilst initially Mann's 12 session therapy model was put forward as a practical solution to long psychotherapy waiting lists, his work and observations provided compelling arguments for the importance of offering shorter, time-limited interventions with a definitive ending. This provided the foundation for the concept of 'ending well' with therapeutic awareness and honesty in CAT (Ryle & Kerr, 2020).

Similar to Mann's therapy model in its brief focused structure, CAT was developed in response to ever-growing demands within the NHS. Ryle recognised that it would be beneficial, and perhaps more ethical, to offer therapy to a greater number of people within the limited resources available (Ryle, 1995). The issues around limited resources and growing demands are still as relevant today and the introduction of The Recovery Model was underpinned by a need to manage some of the dangers of holding huge caseloads within secondary care teams (Collins, 2019). In practical terms, endings are therefore required because NHS services cannot realistically offer indefinite input for service users. The important issue is how these endings are managed.

Whilst there are the practical reasons behind the need for endings with clients, there are ethical ones too. Firstly, Ryle and Kerr (2020) argue that offering a defined number of sessions focusses the minds of the therapist and the patient and helps to clarify the task of therapy, thereby reducing the likelihood of therapeutic drift. The discernible ending does not disrupt the work, but instead gives rise to the same processes as in long-term therapy; the client's issues are simply observed, described and managed in fewer sessions. The effectiveness of time-limited therapies has been repeatedly demonstrated (Parry *et al*, 2005) and therefore there is value to both clients and services in working in this way.

Secondly, there is the issue of reinforcing dependency if endings are avoided. CAT does not see regression as a necessary part of therapy or

development. Instead, Ryle and Kerr (2020) argue that colluding with a service user's fantasy of 'perfect care' is unhelpful. We potentially keep clients stuck in a 'helpless, perfectly cared for' position whereby our clients don't develop from their experiences. This fits with my observation that some service users lose skills with more time held under the CMHT and their identities become more entrenched with 'illness'.

Furthermore, as 'perfect care' is never sustainable, other re-enactments (Blaming–Blamed, Attacking–Attacked) inevitably become part of a service user's interactions with the therapist and/or the team. These re-enactments are potentially even more damaging, and it is important to remember that professionals should, at the very least, do no harm.

Endings are also necessary for staff members. Mann (1973) argues that as treatment length is determined by the therapist (or in my case, the team), the problem with saying goodbye lies within the therapist and their own struggles with loss. The consequence being that endings are avoided, and realistic limits are not given. My observation is staff can become frustrated and hopeless about the prospect of change. These feelings of not being helpful, alongside other work pressures, contribute to staff burnout (Craven-Staines, 2019) and therefore, it is also for clinicians' own wellbeing that endings are a necessary part of clinical work.

Lastly, endings and separations cannot be avoided as they are part of life. By delaying or ignoring the inevitable ending, we do not allow clients the opportunity to express their feelings around loss, nor to internalise the therapeutic partnership. This is likely to translate into clients struggling to hold onto the usefulness of therapy and any gains are lost (Ryle, 1998). Instead, the ending becomes another 'abandoning' or 'rejecting' experience. If we can help clients come to terms with reality and cope with feelings of grief, it will give them a new template for managing future endings. Through having opportunities to independently practice new ways of relating, clients learn that they can and do survive separations and growth is possible (Mann, 1973, Ryle & Kerr, 2020).

How does CAT manage endings and what is a 'good enough' ending?

A 'good enough' ending is one of the key aims in CAT and there are a number of 'tools' that are used to support 'ending well'. Primarily, the ending is discussed from the beginning with some consideration given

to how a client may feel and respond as the ending approaches. This gives therapists the opportunity to predict potential problems and to collaboratively consider exits in advance. Sessions are counted off as the therapy progresses to keep the ending in mind and goodbye letters are exchanged in the penultimate or final session. Clients are invited to write their own goodbye letter to share their hopefulness, sadness, anger or disappointment about the ending and the incompleteness of therapy. The letter also acts as a transitional object to help clients internalise the therapy. Ryle and Kerr (2020) argue these distinctive features of CAT give clients a new experience of endings.

Interestingly, Moran (2019) reflects on the similarities between a 'good enough' ending in CAT and what is considered a 'good death'. Similar features include being open and transparent about the end, to have time to say goodbye and to not prolong things unnecessarily. If the time-limited nature of therapy is a metaphor for life and the finiteness of death, then it makes sense for there to be some parallels in this way. Of course, therapy endings do not mark the end of a client's journey and the learning process continues long after therapy has finished. This transition could equally be considered a beginning; clients starting a new chapter of their lives without service involvement. The metaphor of 'falling off the edge of a cliff' highlights that some clients struggle to disentangle their lives from the relationship with services; hence feeling as if both will end simultaneously. An important part of saying goodbye is therefore helping clients to distinguish between *an* ending (or a new beginning) and *the* end.

Personal reflections on how CAT has changed my approach to endings?

As a trainee Clinical Psychologist, I found setting limits with service users difficult. Whilst therapy endings were largely dictated by the short duration of placements, smaller endings (like the end of sessions) and generally setting limits with clients often felt punitive and uncaring. On reflection, I can now see that I was perhaps trying to 'rescue' clients from their distress, and this was driven by struggling with the feelings of guilt that arose when seeing clients distressed by discussions around boundaries.

With more experience, the support of some helpful supervisors and through my own personal therapy, I began to recognise the importance of endings and boundaries in client work. At the time I was working in a

predominantly CBT service for adults with eating disorders and the benefit of this experience was that I became an advocate of time-limited interventions. This therapeutic stance was reinforced by observing the damage of other services or families colluding with dependency issues in the client group. The downside was that I developed quite a rigid approach to therapy and endings.

Fast forward a few more years, one of the features of CAT that initially appealed to me was the 'boundaried' approach. Since embarking on the CAT practitioner training, I have been given the tools to manage endings in a more contained way as well as a language to talk about loss. I have gained additional insights into my own processes with CAT supervision. At times, I recognise that I distance myself from a client's distress and this is my own unconscious strategy to protect myself from feeling overwhelmed and helpless in relation to a client's pain around endings. Through CAT personal therapy, I have developed increased capacity to sit with painful feelings that arise for myself and clients when endings are in sight and limitations of therapy are realised. I feel more equipped now to try and negotiate my way through the challenges of endings with service users in a way that feels more collaborative.

Throughout CAT training, I have had to face a number of endings myself; saying goodbye to peers, trainers and supervisors. I have felt sad about saying goodbye to those relationships. At the same time, I have been struck by my ability to hold on to their encouraging words and I have taken this as a sign of developing a team of good 'internal supervisors'. I'm aware that in the coming months, my training will come to an end, and I will emerge as an accredited CAT practitioner. My anxiety about losing the security of the course and my trainee status is a familiar feeling and probably mirrors clients' anxieties about ending therapy.

My ambivalence in writing this article has reminded me that I need to be ever mindful about my tendency to avoid my own feelings around endings and loss.

How can I use CAT to help my team manage endings differently?

In moving forward, I think CAT's three R's (reformulation, recognition and revision) offer a framework for approaching the current issues within the service. Initially it may be useful to draw out a contextual reformulation of the current patterns and through supervision, consider the best way to share this with the team.

Ultimately, rather than 'blaming' service users for the problems as discharge approaches, the team needs an alternative narrative (reformulation) around endings. By sharing some of the other contributing factors outlined in this article, I hope as a team we will be able to reflect on the relational aspects to our work and our own feelings about endings. Tools, such as The Helpers Dance List (Potter 2013) and The Boundary Seesaw Model (Hamilton, 2010) may help facilitate some of these discussions over time. For individual clients, there needs to be more reflection on what potential reciprocal roles are being re-enacted at which level of the system around the ending. This recognition may be supported through offering five-session CAT, which would provide a 'map' and an opportunity to discuss both the care plan and the ending with the client and the care co-ordinator (Carradice, 2013).

On a broader level, the recognition that endings for our service users and ourselves are an important aspect of the clinical work will hopefully encourage reflection and exploration of the concept of 'good enough' endings.

Possible revisions to the current ways of working might include encouraging discussions around endings with service users, counting down to the ending and considering ways in which endings can be acknowledged and marked by both service users and clinicians.

Given the challenging nature of influencing systems, my own CAT supervision will be invaluable in continuing to understand these relational dances.

Final Thoughts

Through writing this article, I have gained more understanding of the complexities underpinning the challenges of endings and this has normalised the human struggle with loss. I now feel that I have more compassion towards myself, my clients and my team when I reflect on previous difficult endings. I appreciate that supporting people with endings and teaching and learning how to use endings is always going to be a significant part of my role as a Psychologist and my renewed sense of compassion around endings will be undoubtedly helpful with future clinical work. By sharing my own reading and reflections around this topic, I hope to offer something valuable to other CAT practitioners and to promote further thinking and research around therapeutic endings with service users. My observations of the recurrent patterns and distress

around endings in secondary care inspired me to revisit the literature on loss and this article has focussed purely on complex endings and attempted to answer the question: why do endings feel difficult? Equally, it would be interesting to consider experiences and features of positive endings, such as when saying goodbye may bring feelings of relief or when endings mark an achievement, and there are gaps in the literature about clients who may relate to endings in another way (Accepting–Accepted or Encouraging–Encouraged and Hopeful). As an almost accredited CAT practitioner, my enthusiasm for CAT has perhaps also limited the scope of this article and future discussions may want to address the limitations of CAT in the context of endings. For example, are there differences between predictable and unpredictable endings? In moving forward, I will regularly remind myself, clients and my team that whilst there are plenty of reasons to find endings a challenging experience, endings can also offer opportunities for growth. We have to say goodbye to the old in order to make way for the new. It is only through negotiating repeated endings in life that we develop from our experiences. □

> 'It is the denial of death that is partially responsible for people living empty, purposeless lives; for when you live as if you'll live forever, it becomes too easy to postpone the things you know that you must do.' (Kübler-Ross, 1975, p.164).

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Embodied therapeutic presence:

A proposed extension and clarification of the CAT model of reciprocal roles, relational space and integration when working with developmental trauma

TIM SHEARD

Abstract:
Working relationally with developmental trauma may present profound challenges to therapists and be burdening or exhausting. The potential of therapist embodiment as a relational resource is explored. It appears to integrate readily into the CAT model and may offer clarification and development of CAT theory of reciprocal roles and integration. This approach is based upon the author's clinical work alongside extensive experience in introducing it to CAT therapists in training workshops.

Keywords:
embodied therapeutic presence, therapist embodiment, developmental trauma, self-to-self, reciprocal roles, collusive reciprocation, therapist burdening and exhaustion, therapeutic space, relational space, relational field, projective identification, embodied counter-transference.

Tim Sheard has a background in medicine and qualified as a CAT psychotherapist in the late 1990s. He has also undertaken training in body psychotherapy (biodynamic), family constellations work and transpersonal counselling.

THIS paper seeks to address the profound relational challenges that are frequently encountered when working with the adult life consequences of developmental trauma. In the past these difficulties were often regarded as 'untreatable' (Ryle 1997b pp ix & xi) and still attract diagnostic labels such as 'borderline' and 'personality disorder'. Less pathologising descriptive terms have not, as yet, come into mainstream use (Ryle and Kerr 2020 pp225-230) although the recently proposed 'Power, Threat Meaning Framework' offers a non-diagnostic approach (Johnstone & Boyle 2018). For the purposes of this paper the

term 'developmental trauma' will be used to speak to a wide range of adult life difficulties characterised by partial or full dissociative processes. CAT understands these to be largely unrevised ways of managing relational trauma originating in childhood.

Working with developmental trauma confronts therapists with major challenges. Clients frequently bring stories of childhood abuse and neglect that can be profoundly distressing or indeed horrific. The empathising therapist may suffer 'vicarious trauma' (Rothschild 2006). This may be compounded when abuse and neglect still feature prominently in clients' daily lives: be it as victim or perpetrator. In addition, clients may explicitly act out during the therapy and disrupt or terminate it. This paper focuses on a third aspect of the challenge of this work, on more implicit enactments, which can be more difficult to describe or define, although familiar to all who have worked relationally in this field.

Therapists may feel overwhelmed, deskilled or stuck in a split relational field of great intensity or apparent absence of emotion. They may find that they are unable to think, experience distressing phenomena on a bodily level and/or their customary relational capacities may seem compromised or even disabled. It as if therapeutic or relational space has either been lost or was stillborn: 'doing to' predominates as the core relational stance (Benjamin 2004) and collaboration may seem a distant dream.

Leiman describes this in his paper on projective identification:

> 'with severely ill patients we frequently get the impression of being deluged by their unmanageable experiences. We feel being controlled and 'forced to take in' bits of the joint sequence.'
>
> (Leiman 1994 p107)

Field, a Jungian analyst, vividly describes finding himself quite literally losing the capacity to speak or form words at all during a charged moment with a client. (Field 1996)

The author has facilitated workshops with a few hundred CAT therapists and trainees which have been focused on how therapist embodiment may serve to free up stuck or overwhelming process when working with developmental trauma. Participants had the opportunity to explore the details of their subjective experience when feeling stuck or overwhelmed with particular clients. On a literal level these problematic experiences included physical pain in muscles, abdomen or heart, difficulty in breathing, a choking feeling, numbness, an inability to think,

nausea and concern they might vomit, feeling sleepy, being heavily weighed down, crushed and exhaustion. On a more explicitly relational level participants reported dread at the prospect of a session with a particular client, great anxiety or fear within the session and feeling 'beaten up'. The client might be felt to be invading, occupying, or even violating the therapist's personal space. The overwhelmed therapists' reciprocations varied – some felt as if they were reeling away backwards to try and have space or some simply wanted to 'run away'. It is of note that much of this difficulty was experienced on a bodily level and often involved a sense of invasion of boundaries, indeed of the very interior of the therapists' bodies. Whatever the manifestation, be it invasion or absence, the common factor running through all of the experiences was a subjective sense of an absence of relational therapeutic space within which the therapist and client might begin to engage. As if the potential therapeutic space was either filled up/invaded/over-charged or somehow out of reach, unable to be touched on.

Such difficulties are clearly 'countertransference' reciprocations (Ryle 1997a), and if unrevised they can be understood to be collusive reciprocations. Within the frame of neuroscience these are descriptions of dysregulated states induced in a therapist who is working outside of her own 'window of tolerance' (Rothschild 2006).

It is a core feature of CAT's multiple self states model that it seeks to name, map and make therapeutic use of the problematic self states and relationship challenges characteristic of developmental trauma (Ryle & Kerr 2020). The problematic states and sequences can be jointly described, this process being mediated by diagrams. In many cases this is sufficient to open and hold a therapeutic space and relationship, provide containment and the therapy can progress. However, in some instances this may be achieved at considerable cost to the therapist in suffering somatic burdening and exhaustion, or the process may become stuck and overwhelming for client and therapist alike. Some workshop participants had dismissed these problematic bodily phenomena as a distraction from the real work of the therapy, others as a necessary price of the work simply to be endured, while others sought to include them as important relational phenomena. However, CAT therapists found that *recognition* of an identifying or reciprocating embodied countertransference (Ryle 97a) does not always open the door to revision. It was as if they felt stuck and unable to find a means of moving into a constructive relational position (an 'exit' for the therapist).

It is of note that CAT does not offer a way of engaging directly with

these predominantly bodily relational phenomena, but instead seeks to reflect on them as relational data. It is as if CAT assumes a dualistic paradigm in which the mind and body are separate domains. This is in contrast to neuroscience and associated newer trauma therapies where considerable emphasis is placed on stabilisation of the neuro-physiologically dysregulated client as an essential first step, (Ogden & Fisher 2015), and sometimes, indeed, on stabilising the therapist (Rothschild 2006, Geller & Porges 2014). Such stabilisation is largely mediated by embodied processes/techniques and the integration of these into CAT is being actively explored (Walker in press, Bristow in press). But on a relational level it is as if CAT does not equip therapists to engage directly with this 'subterranean' body-to-body level of communication and relationship in which the normally assumed boundaries of the self, body and other can seem to have unnervingly dissolved.

The question arises of how we may equip ourselves as therapists to engage with, modulate and make therapeutic use of these challenging processes when at the times when they seem beyond the direct therapeutic reach of the CAT model? It is proposed that actively engaging with our own relational embodiment as therapists may be a significant resource.

A brief overview of embodiment

Most psychological therapies, CAT being no exception, appear to be anchored in a dualistic paradigm in which the subject of interest is a disembodied mind or simply behaviour: what we call 'our bodies' are marginalised as largely irrelevant and objectified as a 'thing' and denied any subjectivity. This dualistic splitting has deep roots in western culture (Shea 2001) and can be seen to be an unacknowledged relationship of power, control and exclusion. This is now increasingly being challenged from a number of different quarters:

1. Research in infant development supports the understanding that the foundations of our relational sense of self, other and the world are formed within preverbal, co-embodied relational experience (Trevarthen 2017).

2. Inter-personal neurobiology has widened the focus beyond a single brain, or even two brains into a more complex landscape of embodied nervous systems interacting in relationship (Siegel 2010). This forms the basis of much of the rationale underpinning the newer trauma therapies (Badenoch 2018, Ogden & Fisher 2015, Schwartz *et al* 2017, Taylor 2014).

3. The body psychotherapy tradition has been in existence, but marginalised, for over a hundred years (Heller 2012, Totton 2003). Many of its approaches are being integrated into trauma therapies, (Taylor 2014, Heller & La Pierre 2012, Ogden & Fisher 2015)

4. Enactivist cognitive science assumes a non-dualistic foundation in which cognition, sense of self and relating are inextricably and dynamically interwoven with what we would call bodily structure (Varela, Thompson & Rosch 2016, Galbusera & Fuchs 2013, Kyselo 2014).

5. A 'corporeal turn' is occurring in the wider social psychological and political sciences and indeed philosophy, (Sheets Johnson 2009, Lakoff & Johnson 1999)

However perhaps the strongest argument for the relevance of direct engagement with our embodiment in work with developmental trauma is that much of the problematic communication and associated burdening and exhaustion appears to be mediated by what might be called a body-to-body level of reciprocal roles. In trauma 'The Body Keeps the Score' (van der Kolk 2015).

Experience in CAT relational embodiment workshops

The author has facilitated workshops with CAT therapists and trainees in the UK, Finland and Ireland. The majority of workshops were for one or two days but two residential courses spanning a year were held in Finland and England. In introductory workshops participants were asked to select a client with whom they felt stuck or in some way overwhelmed and then guided through an exercise in which they explored in detail their thoughts, feelings and embodied responses in three situations: imagining being about to see the client, in session and following a session. They were asked to depict their experience in crayon drawings and share with other participants.

They were then introduced to simple exercises in attuning to three different dimensions of embodiment. These are:

(a) Vertical alignment: participants were guided through grounding, but also finding a position of ease of alignment of the head and torso in gravity, perhaps with a sense of a natural upward lift. This accompanied by a whole body scan for muscular tension/holding

and gentle release; the whole resulting in varying degrees of discovery of a relaxed but alert poise.

(b) Visceral attunement: using breath, interoception and felt sense to attune to the abdominal viscera and relational heart (in the central chest) and

(c) an energetic dimension in which participants were guided in exploring their subjective experience of their 'energetic field', of engaging with 'energy' in a form similar to qi gong that involved charging the 'hara' and playing with holding an energy ball in their hands. . .

For detailed descriptions of the exercises and the experience of participants see Sheard (2017) and Sheard (in press) and online audio introductions (Sheard in Press).

The different dimensions were introduced sequentially, layered, and the impact on their imagined experience with the same client explored. No indication was given as to what any relational effect of these exercises might be. To varying degrees the exercises can be understood to be a relational shift from body as object to identification with body as a relational subject.

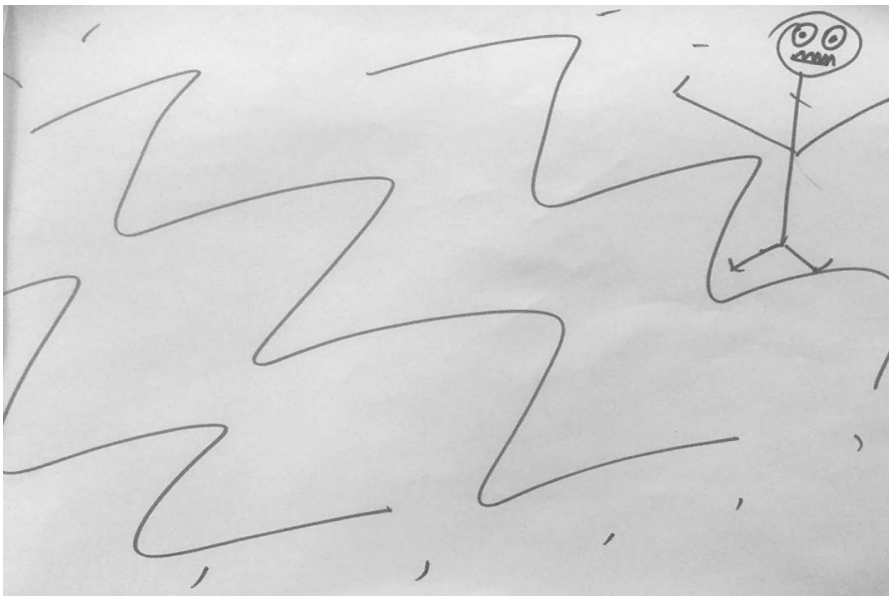
Participants were often surprised at discovering the magnitude and nature of their raw embodied responses when they gave them attention prior to the introduction of embodied attunement, as if they became aware of how much they were carrying and/or their boundaries 'transgressed'. Some participants found the subsequent embodied attunement exercises not particularly helpful but the majority experienced significant subjective changes. The emergent pattern was:

Vertical alignment was associated with greater definition and sense of separateness from the client both in terms of the boundaries of the body and of personal space, along with modulation of anxiety, panic or overwhelm. However, there could also be a sense of a loss of contact with the client.

Visceral attunement to the abdomen and relational heart was layered on top of vertical alignment and often afforded a sense of feeling connection within bounded separateness. Participants gave moving accounts of being able for the first time to feel and see the client as a fellow human being, an experience previously obliterated by the level of emotional intensity and state shifting.

The *energetic level* left some untouched, but many reported a

Drawing No 1: A depiction of a charged and overwhelming relational field. (With kind permission). For a larger library of drawings by participants see website associated with Sheard in Press)



variety of enhanced relational capacities or 'affordances': A strengthening and clarification of boundaries, a sense of greater resource (spirit) to engage, a greater sense of containment of both themselves and the client and an opening of a transpersonal level (Wellings & McCormick 2000).

There is perhaps no great surprise in the first two levels. The English language has many expressions that support this: 'standing her ground', having 'backbone', 'gut feeling', 'gutted', 'heart-felt'. We literally 'articulate' ourselves in space (geometrical or relational 'space') through our musculoskeletal system and experience many emotions and feelings in our bellies and hearts, not in our heads. Many poems and songs attest to this. The energetic level is suggested in the expression 'the eyes are the windows of the soul' and it is becoming much less 'fringe' (Mollon 2018, Feinstein 2021), and a detailed description can be found in Brennan (Brennan 1990). Schwartz-Salant describes integrating an energetic level into Jungian therapy (Schwartz-Salant 1998).

Participants in workshops frequently reported a dilemma in their work: as relational therapists it was as if they could *either* remain empathic and 'open' to contact but burdened/overwhelmed *or* they could put up a barrier and feel safe but cut off and no longer relational. It as if embodiment offers an 'exit' from this in affording boundaries and

separateness *alongside* affording visceral empathic and feeling connection. As if supporting a 'safe enough' and regulated position for the therapist when engaging with the intense and split relational fields of developmental trauma. This is also likely to offer a clearer and safer relational presence for the client to engage with.

Following an eight-day course spread over a year a participant reported:

> I feel steadier, less thrown about, less anxious, more centred in the midst of this difficult work that we do. I feel more resilient, less drained by the work, and have less physical pain in my body and I know that my clients sense this and that it is very containing for me and for them. It gives us both confidence and increases trust in the therapeutic relationship. This is not about knowledge or skill, it's a sense of trusting in myself, trusting in my body, in my whole embodied self, that I can be 'enough'. (With kind permission)

Discussion

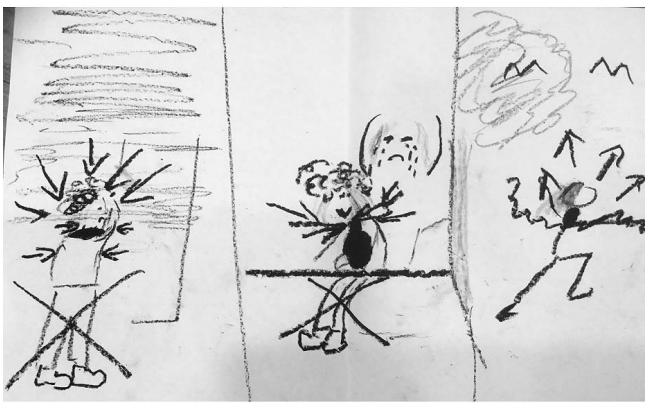
Experience in workshops and the author's practice offer support for the understanding that attunement to, and greater subjective identification with, our bodies can afford a strengthening of relational capacities and mediate a more direct and conscious engagement with bodily communication of split-off reciprocal roles. This is consistent with enactivism theory of 'affordances' (Varela, Thompson & Rosch 2016, Galbusera & Fuchs 2013). It can also be seen to be consistent with the neuroscience derived model of vicarious trauma and the use of embodied techniques to facilitate restoration of a regulated state in the therapist in which higher centres can come back 'online' (Rothschild 2006).

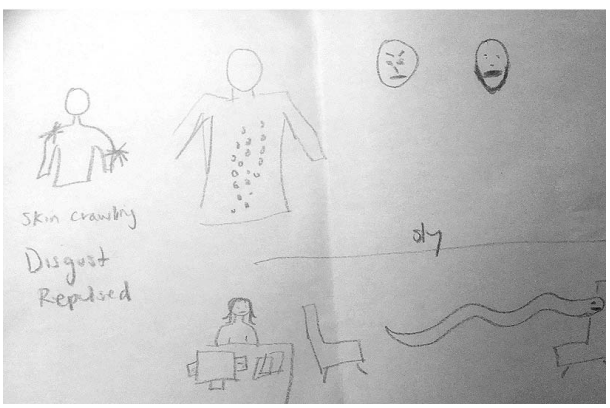
It is as if this approach supports the development of a therapeutic relational stance that might be termed 'embodied therapeutic presence' and could be a significant relational resource in work with developmental trauma. For a clear description of therapeutic presence and client safety related to polyvagal theory see Geller & Porges (2014). Possible implications of this approach for CAT theories of embodied countertransference, projective identification, reciprocal roles, containment, therapeutic space and integration will be briefly explored.

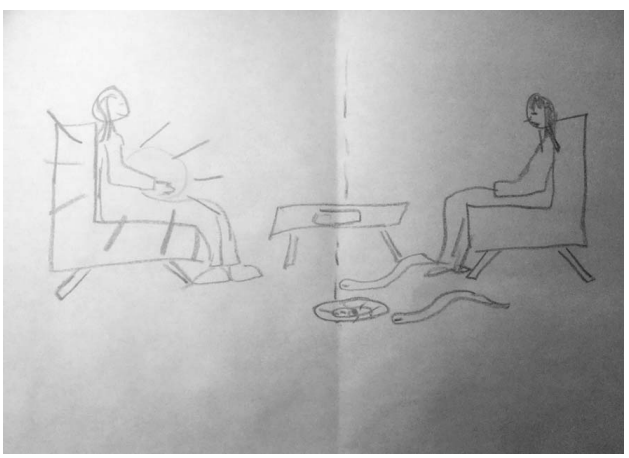
Embodied countertransference and collusive reciprocation

The CAT multiple self-states model (MSSM) makes it clear that therapists

Drawings 2 & 3: The tryptich represents a therapist's raw and overwhelming experience at three timepoints: before, during and after a session. Drawing 2represents her experience following the vertical poise and visceral attunement exercise. The circle in the centre of the chest and lines emanating from it were drawn in red (By kind permission)







Drawings 4 & 5: The fragmented therapeutic space of the first drawing became ordered and contained following attunement to the energetic level, the therapist is to the left holding her energy ball

are likely to be under intense pressure, be it explicit or subtle, to reciprocate problematic reciprocal roles collusively. It is essential to resist this as otherwise collusive reciprocation will be a simple repetition of a long-suffered repertoire of problematic self-states and procedures. Potential therapeutic space would be lost, and the therapy become a maintaining factor. Collusive reciprocation may be more straightforward to avoid if the invitation or pressure is simply to rescue or reject, but bodily level communications of traumatised reciprocal roles present a different kind of challenge. How can the voice of trauma and exclusion be heard, felt and included if it is impacted and concretised in repetitive embodied enactments?

It has long been recognised that countertransference is often experienced through, or mediated by, our bodies (Sedgwick 1994, Sletvold 2014, Soth 2005). This is perhaps to be expected in developmental trauma as the original traumatic events, usually a form of acting out by adults on children, were often bodily mediated (abuse, sexual violation, abandonment). Unless substantially revised it is likely that these states will, at least in part, be communicated to the therapist through the medium in which they were experienced: i.e. body-to-body communication/acting out. This bodily level is at least partially recognised in CAT theory of transference and countertransference (Ryle 1997a) and in Ryle and Leiman's contrasting understandings of projective identification (Ryle 1994, Leiman 1994). However, it is proposed that an embodied approach to CAT clarifies some of these processes.

Embodiment, CAT and therapeutic space

It is as if embodiment offers a paradoxical, part literal, part metaphorical, perspective on boundaries, separateness and relational space. An attempt to resolve this paradox would most likely slip back into dualism. On a literal level it is as if our musculoskeletal system affords us separation but also contact at the edges/boundaries (see Frank and La Barre 2010 for a gestalt based model of 'four fundamental movements', also Dower 2015 describing using Frank's approach within CAT). It is as if this sense of 'definition' gives a clear distinction between the space inside us, our personal space around us, and different boundaries and spaces in and around people and the world. It is as if our abdominal visceral level affords the possibility of empathic resonance with others within our interior space, affording a different form of contact or communion from the musculo-skeletal. The 'relational heart' and the energetic level appear to hover between the literal and metaphorical and are discussed below.

On a more metaphorical level it is as if embodiment may be mediating a greater capacity in therapists to engage with, and to be conscious of, their self-to-self reciprocal roles. CAT therapists widely report that engaging with embodiment makes reciprocal roles much more tangible, felt and real in the present moment (see Sheard *et al* 2000 for an early form of using elicited, partly embodied, countertransference to inform mapping during assessment sessions). Embodiment mediating increased awareness of reciprocal roles is particularly the case for self-to-self reciprocal roles that otherwise can seem vague or elusive. Embodied attunement can open up a landscape of positive embodied self-to-self reciprocal roles. 'Space within' may therefore not just be literal but also metaphorical/relational. As if the capacity to be in positive and enabling self-to-self reciprocal roles is an opening of 'relational space within', while conversely negative self-to-self reciprocal roles restrict, tighten and close it down.

It was striking that the exercises sometimes provoked a feeling of guilt, as if giving attention to oneself through embodied attunement was somehow 'taking something away from the client'. Most stark was the injunction: 'you should be there 100% for the client'. It is suggested that the converse might be the case: 100% attention on the client could well be oppressive and involve a loss of relational therapeutic space. Experience from the author's practice and workshops suggests that the capacity to be in relation with oneself self-to-self *at the same time* as with the client serves to open relational space: that it can support a therapeutic and containing 'space between'. As if the capacity to be present to oneself as a therapist as well as to the client can change the quality of therapeutic presence and open potential relational space for the client to engage in.

CAT has two principle overlapping approaches to opening therapeutic space:

(i) The collaborative stance which includes the sharing of understandings in a prose reformulation and in particular joint mapping which can defuse intensity and constellate a 'third' position for client and therapist to jointly engage with. All of which supports:

(ii) The development in the client of a reflective 'observing eye/I'. Empathic naming and feeling connection also part of the CAT model but the degree of emphasis placed on them varies in the CAT literature (McCormick 1995).

However, these do not appear to involve therapist self-to-self engagement as an explicit part of seeking to open a therapeutic space within which the client and therapist can work jointly, such that the therapeutic process can feel more safe and contained for both parties. Potter's description of 'shimmering' perhaps speaks to the therapist deliberately occupying a certain kind of relational position that opens up a wider scope of possibility through a quality of presence, one that is not over direct or too intently focused on the client but instead responsive to the subtleties of therapeutic space and process (Potter 2018).

Leiman has explored similarities between the joint creation of signs and Winnicott's notion of transitional space, (Leiman 1992) which in turn overlaps with Thomas Ogden's inter-subjective concept of the 'analytic third' (Benjamin 2004) and Bion's understanding of 'containment' (Snell 2021, Kuchuk 2021). The author's experience 'in the room' suggests that embodied self-to-self engagement supports a sense of therapeutic presence in relation to not only the client but also to a therapeutic 'space between'. This can give a sense of relief for therapists from imagining that they have to somehow do all the holding or containing of the client, that they can instead give more of their energy and attention to the emergent therapeutic process. Schwartz-Salant gives detailed descriptions of working on relational processes in a 'space between' on an energetic/imaginal level (Schwartz-Salant 1998).

Projective identification and containment of split-off body-to-body communication

Therapist embodiment may mediate direct and conscious engagement with split-off body level communications. The original traumatic event(s) were an acting out in which any potential relational space-between was obliterated. In coming to therapy, it is as if the voice of this experience is seeking to be heard and included, to perhaps at last have its human(e) homecoming. But it is as if the experience is still in exile, embedded in body-to-body re-enactments (implicit memory) without words or images. It is likely to be communicated in this form. This takes us into the strange and peculiar relational landscape of projective identification (Grotstein 1985, Hinshelwood 1991, Ryle 1994, Leiman 1994) in which it could be said that the split-off experience is looking for some-body to have, to hold, to see, to feel and to include it. If the therapist is at home in her body, then resonance of this experience may well still be felt internally but (a) it is likely to be recognised and (b) be contained more in the

embodied therapeutic 'space between' rather than experienced as stuck inside the therapist's body. Conversely for therapists who work from a position of dismissing their embodiment as largely irrelevant it is as if the split-off experience may become embedded in their disowned and consequently vacant, unoccupied internal relational spaces. If the therapist is not 'at home' in her body, then her body may become like an unoccupied house – vulnerable to squatting. It may be 'broken into' by the homeless, split-off, traumatic experience and squatted, a collusive reciprocation. If the therapist is at home in her body, then she is more present to meet and greet the experience that otherwise might be felt as 'intrusive' or dismissed as uninteresting.

It is as if the phenomenon of projective identification is very telling: if it is not met and engaged with on a consciously embodied level then it is likely to remain out of dialogue, concretised, impacted in the somatic and experienced as invasive and/or dismissed as irrelevant. But if engaged with on an embodied level it is as if relational space can open up around it and integration begin through its being held, symbolised, felt, meaning bridges built, brought into narrative and then to take its place as a memory belonging in the past rather than repeatedly relived and re-enacted when triggered.

An illustration: The strangeness and intensity of embodied relational processes were forcibly drawn to my attention in the late 1990s as a more embodied approach to my CAT work was beginning to take shape Arriving home from a day of CAT I went upstairs, as usual, to get changed. I realised I was feeling unsettled and this increased as I gave it embodied attention. I felt I had to do something or whatever this experience was would linger with me for the evening. I would be stuck with it. Following this decision to include rather than ignore it, the unsettledness rapidly began to take embodied shape as an increasingly strong urge to scream. This wasn't really feasible out loud so I screamed, very powerfully, into a pillow. As I did so I had the odd sensation of 'this isn't mine' and immediately one of the clients I had seen that afternoon came to me. Then it was over. It was if something had moved through me, as if my temporarily 'lending' my body to the experience had included it, made it conscious and freed me of it. It was as if I was no longer unknowingly 'carrying' something for the client, but that a felt experience, 'a voice' had been included and could begin to have a place in the therapy. In time the client and I were able to recognise a 'silent scream' hidden and stifled under layers of professional coping and alcohol abuse. To be clear: I am relating this as I experienced it over twenty years ago, I would hope

now to be more alive in the room to such embodied processes, (as described below), such that the process might be experienced as safer and more contained for both the client and myself.

Possible implications for reciprocal role theory

Ryle's Multiple Self States Model (Ryle 1997b pp 26-42) was groundbreaking in linking a theoretical model of developmental abuse and neglect with the mapping in relatively simple diagrams of the relational challenges experienced in daily life and within the therapeutic relationship. Polarised, intense, reciprocal roles and dissociative state shifts lacking any integrating or helpfully meaningful narrative could be mapped out. This includes self-to-self as well as self-to-other, and other-to-self reciprocations. However, the only self-to-self that appears to reflect, or even mediate, the opening of relational space is the observing eye/I which affords an integrating 'gestalt' or overview. Otherwise, CAT mapping and discourse about reciprocal roles tends to be two dimensional: either concentrating on one reciprocal role dyad at a time, movement between self states or a dialogical sequence. It is suggested that to be in embodied self-to-self relationship modifies the experience for the therapist of self-to-other and other-to-self reciprocal roles and indeed of the quality of therapeutic space. This suggests a different form of mapping in which more than one pair, indeed possibly multiple pairs of reciprocal roles are active at any one moment in three, or more, dimensional embodied relational space. As if embodied therapeutic presence opens up an embodied landscape of multiple reciprocal roles, forming what might be termed a 'relational field' (Snell 2021, Schwartz-Salant 1998). This might sound like trying to play three dimensional chess but our embodiment immediately affords us three, or more, dimensional relational experience. As if the therapeutic space has both a literal place in the room: both between and around therapist and client but it is also felt or sensed on a relational, more metaphorical, level of alive process. At the same time we can experience supportive reciprocal roles from our supervisors and trainers in the space behind us, 'taking our back', (or conversely, critical self-to-self voices 'on our back'), we can have the 'shoulder to shoulder' support of colleagues *beside* us, we have the ground and earth *beneath* our feet, our own (wounded) child self may be held in the background, we are still *within* nature, the biosphere, even when in a building (Rust 2020), and so on. Engagement with all of these relational spaces or orientations can be mediated through embodied presence. This three dimensional embodied mapping may of

course be extended to work with the client's embodied reciprocal roles, in particular rendering negative self-to-self reciprocal roles more tangible and supporting the finding of positive embodied reciprocal roles as exits.

Describing ourselves as embedded, or perhaps more accurately, constituted, in an embodied relational field of active reciprocal roles perhaps points more clearly to CAT being a systemic model. This is already implicit in CAT's inclusivity and the notion of the multi-voiced self and is explicit in contextual reformulation (Ryle & Kerr 2020, p269-278) In a systemic model integration would be understood as an 'emergent process' arising spontaneously within a complex system (Capra & Luisi 2014); in the context of CAT the container of this emergent process might be understood to be the therapeutic relational space.

Integration

Embodiment may cast a fresh light on aspects of CAT understandings of integration.

It offers a direct way of including and bringing into 'dialogue' split-off bodily enactments that may otherwise remain marginalised and impede if not derail the therapeutic process. They can be felt in a resonant way within the therapist's body space but can be more readily consciously engaged with and contained within the embodied relational 'space between'. A dialogical CAT therapist poetically described these embodied spaces as 'the birth-place of signs' (personal communication during a residential course).

The therapist's relational 'space within' (enhanced through embodied self-to-self reciprocal roles) supports the opening of potential relational 'space between' that can contain the therapeutic process. If the client is able to engage in this 'joint' space then the possibility arises of relational space opening up within the client (client self-to-self) as the therapy progresses, i.e. internalisation. (This may be supported by work with the client's relational embodiment, but this is not seen as essential to this embodied relational space understanding of internalisation).

Embodied therapeutic presence supports different dimensions of containment and integration complementary to the CAT observing eye/I. Our relational hearts can explicitly be included, and experience suggests they afford an integrative function, as indeed is suggested in many cultural narratives of the heart in literature, song and spiritual discourses. It is as if it affords a translation of emotion into human feeling, as if it mediates

feeling another, being felt and love. It may be the primary locus of narcissistic wounding to the sense of self. As if it takes the literalness and physicality of emotion, translates it to a conscious level and opens the possibility of a felt meeting that touches and changes both parties at the level of 'I and thou'. It is suggested that the 'feeling heart' is relationally and qualitatively different from an observing eye/I and can profoundly complement it.

In relation to integration the energetic level appears to afford an enhancement of a sense of containment, what might be termed mindful presence (Siegel 2010) and for some an opening of a transpersonal level that can support symbol formation and serve integration. Kalsched describes a Jungian approach to developmental trauma (Kalsched 2013) and Schwartz-Salant, also Jungian, describes working with the 'subtle body' within an energetic relational field (Schwartz-Salant 1998).

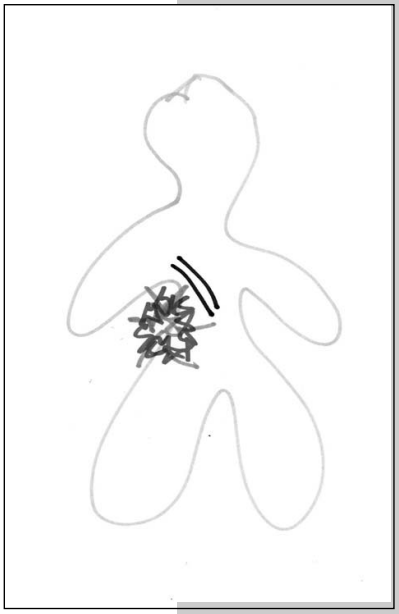
It might seem odd that attuning to and augmenting our subjective identification with what we call our bodies leads us not into a mechanistic world of anatomy and physiology but rather opens up different dimensions of subjective relational experience. But such an expectation belongs fair and square in our dualistic cultural heritage, in which body and mind, the material and the spiritual, ourselves and nature are split apart. It is as if moving beyond this old cultural paradigm affords new relational possibilities. □

ACKNOWLEDGEMENTS

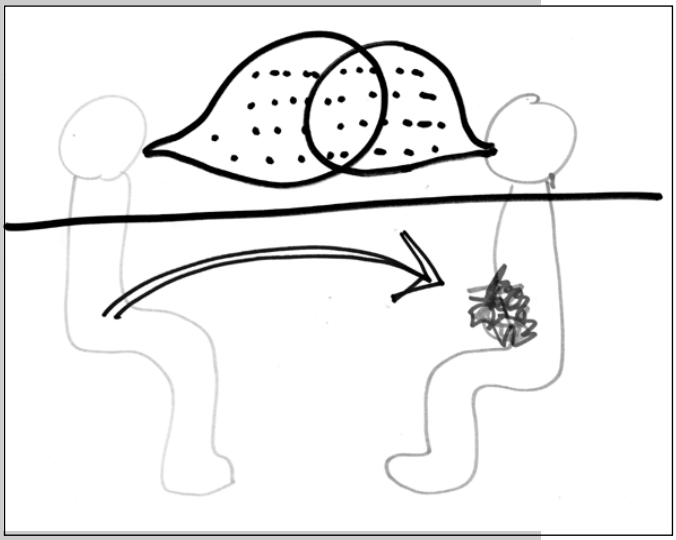
The author wishes to thank all of his clients and workshop participants with whom he has learned and developed this work. This paper is written with the understanding that 'we teach what we need to learn'.

APPENDIX

Here (overleaf) are a series of drawings seeking to depict some of these processes.

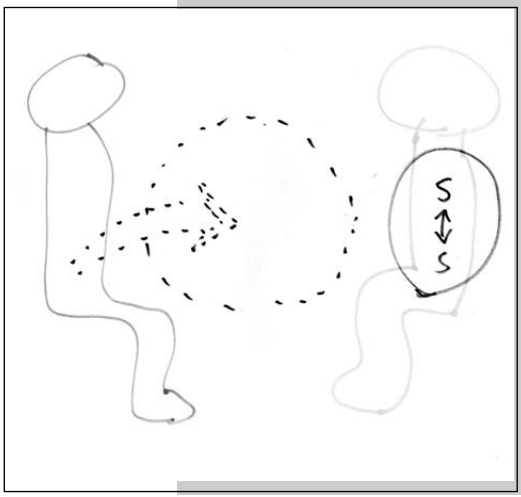


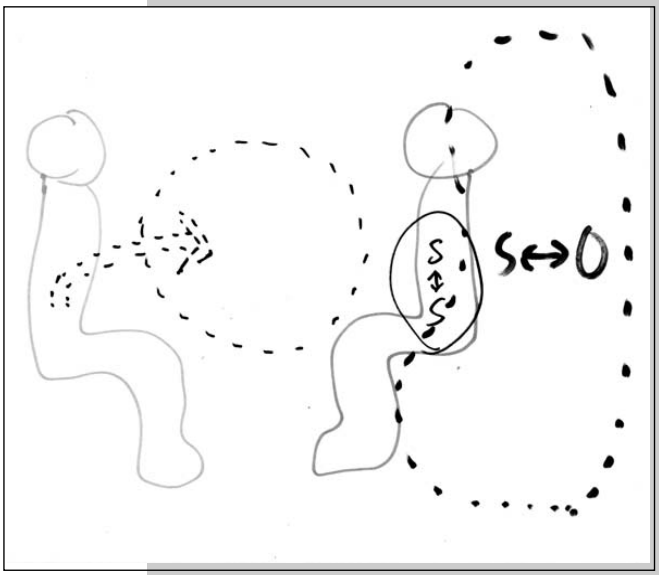
Client's traumatic experience split off in body (implicit memory) out of relationship, dialogue and narrative



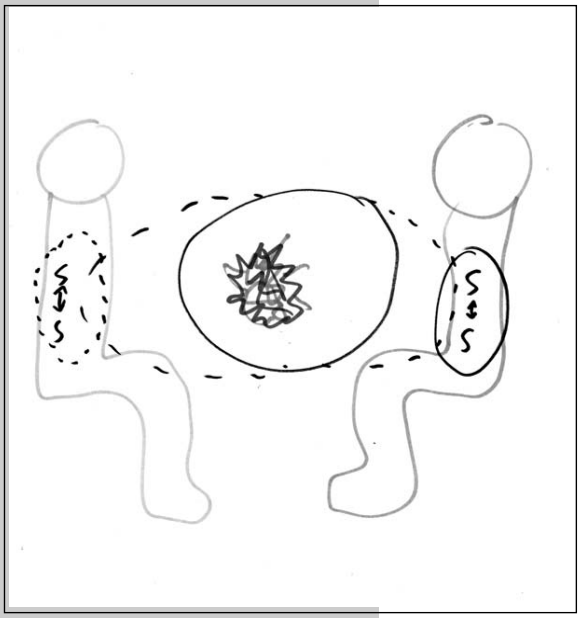
Therapist conducting therapy on a disembodied level and split-off experience seeks inclusion in therapist's body: projective identification as invasive as therapist not in conscious embodied dialogue

Therapist embodied self-to-self, space between and beginning of containment



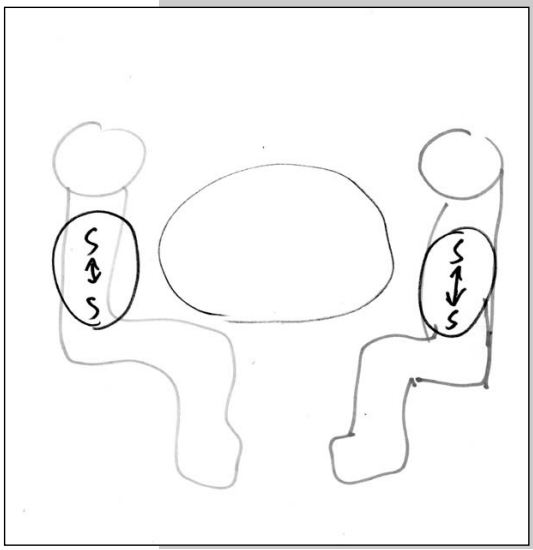


Therapist self-to-self 'backed up' e.g., by supervisor/ trainer/partner/family



Split-off experience contained in the space between/therapeutic space and coming into dialogue. Self-to-self beginning to form in client: internal relational space, beginnings of internalisation

Internalised: client's self-to-self relationship sufficiently established and the space between is relatively empty and can end



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An Evaluation of the Influence of CAT Personal Reformulations on Reflective Capacity in Trainee Clinical Psychologists

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Abstract:
Introduction: Cognitive Analytic Therapy (CAT) 'personal reformulations' (PRs) have been offered at some Doctorate in Clinical Psychology (DClinPsy) programmes as an opportunity for continuing personal and professional development through reflection. It might be hoped that CAT PRs would increase reflective capacity, although no published research on reflective capacity and CAT PRs exists.

Aims: This service evaluation aimed to evaluate the effect of CAT PRs on reflective capacity and to understand how they were experienced by trainees.

Methods: A mixed methods approach was used. The quantitative Reflective Practice Questionnaire was administered pre- and post-CAT PRs, and thematic analysis was used on qualitative data collected in an online survey.

Results: Twenty trainees participated. There were no significant group-level differences between pre- and post-CAT PR scores on components of reflection. Reliable Change Index (RCI) calculations indicated some individual-level improvements on nine sub-scales,

although a mixed picture is found. Qualitative data suggests the experience was helpful for personal and professional development for some trainees, although issues with timing and the content of sessions were identified.

Conclusions: Data does not support CAT PRs as the specific mechanism for change, and only a small number of participants indicated how changes in reflection would translate to practice. Findings may reflect overambition in expecting CAT PRs to increase reflective capacity, given their brevity, or methodological limitations of the evaluation. There are inherent challenges in disentangling influences of CAT PRs from other learning occurring through academic and placement-based training.

Keywords:
Cognitive Analytic Therapy, personal reformulation, reflective capacity, trainee clinical psychologist*, reflective practice.

Introduction

Background

Doctorate in Clinical Psychology (DClinPsy) training programmes have embedded a 'reflective-practitioner' stance in training criteria (Galloway, Webster, Howey & Robertson, 2003), emphasising the synthesis of technical and reflective skills to enable self-awareness and reflective capacity. This is in line with the Health and Care Professions Council (HCPC) Standards of Proficiency (HCPC, 2019), and the British Psychological Society (BPS) practice guidelines (BPS, 2017). However, there is a lack of empirical support for reflection directly improving practitioner outcomes (Lavender, 2003), perhaps due to challenges in experimentally studying reflective capacity without a unified definition (Lyons, Mason, Nutt & Keville, 2019).

Several definitions of reflective capacity and models of reflective processes have been developed and applied to training and practice. Reflection is considered by Schön (1987) as a deliberate act of attending to assumptions and beliefs occurring during (in action) or after (on action) an event. Other theorists consider it a process or cycle of doing, reviewing, concluding and planning, influencing skills and discovery (Kolb, 1984) and change (Gibbs, 1998). However, a challenge amongst existing definitions is that proposed reflective processes are highly variable and difficult to operationalise, resulting in heterogeneity in attempts to measure and observe reflection (Gillmer & Marckus, 2003).

One commonality in the literature is of reflection as an internal process; therefore, it could be argued that attempting to evaluate the properties of an atheoretical concept using pre-defined outcomes is reductionist (Galloway *et al.*, 2003). Nonetheless, evidence-based practice necessitates the critical evaluation of processes widely used by healthcare professionals. Further rationale for studying reflective capacity in healthcare professions comes from evidence of the benefits of reflective practices, including reducing practitioner burnout (Nielsen & Tulinius, 2009) and improved practitioner empathy for clients (Spendelow & Butler, 2016). This is of importance for trainee clinical psychologists who face profession-specific demands that increase vulnerability to distress (Dunning, 2006), such as professional self-doubt and long clinical hours (Gilroy, Carroll & Murra, 2002).

Increasing Reflective Capacity

Opportunities to increase reflective capacity can be facilitated via numerous therapeutic modalities, through personal reflection or exercises within personal therapy, peer learning, clinical supervision or mentorship experiences and reflective practice groups.

Bennett-Levy and Lee (2014) found such exercises can enhance self-reported reflective capacity, but focused specifically on reflection in Cognitive Behavioural Therapy. Although opportunities for developing reflective skills, using therapeutic modalities, are available in DClinPsy training, they are often extracurricular (Wigg, Cushway, & Neal, 2011). This renders reflection a challenge to routinely evaluate and to determine the impact on client outcomes.

Evaluating Reflective Capacity

Research on reflective capacity has been largely qualitative evaluations exploring the appraisal of reflective capacity, rather than the development of reflective skills (Moon, 2013). Quantitative studies using valid and reliable measurement tools and a pre-post design may be used to demonstrate whether reflective practices influence reflective capacity more robustly than qualitative studies. The Reflective Practice Questionnaire (RPQ; Priddis & Rogers, 2017) was developed as a direct measure of reflective capacity and associated psychological constructs. Research has demonstrated the utility of this measure to evaluate the acquisition of reflective skills (Rogers *et al.*, 2019). While there have

been other attempts to develop quantitative measures of reflective practice, these have been designed for specific samples or the appraisal of one specific reflective activity, rather than reflective capacity as a construct (Priddis & Rogers, 2017), making the RPQ the only available tool for the measurement of the latter.

Quantitative and qualitative approaches can examine different aspects of the development of reflective capacity and do so from different epistemological positions. These could be seen as opposing positions but mixed methods approaches, which intentionally use quantitative and qualitative data, maximise the strengths and minimise the weaknesses of each type of data, and can be useful for studying complex phenomena and hard-to-measure constructs (Creswell *et al.*, 2011). There is an absence of mixed methods research regarding reflective practice, which would arguably be appropriate for developing an understanding of the construct of reflective capacity, given its complexities, and thus is the approach taken in this evaluation.

Cognitive Analytic Therapy (CAT) and Reflective Capacity

Cognitive Analytic Therapy (CAT) uses sequential diagrammatic reformulations, map sequences of external, mental and behavioural events, and their repetition in self-management and relationships (Ryle & Kerr, 2003). This process has been adapted to develop 'personal reformulation' (PR); PRs are used with trainee clinical psychologists and therapists for personal and professional development that involves mapping personal patterns of relating relevant to work roles with clients, colleagues and peers. (Catalyse, 2020). CAT PRs typically consist of either a single session of 2.5 hours with a break, or a two-hour session with a one hour follow-up session, usually a month later (Catalyse, 2020). During CAT PRs, a visual representation of procedural patterns and sequences of actions is created, including consideration of the impact of and potential responses to these. CAT PRs are inherently a structured and facilitated process of reflection and thus might be expected to lead to increases in reflective capacity.

CAT PRs, as an optional part of an intensive week-long CAT training course for mental health professionals working in Community Mental Health Teams, have been shown to be personally helpful and valuable in understanding CAT from a client's perspective, although PRs were also viewed by some as 'nerve wracking' or 'too short' (Thompson *et al.*, 2008, p. 134). It is important to note that the details of the impact of PR relative to the rest of the training package, including how many of the

12 staff opted into this element of the training. An unpublished evaluation of CAT PRs with trainees at one DClinPsy programme highlighted their potential to improve self-reported personal understanding and awareness, and discovery of the potential experience of clients (Davies, 2018). However, despite extra-curricular PRs being offered by some DClinPsy programmes, there are no robust published evaluations of their impact.

Service

The Trent DClinPsy programme is one of 30 HCPC approved and BPS accredited professional clinical psychology training courses in the United Kingdom. The programme places emphasis on the development of reflective skills via multiple methods including reflective practice groups, supervision, and written reflective assignments (Clearing House for Postgraduate Courses in Clinical Psychology, 2019). Continuous professional development (CPD) is also a requirement to equip trainees with the competencies, skills and knowledge to enhance wellbeing at work and prevent burnout and stress (Trent Doctoral Training Programme in Clinical Psychology, 2019).

CAT PRs

To support CPD, the programme offered funded individual CAT PRs to all first- and second-year trainees, facilitated by one of two external CAT practitioners. These were optional but funded for all who wished to take them up. Sessions consisted of an initial two-hour session and a one-hour follow up session approximately one month later, to allow time for strategies identified in the first session to be utilised. The focus of the initial session was on a method of 'mapping' relational (or reciprocal) roles, the feelings that occur during engagement with these roles, and how these are managed. The 'map' serves as a tool of recognition and trainees were encouraged to take the map away. The initial session finished with reflective conversation about the map and active strategies to work on, such as adaptation of unhelpful patterns and 'exits' from these. The follow up session provided a space to review the 'map' and any attempted behaviour change, and to reflect on the experience of the process.

Aims

This service evaluation examined outcomes for trainee clinical psychologists who completed a CAT personal reformulation, with specific aims to:

- Evaluate the effectiveness of CAT PRs as a tool to improve reflective capacity of trainees.

- Gain an understanding of how CAT PRs were experienced by trainees, including whether and how they have impacted on clinical practice.

Method

Design

A mixed-methodology design was employed. Data was collected in the form of paper-based quantitative Likert-scale surveys and qualitative online survey data used to contextualise findings. As an evaluation of existing practice, the project was exempt from ethical review but conducted in line with ethical principles and guidelines.

Participants

First-and-second year trainee clinical psychologists from the Trent programme who accepted the offer of individual CAT PRs (n = 31) were invited to complete a validated measure of reflective capacity before and after CAT PRs, and an online survey four weeks later.

Outcome Measures

Reflective Practice Questionnaire (RPQ).
The RPQ (Priddis & Rogers, 2017) is a 40-item self-report measure comprising ten 4-item sub-scales. The first four sub-scales: Reflective-in-action (RiA), Reflective-on-action (RoA), Reflection with others (RO) and Self-appraisal (SA) measure reflective capacity. Related constructs are also measured, named Desire for Improvement (DfI), Confidence – General (CG), Confidence – Communication (CC), Uncertainty (Unc), Stress interacting with Clients (SiC), and Job Satisfaction (JS). Responses are given on a Likert scale of 1-6 (1= not at all, 6 = extremely). Sub-scale scores are calculated by summing and averaging the four items in each

sub-scale. Priddis and Rogers (2017) report good internal consistency of survey items and reliability of this questionnaire to measure reflective capacity across public, mental health practitioner and medical student samples (Rogers *et al*., 2019).

CAT reformulation evaluation questionnaire.
JISC online survey software was used to construct a survey combining Likert scales and comment boxes. Reflective practice questions utilised in SP/SR exercises (Bennett-Levy *et al*., 2009) were included, adapted for a specific CAT focus: (1) Observe the experience, (2) Clarify the experience, (3) Implications of the experience for clinical practice, (4) Implications of the experience for how I see myself as a person or therapist, (5) Implications of the experience for understanding of CAT therapy and theory.

Procedure

Phase One.
All trainees undertaking CAT PRs were provided with a hard copy of the RPQ in their university in-tray and prompted by e-mail to complete this prior to the CAT PR and return it in a numbered envelope for anonymity. Hard copies of the RPQ were provided due to the measure being standardised, and for anonymity for the researcher to match RPQs before and after CAT PRs. Trainees were informed in e-mails that by engaging in the study they were giving informed consent to participate. Trainees then completed CAT PRs.

Phase Two.
Two weeks following the second PR session, trainees were requested by e-mail to collect a follow-up RPQ from a university site. Post-measures were numbered corresponding to the initial numbered envelope and returned to the first author anonymously. The second author held a master copy of names corresponding to numbers in a locked cabinet and office, to protect participant anonymity. A follow-up reminder e-mail was circulated a week later.

Phase Three.
The anonymised remote online survey was distributed via e-mail four weeks following the second PR session and trainees were given up to four weeks to complete this. Although to some extent arbitrary, the timescale was chosen to try to balance giving trainees time to apply the learning from the PR session, and recognise any changes in thinking or practice, against the PRs seeming distant in light of changes in placements.

Analysis

Analysis of Quantitative Data

Anonymised data were entered into an Excel spreadsheet. IBM SPSS Statistics for Windows, Version 24 was used for analysis. Wilcoxon Signed Ranks tests were conducted as data did not meet assumptions for parametric tests. Reliable Change Index (RCI) criterion were utilised to conduct individual-level analysis on quantitative data.

Analysis of Qualitative Data

Open text responses were analysed using inductive thematic analysis (Braun and Clarke, 2006).

Results

Of those invited to take part (n = 31), 16 (52%) were in the first year of DClinPsy training and 15 (48%) in the second year. Pre and post RPQs were returned by 20 trainees (64%). Four returned pre- and two returned follow-up RPQs only, totalling 26 participants (83% response rate). Over two thirds of participants (64%) responded to the online survey. Participant numbers for RPQs were not matched with online survey data although for both the RPQ and the online survey collectively, nine (45%) were in their second year and 11 (55%) in their first year of DClinPsy training on the Trent programme.

RPQ Results

Table 1 reports descriptive statistics and the results of within-group difference calculations for pre- and post-CAT reformulation RPQ scores. At the group level, i.e., looking at aggregated data from all participants, there were no significant pre-post differences in RPQ scores on any subscales.

Reliable change calculations were computed at the level of individual pre- and post-RPQ mean scores, according to the method summarised in Evans, Margison, and Barkham (1998). Criterion values were computed based on test-retest reliability values (Cronbach's alpha), and standard deviations for each sub-scale as presented in Priddis and Rogers (2017). Changes of greater magnitude than the criterion were considered to indicate reliable change.

Table 1
Results of Wilcoxon Signed Rank Tests for pre- and post CAT reformulation RPQ scores

RPQ sub-scale	Pretest median (IQR)	Posttest median (IQR)	*Z*	*p* value
Reflective in action (RiA)[b]	4.25 (3.44 – 4.5)	4 (3.25 – 4.25)	-.966	.319
Reflective on action (RoA)[a]	4.50 (4.19 – 5)	4.75 (3.88 – 5.06)	-.196	.845
Reflective with others (RO)[b]	5 (4.5 – 5.31)	4.75 (4.18 – 5.25)	-.954	.340
Self-appraisal (SA)[b]	4.25 (4 – 4.5)	4.25 (3.62 – 4.75)	-.745	.456
Desire for improvement	5.62 (5 – 6)	5.37 (4.44 – 5.75)	-1.54	.123
Confidence – general (CG)[a]	2.12 (1.25 – 2.56)	2.12 (1.56 – 3.25)	-.619	.536
Confidence – communication (CC)[a]	4.25 (4 – 4.5)	4.5 (3.69 – 5)	-.732	.464
Uncertainty (Unc)[b]	3.62 (3 – 4.06)	3 (2.44 – 3.87)	-1.61	.105
Stress interacting with clients (SiC)[b]	3.38 (2.62 – 3.75)	3.12 (2.19 – 3.56)	-1.60	.109
Job satisfaction (JS)[b]	5.12 (4.43 – 5.75)	4.87 (2.06 – 5.75)	-.385	.700
Reflective Capacity (RC)[b]	4.44 (4.17 – 4.64)	4.44 (3.97 – 4.78)	-5.18	.605

Note. RPQ = Reflective Practice Questionnaire, IQR = Interquartile range. RPQ sub-scales were scored on a range from 1-6, where higher scores indicate higher self-reported ratings. One RPQ item (number 37) was reverse scored prior to analysis.
[a] Based on negative ranks
[b] Based on positive ranks

Table 2 Reliable Change Index Summary Statistics for RPQ sub-scales

Table 2: *Reliable Change Index Summary Statistics for RPQ sub-scales*

	Reliable Change Criterion*	Reliable deterioration		Uncertain change		Reliable improvement	
RPQ sub-scale		*n*	%	*n*	%	*n*	%
RiA	1.25	0	0	20	100	0	0
RoA	1.16	0	0	18	90	2	10
RO	0.56	3	15	14	70	3	15
SA	0.68	2	10	17	85	1	5
DfI	0.54	4	20	14	70	2	10
CG	0.61	2	10	11	55	7	35
CC	0.55	2	10	13	65	5	25
Unc**	0.56	1	5	13	65	6	30
SiC**	0.66	2	10	13	65	5	25
JS	0.66	3	15	14	70	3	15

Note. RPQ = Reflective Practice Questionnaire, RiA = Reflective-in-action, RoA = Reflective-on-action, RO = Reflective with others, SA = Self-appraisal, DfI = Desire for improvement, CG = Confidence – general, CC = Confidence – communication, Unc = Uncertainty, SiC = Stress interacting with clients, JS = Job satisfaction.
*Reliable Change Criterion = minimum change score needed for change to be statistically reliable
**Lower score = improvement

Table 2 summarises reliable change calculations in this sample. To determine reliable change, participants who did not provide pre-measures (n = 2) or post-measures (n = 4) were excluded from further analysis, leaving 20 (64%) participants.

Most scores fell under the category of uncertain change (73.5%), indicating difficulty detecting reliable change between the two time points on the RPQ. Across all ten sub-scales, 19 scores showed a reliable deterioration, and 34 demonstrated a reliable improvement. No reliable change was indicated for 'Reflective-in-action'. 'Reflective with others' demonstrated equal percentage deterioration (15%) to improvement (15%), as did the 'Job Satisfaction' sub-scale. Only a very small proportion (2%) demonstrated a reliable improvement on 'Reflective-on-action'.

Online Survey Results

Likert scale data from the online CAT PR survey for questions 16-20 (Table 3) were used to consider the effectiveness of the CAT PRs on reflective capacity and associated psychological constructs.

Most respondents rated above the mid-way point on Likert scales regarding CAT PR's impact on ability to work with clients, increase knowledge and awareness of emotions on self, others, and behaviour; and on increasing overall personal awareness. Mixed results were found regarding whether CAT PRs increased awareness of how respondents' own emotions might affect others, and ability to work with clients.

Table 3 Lickert scale data for CAT reformulation survey questions 16–20 from online survey

Questionnaire item	Not at all (1)	Slightly (2)	Moderately (3)	Very much (4)	A lot (5)
Did the CAT reformulation session increase your personal awareness of yourself?	0% (n=0)	10% (n=2)	15% (n=3)	60% (n=12)	15% (n=3)
Did the CAT reformulation session increase your awareness of how your own emotions affect your behaviour?	0% (n=0)	10% (n=2)	15% (n=3)	65% (n=13)	30% (n=6)
Did the CAT reformulation session increase your awareness of how your emotions affect others?	10% (n=2)	30% (n=6)	15% (n=3)	40% (n=8)	5% (n=1)
Did the CAT reformulation session increase your knowledge of what helps your job performance or what may hinder it?	0% (n=0)	0% (n=0)	25% (n=5)	60% (n=12)	15% (n=3)
Do you feel that the CAT reformulation session has or will increase your ability to work with clients?	5% (n=1)	15% (n=3)	40% (n=8)	30% (n=6)	30% (n=6)

Thematic analysis of the qualitative data (TA; Braun & Clarke, 2006) led to the identification of four themes, with subthemes, relating to a range of ways in which trainees used their learning. Gender neutral pseudonyms were created for participants.

Seeing the unseen

Some identified CAT PRs as allowing for recognition of factors that may have otherwise gone unexamined.

Self.

Five participants identified the process as affording previously absent opportunities for self-discovery. One had taken reflections forward into placement: 'Without this map I think I would not have reflected on this experience with my clinical supervisor' (Mo). All five acknowledged that the CAT PR was linked to self-reflection they 'may not have pursued otherwise' (Sasha).

Self in relation to clients

Five of six participants felt CAT PRs were helpful for reflecting on their own experiences in session with clients, with one recognising 'my responses can be unhelpful for clients' (Alex). The remaining participant reported more clarity about their clients' relational patterns than their own following CAT PR.

Self as client

Six noted the experience offered insight into client experience, for example 'a better understanding of how our clients feel' (Ziggy), but did not report specific details of this insight or how it impacted them and their work.

Application and use

Most participants identified going into the process with an intent to use it as a personal or professional development experience, and there was some evidence that they made use of their learning after the CAT PRs.

Recognising patterns

Prior to PRs, some hoped for greater awareness in 'interactions with clients and other professionals' (Yoshi), and others to reflect on patterns 'with clients and supervisors' (Sasha).

However, there was no indication that new awareness necessarily led to behavioural change, with only two participants linking recognising patterns with utilising exits, as per the intent of CAT PRs. Further, contradictory information from Max noted: 'I have not changed my behaviour because of the reformulation because it did not address my readiness for change', highlighting limitations of potential increased awareness on application to practice.

Intent to apply

Fifteen trainees identified intent to use recognition of patterns, for example to 'be more open with colleagues' (Ainsley), use CAT 'effectively in therapy' (Jude), and 'reflect with my supervisor about a difficult experience' (Mo). One third of these trainees spoke of benefitting from using the CAT 'map' specifically with supervisors and for one participant with their mentor, although how this was used was not specified.

Experience of the process

Trainees identified factors relevant to relational and practical elements of CAT PRs.

Safe space

Seven trainees identified the experience as validating and therapeutic, e.g. 'feeling like someone understood' (Reine). However, only Jude related this specifically to the use of CAT PRs: 'It helps in normalising that we all have relational patterns and reciprocal roles'. For others, a validating space was beneficial but not necessarily due to CAT. A small number of participants valued an external facilitator due to 'absence of scrutiny from the course'.

Discomfort and benefit

Eight participants regarded the process as emotionally difficult, with some reporting feeling 'vulnerable' (Ziggy), and 'initially overwhelmed' (Jamie). None associated such feelings with aversive outcomes, and some suggested they 'later felt empowered' (Jamie), or that the facilitator created a space that was 'challenging but comfortable' (Oli).

Timing and clarity

Three trainees identified the timing of the CAT PRs as inconvenient relative to placements, resulting in fewer opportunities to apply learning. However, one participant directly contradicted views on the length, reporting timing as 'really helpful to give you space to reflect upon it' (Alex). Two desired more time between CAT PRs, e.g. to 'think about some exits I may use' (Ziggy). Although a small number raised this as an issue, comments regarding timing were highly varied and therefore salient. A small number of participants expressed a lack of clarity, having had expectations of focusing 'on relevant personal patterns of relating' (Max), but finding sessions were 'framed as not being personal therapy' (Jude). For some 'it was really difficult at times not to move into my personal life' (Alex). Contracting regarding the use of a therapeutic process for professional development is worth consideration.

Personal professional development

Becoming a better therapist

Over half of participants thought the process would help them to develop as therapists. This was linked to CAT for some, e.g. 'I feel I am now more able to notice when I am being drawn into unhelpful patterns with particular clients' (Alex). Most talked about more general development of clinical and personal skills. One identified a specific CAT-related change in 'the way I offer endings to clients and colleagues' (Stevie).

Being human/good enough

A small number of trainees identified changes in self-perception such as being 'more comfortable with being imperfect' (Sasha) and 'good enough' (Andy). Two participants underscored the value of being reminded to utilise self-care.

Discussion

This evaluation aimed to address the lack of mixed methods research into structured reflective opportunities within DClinPsy training, with a focus on CAT PRs.

Aim 1: To evaluate the effectiveness of CAT personal reformulations as a tool to improve reflective capacity of trainees.

Quantitative RPQ results did not indicate any significant (aggregate) change in reflective capacity, or associated psychological constructs following CAT PRs in this sample of trainees. Evidence exists for the utility of the RPQ in detecting practitioner differences in reflective capacity across sub-scales (Priddis & Rogers, 2017; Rogers *et al*., 2019), although sample sizes have been somewhat higher in published research. Individual-level analyses indicated most participants reported no reliable change following CAT PRs. In fact, no reliable changes were detected in core components of reflection (Reflective-in-action, Reflective-on-action, Reflective with others) This could indicate that CAT PRs were not effective as a tool to improve the reflective capacity of trainees in this sample.

Individual level improvements were observed for 'Confidence – general' and 'Confidence – communication' for some participants. This is consistent with a mental health practitioner sample described by Rogers and Priddis (2017), who reported high levels of confidence as measured by the RPQ. It is not possible to conclude by what methods an increase in confidence may have occurred. CAT utilises a specific process of mapping through modelling and communication, and CAT PRs may have led to an increase in self-rated confidence through this process. However, there is research evidence that confidence may be subject to over-estimation (Ames & Kammrath, 2004), and a reliable shift in confidence in this sample is not linked to evidence of changes in clinical practice, such as increased competence.

For some participants, CAT PRs were associated with reductions on the sub-scales 'Uncertainty' and 'Stress interacting with clients'. Further, qualitative data indicated that CAT PRs provided opportunities for trainees to see patterns previously unseen, and to allow themselves to be imperfect in their practice. This may indicate why improvements in 'Uncertainty' and 'Stress interacting with clients' were found for some, although quantitative and qualitative results were not matched in this evaluation.

Given the brevity of intervention, it might be considered ambitious

to expect that two CAT PR sessions would lead to measurable increases in reflective capacity, despite them offering a facilitated and structured process of reflection. It may be that longer-term interventions are required to increase reflective skills. That said, there is evidence from the qualitative data that trainees did experience some changes in reflective capacity, for example through taking reflections to clinical supervision and considering their implications for clinical practice. It may then be that the quantitative findings may reflect the methodology of the evaluation. One disadvantage of the PR tool is its brevity, and CAT PRs may not provide a comprehensive opportunity for meaningful changes in reflective capacity. It may also be the case that the evaluation did not allow sufficient time following the PR for trainees to embed their reflections in practice and that a follow-up completion of the RPQ may have reflected further change. In addition, while the RPQ is a validated tool measuring reflective capacity and associated psychological constructs, it may not capture outcomes pertinent to the typical intent or content of CAT PRs and there may be a need to develop a more specific tool.

Although possibly a reflection of the methodology, in the absence of quantitative evidence of improvements in reflective capacity and data on how respondents reflect on and in practice, results cannot be said to reflect meaningful post CAT PR improvements in reflective capacity. Furthermore, improvements in psychological constructs associated with reflective capacity such as uncertainty, confidence and stress interacting with clients may also be influenced by clinical experiences on placement and other components of DClinPsy training not captured in this evaluation, such as teaching and reflective practice groups.

Quantitative online survey data indicated improvements in self-awareness, but there was a mixed picture for increased knowledge of emotions affecting others and ability to interact with clients, with some participants rating 'not at all' to these questions. This may indicate the ability of CAT PRs to improve personal awareness, in the absence of ability to affect changes in client work. In fact, qualitative data provides supportive evidence that CAT PRs improved components of reflective capacity for some trainees, however this is not supported by quantitative data, and limited information was given regarding how changes were used or applied to clinical practice. Due to the non-visible nature of reflection, it can be a challenge to explore the relationship between changes in reflection and changes in clinical practice (Mann, Gordon & MacLeod, 2009), calling into question the clinical utility of reflection amongst healthcare professionals in the absence of supportive evidence.

It is also possible for some participants that reported experiences of discomfort arising from the CAT RPs and dissatisfaction with the timing of and between sessions may have impacted trainees' ability to fully benefit and reduced the likelihood of change in reflective capacity.

Aim 2: To gain an understanding of how CAT personal reformulation sessions were experienced by trainees, including how they have impacted on clinical practice.

It is difficult to disentangle the effects of CAT PRs from other CPD and training activities, such as placement and teaching, which may influence reflective capacity. Qualitative data provides some evidence of partial changes in awareness of self and others. CAT is a relational approach which requires attunement to the roles of self and others, including unconscious processes (Ryle, Poynton, & Brockman, 1990) and identification of 'exits' from unhelpful ways of relating (Ryle & Kerr, 2003). Therefore, it is in line with expectations that CAT PRs supported the identification of relational patterns for some trainees, including previously hidden ones. However, quantitative data did not demonstrate the effectiveness of CAT PRs to improve reflective capacity, calling into question the specific skills or metacompetencies that CAT PRs may be expected to influence. In fact, trainees reported that the more general therapeutic processes, rather than CAT specific elements, were most helpful for personal and professional development. Considering research evidence that therapeutic outcomes are heavily influenced by general rather than specific components (Wampold & Imel, 2015), the most important mechanisms of change in these sessions may have been the therapeutic relationship and safe space provided.

CAT PRs were identified by some trainees as supporting their understanding of themselves in relation to clients, as well as opportunities to experience a client's perspective. Research suggests that greater self-awareness can increase empathy and understanding of clients' needs (Strozier & Stacey, 2001). A small number of trainees also identified intent to apply their discoveries on placement with supervisors and colleagues, which may indicate the positive impact of CAT PRs on trainees' clinical work. However, despite speaking of greater self-awareness, most trainees did not discuss how this would impact on their behaviour. Without data on changes in practice for trainees, it is difficult to determine how, if at all, CAT PRs impacted on trainees' clinical work and client outcomes, over and above self-reported increased awareness.

A theme regarding the process of CAT PRs as uncomfortable yet helpful for some may indicate the experience as one of self-discovery. Chaddock (2007) found that new insight and self-awareness can result in a questioning of confidence and competence. However, RCI criterion suggest that confidence increased reliably in a small proportion of trainees, which would contradict an expectation that confidence may decrease as trainees become more aware of their skill level (Bennett-Levy & Beedie, 2007). The evaluation would have benefitted from attempts to match qualitative and quantitative data to further contextualise these findings.

Strengths, Limitations and Future Directions

This evaluation is the first to use the RPQ as a measure of change in a pre-post intervention design, and to attempt to evaluate the ability of CAT PRs to improve reflective capacity. However, aggregate differences were not detected with the RPQ in this study. More longitudinal research with larger participant samples may be required to determine the utility of the RPQ for examining within-group differences more generally. To disentangle the effects of CAT PRs relative to other reflective opportunities, the RPQ may not be applicable to future evaluation of CAT PRs. Use of a reflective measure oriented to CAT theory could support the identification of CAT PR-specific changes, although at present no quantitative CAT measures exist. The Helper's Dance Checklist (Potter, 2014) provides scaffolding for building reflective discussion but is not appropriate for determining within-group change. Other methods of evaluating reflection may need to be utilised, such as ratings of aspects of reflective capacity in reflective writing (Rogers *et al*., 2019).

This evaluation was strengthened by a mixed methods design to detect change through objective measurement, and capture participant experiences. However, the small sample size utilised in a specific training context over a short time span limits the generalisability and utility of the current study. Further, the evaluation would have been improved by asking participants specific questions regarding behavioural change, considering the purpose of using two CAT PR sessions is for trainees to have opportunities to apply the 'mapping' process to a real-world context.

Implications for the Trent Programme and DClinPsy Training

Overall findings from online survey data indicate that CAT PRs were

experienced by some trainees as a helpful addition to training and CPD already offered. While qualitative evidence suggested an increase in awareness, this was not supported by the validated measure used in the study. The addition of triangulated measurement methods such as CAT-specific qualitative and quantitative measures, and appropriately timed placement supervisor ratings of reflective capacity, may benefit future evaluations on CAT PRs. However, consideration should be given to the utility of reflection as a focused training technique, in the absence of empirical support (Mann *et al*., 2009). Further, components of CAT PRs identified as supporting personal and professional development were not identified as CAT-specific. This supports the addition of CPD opportunities in which reflective processes are used but does not provide specific evidence or rationale for CAT PRs.

A small number of trainees identified limitations of CAT PRs, relative to timing in their clinical training, and an unclear distinction as to whether sessions should focus on professional or personal situations. It is a challenge to separate one's 'personhood' from reflective processes, and there is debate as to how understanding the self from a personal perspective in a professional role should be incorporated into professional psychology training (Norcross, 2005). From this evaluation, consideration should be given to how this distinction may be achieved in a containing way, as the difference between personal development and individual therapy may lie in the depth of examining oneself in the work (Izzard & Wheeler, 1995). One recommendation may be for clear written or oral information on CAT PRs, and contracting regarding the nature of sessions, to be provided to trainees in preparation of the process.

Timing issues for some trainees may have also impacted on how much benefit they were able to derive from CAT PRs, reflected here in RPQ scores and qualitative comments. It would be justified to offer CAT PRs and other CPD opportunities more flexibly for trainees to derive the most benefit from them as a resource. □

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The development and evaluation of 'Map and Talk' reflective practice groups

with ward-based staff in an acute adolescent psychiatric inpatient setting

JOHN MULHALL

Abstract:
The author has piloted and established ward-based reflective practice groups in a setting characterised by high expressed emotion, instances of aggression and violence, and multiple demands on front line nursing staff. This paper discusses the development of a regular and flexible Cognitive Analytic Therapy (CAT) approach towards enhancing relational understanding and emotional scaffolding for nursing staff within an adolescent psychiatric inpatient unit, through 'Map and Talk' reflective practice groups. The groups are facilitated within existing resources (no extra funding to cover shifts for nursing staff, specific CAT skills training, or external facilitation), and the paper goes on to present an evaluation that was conducted using a qualitative questionnaire and a thematic analysis. Feedback examples are used to illustrate the main themes that emerged. Overall, staff were appreciative of and positive about the reflective space, and the CAT approach – especially the CAT mapping. All respondents said they would recommend the group to others.

Finally, the paper discusses aspects of organisational mapping and parallel processes to explore relational dynamics, barriers, and potential fracture lines between non ward-based (upstairs) and ward-based (downstairs) staff, as well as those between nursing staff and patients. The layout of a building can unwittingly feed into such potential team divisions, and create unhelpful, and untrue, myths and legends that can be hard to dispel. This paper is likely to be of specific interest to professionals setting up reflective practice groups within their own place of work.

Keywords:
Adolescent Inpatient, Reflective Practice, Map and Talk, CAT

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Introduction

The inpatient setting is a tough place to earn one's living. Taking temporary responsibility for the lives of young people (children) in significant intrapersonal crisis can be exceptionally challenging. The risks are daunting. These environments can place nursing staff in significant moral distress (Musto and Schrieber, 2012). Acutely psychologically unwell young people have high rates of self-harm, suicidal behaviour, and indeed suicide (Hawton *et al* (2012); Griffin *et al* (2018)). When a young person self-injures on a ward, it is damaging for all concerned. The anxiety amongst the staff team is correspondingly high. The chronicity and acuity of cases admitted and rates of violence towards staff on inpatient wards are rising, (British Psychological Society 2012), (Itzhaki *et al*, 2015; Foster, 2018). These assaults are both psychologically and physically damaging to the staff themselves and to the therapeutic relationships between the young person and their treating team, (Burrows *et al,* 2019). Compassion fatigue, secondary traumatic stress, and burnout are seen as occupational hazards for professionals working in these specialised contexts, and specifically for registered mental health nurses (RMNs) and healthcare assistants (HCAs), who spend the most time 'at the coalface' working directly with the young people (Ward, 2013; Matthews and Williamson, 2015; Foster, 2018).

Reflective practice groups are one approach to maintaining the wellbeing, and compassion satisfaction of the staff doing this work (Ray *et al,* 2013; Stamm, 2010; Foster, 2018). This paper is an account of a reflective practice initiative for nursing staff designed to help them better understand the complex presentations of patients and their care systems, the relational stressors of all aspects of the work, and the strong pushes and pulls to reciprocate unhelpful patterns of relating (Ryle and Kerr, 2002, 2020). It is a relational approach which means that it seeks to understand people by looking not solely at disorder in an individual person, but at what is going on **between** people and with the surrounding system. The task of 'understanding' the young people in our care is approached by reflecting on their personal history, and on our responses to them which are usually indicative of their early patterns of relating and of being related to.

Cognitive Analytic Therapy (CAT) and reflective practice groups

CAT has given us some extremely effective tools to help understand complex relational interactions; Reciprocal Roles and Reciprocal Role Procedures (Ryle and Kerr, 2002), Mapping (Potter, 2010, 2014 & 2016), Observing Eye/I (Akande, 2007) – to name but a few. This approach and concept has long been applied to community mental health teams (Kerr *et al*, 2007), (Potter, 2010), and care orientated settings (Shannon *et al,* 2017), and particularly, inpatient teams (Kemp *et al*, 2017).

Within this specific type of practice, perhaps a gold standard approach would be a whole unit philosophy – to have external facilitators who train the whole team in CAT skills, develop a common language for understanding relational behaviour, and provide ongoing reflective practice groups thereafter. A silver standard would be a specific department philosophy – with external CAT facilitators providing a planned and consistent staff reflective group format and schedule. A bronze standard would be to establish a consistent meeting opportunity, within usual resources (no additional costs/external facilitators) but ensuring that there is a contained therapeutic space with a CAT frame, philosophy and approach, where staff can explore the relational dynamics of the inpatient setting, and the impact this has on them and their work.

This paper talks about a 'bronze' standard approach, 'cutting your coat according to your contextual cloth' (Mulhall, 2015), within the zone of proximal development of that environment (Vygotsky, 1978). Whilst outlining the context and possible limitations of this situation, it is not to detract from the potential value and benefits from harnessing the expertise within, rather than outsourcing to external experts – who could be perceived as outsiders who know nothing about this specific environment and work, for example.

The Centre and context

The Centre comprises two wards, a 15-bedded generic ward, and a 10-bedded psychiatric intensive care unit (PICU). Although the wards are different in terms of their acceptance threshold criteria, and in terms of how they are managed, the map and talk work is ostensibly the same.

How the group(s) evolved

I have been a CAT Psychotherapist at the adolescent inpatient unit for approaching nine years now. A long-standing, psycho-dynamically and

externally facilitated staff group, open to all staff had been stopped – it was poorly attended, and associated costs were an unjustifiable expense. However, it had left the unit with a significant hole in the provision of staff support/reflective space. In particular, the nursing staff had few opportunities to sit down and think about the complexities of the work and its impact on them. With the approval of my manager, and under my initiative, I looked at the possibility of myself bringing a CAT approach to supporting staff in their work through reflective practice.

CAT Theoretical influences

I had begun reading about the 'Four Ps' (Pause, Pull, Pattern, Professional Response) work and model of Annesley & Jones (2010 & 2011), and how this could be used as a tool for thinking and reflection on one's own interactions with patients. The original group was set up on these, and general CAT principles, about six years ago.

As time went by, I was inspired to develop this initial thinking and practice after attending the International CAT Conference in Greece in 2015. There I listened to Mark Ramm and Jamie Kirkland, as well as Nicola Kemp, Alison Bickerdike, and Clare Bingham talking about their CAT approaches to reflective practice – building on the work of Steve Potter (2010) and others previously mentioned. The term 'Map and Talk' was used, which I instantly liked, and thought was an excellent description of what CAT in action looks like in this context.

With initial experience of facilitating staff support at the unit under my belt, together with an increased knowledge base, enhanced enthusiasm, and support from my own supervisors and manager, I relaunched the staff support initiative as a reflective practice space. I used enticing slogans such as; 'We are in it together, so let's try and understand it together' (Kirkland & Ramm, 2015), 'Shared thinking time to assist and build reflective capacity', 'to map situations and difficult moments', 'to build the ability to zoom in and out of situations, and recognise patterns of relating', 'not necessarily a space to find solutions – though it is hoped that they might occur', to build enthusiasm to make the groups happen, consistently.

The group was open to all staff, and attendance was not compulsory. In its infancy, attendance was mixed and erratic. Over time it became apparent that those who seemed most in need of it, and more likely to attend, were the nursing staff. The groups have continued to evolve, and for the last three years, they have been known as 'Map and Talk' reflective

practice meetings. After several years of trying various midweek arrangements, the unit has arrived at the fact that it can achieve the most consistent attendance for nursing staff if they are facilitated at the weekend. This is a time that is not so highly structured with clinical meetings and other demands on staff. There may also be more leave and visits for patients, which can free up nursing staff time. Therefore, the current, and most consistently attended structure so far, is that 'Map and Talk' groups are facilitated (by me) on each ward, separately, for an hour every Sunday.

At these meetings we attempt to explore the convergence of four main areas: the patient and their history, the patient's family or care system, the service with its demands and constraints, and staff members individually and collectively.

Evaluation

After six years of facilitating reflective practice groups in the unit, a more formal and current evaluation was indicated as part of usual good clinical practice. Data collection needed to be simple and easy. The most pragmatic way of doing this was with a questionnaire. In terms of devising the questions themselves, I was mindful of trying to keep it brief and straightforward, and to elicit more qualitative than quantitative responses.

Sample

As is usual in these types of environments there is a high turnover of staff (Foster, 2018), and therefore of group attendees. On each ward there is approximately a whole time equivalent of 15 RMNs and HCAs which is overall in the region of 25 regular staff providing the care and support for 25 patients across both wards. There is also the addition of regular and irregular bank staff, and agency staff when observation levels are high. Some staff are also regularly on nights.

There has been quite a difference between how many groups staff have attended, depending on their length of service, availability on a Sunday, and being able to be freed up from ward duties to attend. So, some members of staff have attended over 20 sessions, and others (newer or irregular members of staff) only twice. It was decided to send the questionnaire to all current nursing and health care staff who had attended the group more than twice.

Questionnaires

25 questionnaires were distributed, 17 were returned, giving a return percentage of 67%. This included six HCAs, and 11 nurses comprising three Associate Practitioners, five Staff Nurses, two Charge Nurses, and one Ward Manager. This represented nine responses from the Generic ward, and eight from the PICU. Respondents were invited to return their questionnaires anonymously, virtually all did not. All respondents consented to the author using their questionnaires for the purpose of service evaluation, and this paper.

When devising the questions themselves, I wanted to try and capture how helpful the Cognitive Analytic Therapy aspects of the group were, but I didn't want to use CAT technical terms (such as reciprocal roles, reciprocal role procedures, enactments, etc.) as I thought it would put people off responding.

The first three questions centred on how helpful Map and Talk was in helping staff in their patient interactions/understandings, the fourth was in relation to useful tools, the fifth was in relation to anything unhelpful, the sixth (in keeping with the UK NHS staff survey questionnaire) in relation to recommending the Map and Talk approach to friends or family, and the seventh in relation to anything else they might have to say about the initiative.

Analysis and responses

A Thematic Analysis (Braun & Clarke, 2006) of the returned questionnaires was carried out by a Clinical Psychologist colleague with no involvement in the groups. From this thematic analysis, five broad themes emerged (**bold**), which are reported below. Examples of responses (evidence in relation to the five broad themes) appear in *italics*.

1) A valued forum for self-expression; a safe space to share, containing, supportive/caring, professional, time to 'step back'.

> *It gives me a forum to 'offload' any worries or queries I have regarding a patient/staff/building issue. But not just that, it gives me a person who can answer back in a professional way, and he can then point me in a good direction, and possibly give me a different perspective on something that has been bothering me.*

> *It's good to express my views and hear those of others.*

Just the space to vent and explore how our difficult patient group care gets inside of us.

Yes, it's very helpful and supportive, and also puts me in a good frame of mind for the day.

I would like to say thank you. I find it very useful, and I like coming into the group to give me a different headspace to think. It is not that often in the week I have time to sit and think and discuss, and I think that this should very much continue to be a protected time.

2) 'Why we see what we see' (increasing understanding); breaking it down, seeing the bigger picture, benefits of broad learning tools (seeing the pattern), sharing views, reading more widely.

It helps to get a better understanding of what is going on for a particular patient. It also helps staff to become self-aware about our own attitudes and behaviour towards patients, and how we can support them.

When a patient has been let down in the past, they can put up huge defensive walls, and to protect themselves, sabotage (in verbal, physical or emotive attacks towards staff or others around them) any form of care of compassion towards them, as they see it being fake, false or untrustworthy.

Highlighting when discussing a situation that hits a personal experience, and realising you've been drawn in, and how I can be better prepared through this awareness.

I like the use of 'mapping'.

3) Personal and professional growth; building empathy, better self-awareness, feeling empowered and valued, improved self-efficacy, reduced/managed anxieties.

It adds a psychological aspect to my work. It allows me to stop and think about the situation in a controlled and encouraging environment.

It helps me to take a step back and look at things more clearly. It also helps me to understand people's behaviour.

Support when feeling overwhelmed by the job, and unsure and anxious. Being able to talk about this and share concerns with colleagues.

It's sometimes difficult on the ward to free staff up to attend on the dates set aside and sometimes you may be unable to attend groups for several weeks due to shift patterns and staff availability, despite wanting to come to the groups to help with processing. When we are able to go, it's fantastic and staff feel more energised and focused back on the ward with the team.

It can sometimes be a helpful break from the ward environment. Reassuring, self-affirming and teambuilding.

4) Noticing the pushes and pulls; impact of negativity, struggle to keep boundaries (team and self), dynamics of attachment/care seeking (seeking attachment, understanding defences, self-sabotage).

Too many pushes and pulls to mention!

When patients invite you to feel something and having the experience to know to go with it, or deflect it positively.

Negative staff pulling me into a negative mood, due to high stress and them feeling uncontained.

There have been situations whereby a young person has managed to engage me in a childish back and forward argument about something they had requested.

5) Service improvement; identify new path's, implementing change.

It is helpful to think in a little depth about a particular patient and has been insightful to hear the views of colleagues. It is helpful to look holistically at situations and sharing staff experiences to gain more understanding in order to develop skills to achieve improved outcomes.

I find that the sessions provide an opportunity to reflect on our practice, to unpick the young people we have at the time, and what their care looks like, and how we might improve it. But also provides a safe and supportive environment to tackle (sometimes personal) issues that can be impacting our roles on the ward.

We are able to look at roles of the young person and why they might be behaving in a certain way. Discuss interventions that may not have been tried yet.

I think it's a godsend. I feel all staff should be given the opportunity to attend.

Observations

The five broad themes that emerged from the thematic analysis are encouraging and can bring helpful buffers to the terrain of this difficult setting. From a professional, patient, family, and managerial perspective, we would want staff in units like this, doing this challenging work, to have access and exposure to a valued forum for self-expression, increased understanding into 'why we see what we see' on the wards, a place for staff personal and professional growth, a method for developing our own capacity to notice 'pushes and pulls', invitations to join unhelpful dances (Potter 2014), and on the ground reflection about service improvement. This can only lead to better service delivery, and therefore better outcomes and patient experience. As a cautionary thought the qualitative data is drawn from a limited number of respondents but those who know the team and the work see it resonating with overall perceptions of the Map and Talk work.

Perhaps most striking were the replies to Question six. All 17 respondents (100%) said they would recommend it. . . '*yes, definitely, most certainly, absolutely, without a doubt'*.

One respondent made the interesting additional observation to this question. . . '*Yes, . . . however, you need all the staff to participate fully to get more benefit*.'

I take that to mean either that there needs to be more of the (whole?) staff (shift) team in it, or, that participants need to allow themselves to interact more when in it – to get more benefit. The unit continues to think about how it can enhance attendance, but solutions are challenging given the limits of staff resourcing and as, ultimately, the patients on the wards require high levels of nursing.

At the Centre we have acknowledged the presence and effects of both primary and secondary trauma on the staff team, and have developed and implemented additional forms of staff support, in the form of the Group Traumatic Experiences Protocol (GTEP) which is openly accessible

to all staff in the building (Shapiro and Moench, 2017).

> *I don't think anything is unhelpful, but sometimes it may bring back some memories at times, I guess sometimes with the culture we have on the ward, it can feel like we are escaping the work that we need to do. Or we feel negatively/defensively about taking the time to attend the session (on a short-term basis), rather than focus on the positive impact that attending the group has in the long term.*

When reflective practice initiatives are facilitated solely within existing resources (no extra cover), in an environment where demands can be relentless, this can easily fuel **ignoring** and **self-denying** procedures in relation to **depriving, neglecting and overlooking** one's own needs, and even guilt – probably at the time you might need to take the reflective space the most.

Facilitation

Ideally one would not choose to have a sole (internal) facilitator for this type of work. The additional support, energy, and observations that another facilitator might see could be enriching for all. However, a sole facilitator is the reality of the situation. There have been many times along the road that the groups have looked like they could come to a halt. Many a good initiative has 'run out of steam' through loss of patience or interest in these often furiously busy and demanding environments. Despite their obvious value, keeping these groups going, perhaps surprisingly to outsiders, requires a significant amount of facilitator persistence and flexibility – which can of course lead to its own enactments when feeling **isolated**, or not feeling **valued**. One has to not take it (non-prioritisation of the group on any one given day) too personally (**rejecting** to **rejected**), which is not always easy to do. Solid regular supervision is essential.

The wider picture

Whilst developing deeper relational understanding of the patient and staff dyad is extremely important, and has also been extensively reported above, one also has to try and understand patterns and enactments through the lens of the service demands and constraints and the wider multidisciplinary team. An example of organisational orientated mapping, with particular relevance to themes two, three and four above *(2. 'Why*

we see what we see', 3. Personal and professional growth, 4. Noticing the pushes and pulls) is discussed below.

Generic maps

Over the years, many specific maps have been co-constructed within the groups, exploring a wide range of issues from critical, over involved and intimidating parents, perceived ineffective/absent management, use of ineffective (agency or bank) staff, patient violence, patient challenging behaviour, patient distress, and serious risk related behaviour. It is both incredible and enlightening to see the links and patterns that emerge between all these seemingly different things. From this work, a generic organisational map has emerged and it would have been difficult to think that the pure design logistics of a building would make such a significant contribution to a potential fracture line in the whole unit multidisciplinary team. By this, I mean that it costs less to construct a taller building than a wider single-storey one, and this is reflected in the design of the Centre where the upstairs part is used as the bases for doctors, therapists and administration, and young people are not allowed there due to the window/height risk – an upstairs and downstairs is physically created.

Within inpatient work, it is not unusual for there to be (conscious and subconscious) tensions between those at the coalface, and those not in continual contact with the whole patient group (on shift). This also reflects possible issues with professional standing, and perceived privilege. This fracture line can become magnified by the internalisation of an 'upstairs–downstairs' metaphor, and then reinforced by the actual geography, which can then permeate subsequent interactions, see figure 1 [overleaf].

This map has been useful to hold in mind in terms of understanding how staff members can find themselves in difficult and **exposed** positions when they feel **unsupported**, **unacknowledged, overruled** or **undermined**. The danger is that this can lead to a **scapegoated** or **neutered** position, or a **distanced subgroup** position. None of these are particularly helpful for any service. Bringing this map out alongside the current issue being discussed has proved helpful.

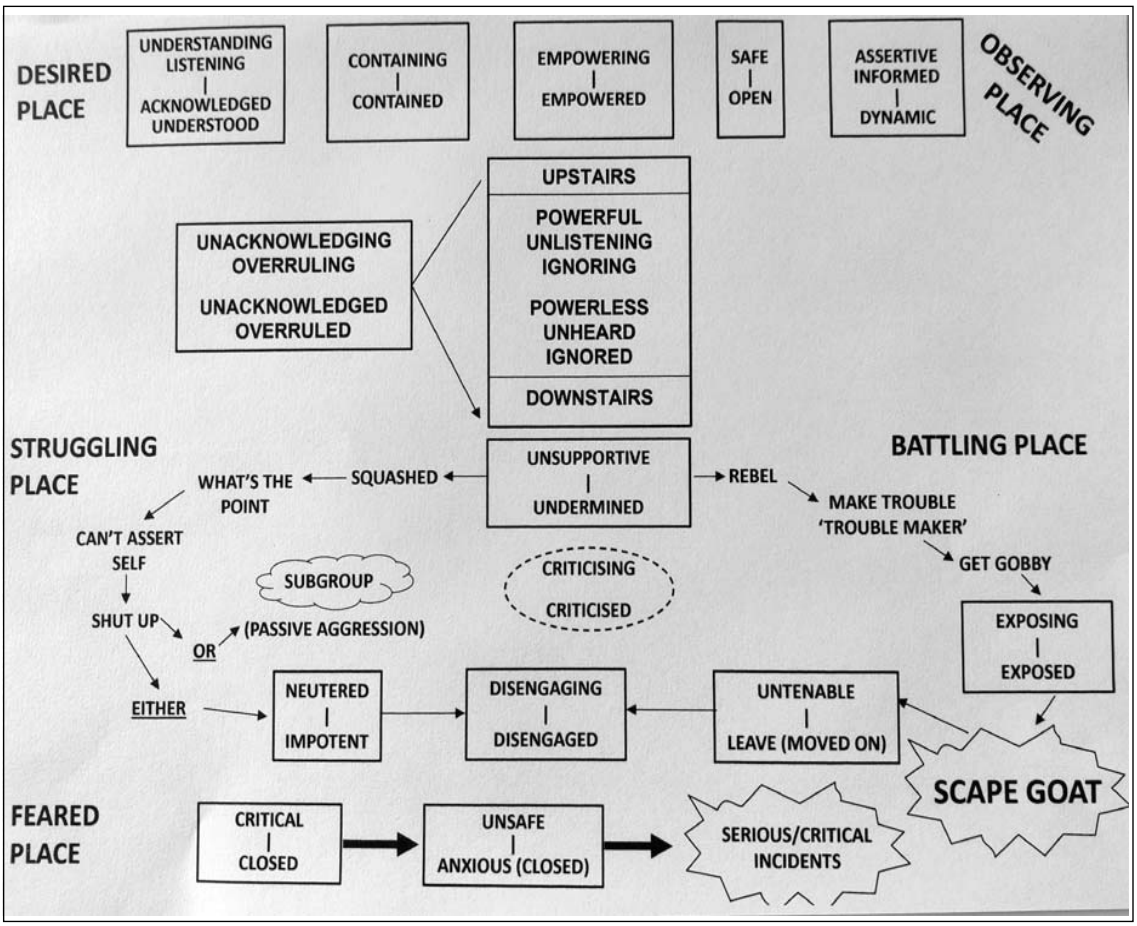

Figure 1

Integration

As stated previously, the target group for map and talk sessions is ward-based nursing staff. When one thinks of the whole clinical and management team, again, ideally, the thinking that happens in map and talk could be increased in value if it had the opportunity to be more integrated into the workings of the whole Centre. However, it also has to be acknowledged that it is just one of a number of initiatives and models of reflection present within different parts of the unit, and some people in the building, for many reasons, may never be too aware of its content or function. For example, some of the multidisciplinary team and ward managers are required to be part of a regular DBT Consult group as the Centre heads towards accreditation in this treatment model. In this situation attendees can meet consistently and regularly, and keep

themes going as they are in control of their own diaries, unlike nursing staff. It is also an organisational goal to attain this accreditation, and there are multiple people linked to this goal, so there is more organisational drive and specific focus behind it. Many wider team senior professionals may also be saturated by supervision demands also.

During its existence Map and Talk has perhaps assumed a low overall profile. The facilitator has chipped away at the many prevailing dynamics and addressed potential fracture lines in the best way they could. Now that Map and Talk has developed a more solid platform and clear identity, the facilitator has attempted to raise its profile. Undertaking this evaluation is part of that process. There is evidence to suggest that the collective efforts of the whole multidisciplinary team are making some helpful inroads (exits) into dispelling the upstairs–downstairs myth and legend, by developing a (more) **attuned**, **available**, and **responsive to**, **listened to**, **understood** and **connected** role. For example, I was heartened to receive an email very recently from a nursing colleague who became pregnant and had to carry out her duties away from the risks on the ward (upstairs). She gave her full consent for me to share her departing observations as follows:

> *I just wanted to say thank you to everyone who has supported/ responded to my questions/emails over the past few months.*
>
> *I enjoyed my time sitting upstairs with everyone before I left. It was a real eye opener to be able to see all the hard work that goes into each young person's case on the ward, I think being within the ward and especially doing a lot of nights I was hidden away from all the other work that goes on past the ward doors. I think as part of the nursing team you get so caught up in firefighting and managing that you forget about all the other work that goes on.*
>
> *Each one of you do an amazing job and being able to sit at home and read everyone's notes from therapy/CPAs/social care and to be involved in the million email trails that go on for each young person has given me a great insight into what each person does for the unit and the dedicated work of all the team 'upstairs'.*

Perhaps the Centre is often more integrated than the myths would have you believe. Although perhaps there are still echoes of the legend in some of the language?

Parallel processes

There can also be a powerful parallel process in relation to the organisational dynamic which can be enacted between patients and nursing staff on the ward itself **(revisit figure 1)**. It can often feel to patients that nurses and health care assistants are in a position of holding **power** and **control** over them (which is true insofar as they hold the keys to the doors and can say yes or no to requests for leave) and can be **ignoring** of their self-perceived needs and wants, especially when they are busy in the ward office. In response to this, patients can often feel **ignored** (not properly cared for), and **powerless**, leading them to feeling **overlooked**. This can then escalate risk behaviours as they seek more care and attention, usually through behaviour that demands action and intervention. Although this is a common pattern for such establishments, ultimately this can then lead to some young people being **scapegoated** and experienced as an impossible patient who either needs to be moved to a higher level of care than can be currently provided, or abruptly discharged. Sometimes this is an accurate assessment, and at others it can be because there is something within the patient and their system that is hard to connect positively with.

Some patients can go through an opposite type of pattern of giving up on the unit, and they then move towards **disengagement** and impulsive self-discharge from the inpatient service, without addressing something important, and their cycle of being **unheard** or o**verlooked**, or **alienated** may well continue and lead to subsequent multiple unsatisfactory admissions. There can also be a strong pull for them to be conscripted into joining a **subgroup (**anti-group, Nitsun 1996**)** of 'nothing to lose' (rebellious) patients who really do up the anti with the ward team. It can be hard for the nursing and multidisciplinary team to recognise or acknowledge their role in these patterns for many reasons, so any opportunity to reflect on this is extremely important.

Concluding remarks

As previously mentioned, retainment of nursing staff is often challenging within inpatient units, as compassion fatigue, primary and secondary trauma, and subsequent burnout can run high (Ray *et al,* 2013; Stamm, 2010; Foster, 2018). Naming the possible systemic enactments and entrapments that can feed into this, as well as the (often disturbing) aspects of the job can be really helpful in terms of staff finding a middle ground that they can more healthily inhabit for longer periods of time.

Ultimately, exploring this can help ward-based professionals achieve more compassion satisfaction within their work, and then make more conscious (less reactive) decisions about their careers.

The feedback itself seems to indicate that, with the support of consistent map and talk sessions, ward-based professional staff are developing increased recognition of the concept of being pushed or pulled into potentially unhelpful encounters, enactments and entrapments with patients, and their care systems and how potentially damaging reciprocations might be avoided.

Delivering staff supportive measures of value, which may contribute towards retainment and therefore consistency, without extra resources, can be extremely challenging – but it is needed and is appreciated, despite often relentless and overwhelming competing demands.

Overall, Map and Talk' enhances professional and personal understanding and is recognisable as an approach specific to CAT.

The last words – are left with the ward-based professionals engaging in this process:

> *'Mapping is very important to our kind of job. It helps to understand the patients better and also enhances staff awareness.'*

> *'To have a visual representation of what we are discussing, and seeing this mapped out as we go, assists me to break this down and see it much clearer [sic] in my mind. Having the space to discuss things and view other colleagues' ideas, to obtain a much more rounded way to approach a situation and/or patient is sometimes lost in the day-to-day running of the ward. But the session provides a good basis to do this and enables us to learn more from each other and take account of each other's strengths and weaknesses, which can sometimes impact on the ward.'* □

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Reviews

Psychotherapy research and CAT

- **The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work** (Second Edition) (2015) Bruce E. Wampold and Zac E. Imel London: Routledge (pps. 323) £38.99

- **Journal of Psychology and Psychotherapy, Theory, Research and Practice** Special issue **on** *Cognitive Analytic Therapy: Research Developments and Insights* **Vol. 94, (S1)**

Frank Margison

It is unusual to review a book that is already six years old – especially a second edition – but in discussion with the editors we agreed it is a book that focuses many of the current debates around research in psychotherapy. This review is in the context of a recent special journal issue dedicated to research in CAT. In February 2021 the *Journal of Psychology and Psychotherapy: Theory Research and Practice* published a special issue on *Cognitive Analytic Therapy: Research Developments and Insights,* edited by Peter Taylor and Samantha Hartley (2021).

This extended review goes beyond discussion of The Great Psychotherapy Debate and looks at developments within CAT research to develop the book's main themes.

The special issue also addresses some of the comments I made in an editorial article just over twenty years earlier (Margison, 2000) in the same journal (then called British Journal of Medical Psychology).

> 'A summary of the main literature on cognitive analytic therapy (CAT) is given. Ryle first developed CAT over 20 years ago and use of the model is increasingly widespread in diverse settings and with various conditions. CAT stands as an example of modern dialogical approaches to therapy, and

> the underlying theory is consistent with that stance. The developments within training stress self-reflexive practice and the maintenance of a collaborative approach. In contrast, however, to the rapid development in training and practice the research summarised here is primarily descriptive with a small number of open trials and one randomized controlled study in a physical disorder (Type I diabetes). The urgent need for randomized controlled research in this treatment is highlighted.' (p. 145)

In turn, that editorial was looking back a further twenty years to the period when CAT was first formulated (Ryle, 1980). Later in this review we can compare the views of the special issue editors to the comments above and look ahead to the options for the *next* twenty years.

The Great Psychotherapy Debate

The Great Psychotherapy Debate critiques the 'medical model' underlying psychotherapy research – a stance that might be welcomed by many CAT therapists. They suggest a 'contextual model' as an alternative, which, with its focus on the therapeutic relationship, may be much more congenial for many readers. But, even this contextual model still poses some important challenges for those interested in developing research in CAT as discussed later.

The Contextual Model sits at the centre of the debate between, on the one hand, proponents of evidence-based treatments (essentially the medical model under another name the authors argue) and, on the other, proponents of the so-called 'common factors' (key ingredients of successful psychotherapy that transcend tribal boundaries) (Wampold & Imel, 2015, p.viii).

> 'The current version of the Contextual Model explicates three pathways that purportedly explain the benefits of psychotherapy. The model is grounded in what is known about humans and human healing – that is, the model is grounded in the social sciences, broadly speaking. The basic premise of the model is that the benefits of psychotherapy accrue through social processes and that the relationship, broadly defined, is the bedrock of psychotherapy effectiveness (*op cit.* p.50) . . .
>
> 'Before the three pathways can be employed, the therapist and the client must form an initial bond. After the bond is formed, the therapist and patient create a 'real' relationship, the first pathway to client change. Through explanation and treatment actions, expectations about therapy are created, which in and of themselves create a second process of change.
>
> 'The third pathway involves change that is a result of carrying out treatment actions'. (*op cit*. p.53)

Although the book examines each component in some detail and provides a good vantage point for reviewing the state of psychotherapy, it is striking how difficult such a model is to disprove. Perhaps one point we can conclude from the book is that testable hypotheses that can refute a theory are very difficult to

formulate in psychotherapy research and that we should also consider research methods that improve practice. In dismantling the premises of the medical model, we can also see the limitations of a 'winner that takes all' approach and find space for looking at alternative ways of doing research.

Dismantling the Medical model

The authors address what they see as the main pillars of the medical model – diagnosis, evidence based medicine, and the randomised controlled trial [RCT].

The authors start with a section critiquing 'The Medical Model' more generally (*op cit.* p.8), but this section would be better described as a critique of the *disease concept* in medicine, especially when applied to mental health problems. They point out that traditionally, a disease entity has five key elements:

- An illness or disease can be delineated
- A biological explanation is proposed for the disease
- Associated physiological mechanisms of change are identified
- These changes lead logically to therapeutic procedures
- The procedures have a specificity in relation to which treatments work and why

The logic of these elements is attractive, but predictably most of medicine (rather than just psychiatry) fails to meet these idealised criteria.

The book in fact focuses mainly on the 'specificity' argument:

> 'In medicine, specificity is established in two primary ways. First, the treatment can be shown to be more effective than a placebo treatment, thus ruling out incidental causes related to the context of the treatment. . . The second means to establish specificity is to establish that the medical treatment operates through its intended mechanism.' (*op cit*. p.9)

They point out that 'ruling out incidental causes' in this context can be reformulated as 'throwing out the baby with the bathwater' as key aspects of therapy are neglected. For example, the placebo effect is not something that *interferes* with psychotherapy but actually *contains* important aspects of the change process.

Partly in response to criticisms about specificity, however, there was a new push towards medical treatments being selected by rigorous and systematic review of evidence designed to overcome underlying biases:

> 'Evidence-based practice is the integration of best research evidence with clinical expertise and patient values' (p. 147). This definition has been described as a 'three-legged stool,' in that the use of evidence (first leg) is to be balanced with the expertise of the clinician (second leg) and characteristics and context of the patient (third leg). Nevertheless, an examination of the seminal book on evidence-based medicine, *Evidence-*

based Medicine: How to Practice and Teach EBM (Sackett *et al*., 2000) reveals that the focus is on evidence related to the quality of diagnostic tests and effectiveness of treatments [rather than the desired three-legged approach].' (*op cit*. p.11).

The development of Practice Based Evidence [PBE] as a counterweight to Evidence Based Practice is described as a way of restoring balance (Barkham & Margison, 2007), by building evidence from the ground up. PBE has the advantage of being able to collect huge samples with participants who are more typical of the general population. The focus is on effectiveness [change occurring in ordinary practice] rather than efficacy [clients treated under heavily controlled research conditions]. Interesting as this approach is, it is essentially tangential to their main argument, which concerns a deeper level of medicalisation of psychotherapy (*op cit*. p27-28).

The book demonstrates the extreme medicalisation of psychotherapy research in the last half-century by exploring the primacy given to randomised controlled trials [RCTs] as the 'gold standard' (*op cit*. p 11) and the 'introduction of the placebo' condition (*op cit*. 13), where the so-called 'nuisance variables', may, of course be what matters most to an individual client:

> 'Although the use of placebo control groups in psychotherapy research is problematic, historically [they were] emblematic of psychotherapy's close connection with medicine. Psychotherapy was adopting models of research that were used by medicine to demonstrate the effects of medications, thereby conceptualizing psychotherapy as a medical treatment. This is a trend that has increased over the decades such that beginning in the 1980s psychotherapy began to label its outcome research as clinical trials as it sought to establish the viability of particular treatments for particular disorders'. (*op cit*. p.24)

The book gives an effective critique of the idealisation of the medical model of psychotherapy research, but to my mind understates the extent to which this ideology determines where almost all research funding goes. This way of allocating research funds has profound, if unintended consequences for our field: the closer a therapy can resemble the medical model the more likely research funding will be given. Invariably, a new therapy can be shown to be effective against a placebo or treatment as usual condition, so then the therapy calls itself evidence-based (or empirically-supported). In turn, this particular type of evidence determines the content of clinical guidelines as there is an established hierarchy of evidence with meta-analysis of large RCTs at the top. Moreover, the research that is funded usually focuses on tightly defined research diagnostic categories further reinforcing a single diagnosis as the norm rather than the common mixed clinical pictures seen in non-research practice. This generates a self-perpetuating cycle further consolidating the grip of the medical model.

> 'The *de facto* requirements of clinical trials advantage treatments that are

> readily manualised, time-limited, and focused on symptoms' (*op cit*. p 273).

Despite the inevitable limitations of the evidence base derived from these processes, however, we can note some important gains that have implications for our practice:

- A key medical research design – *the meta-analysis* – was driven, in fact, by a seminal early psychotherapy paper by Smith and Glass, (1977), who aggregated the results of studies that compared a psychotherapeutic approach to some type of comparison or control group (*op ci.t.* p.24). The positive finding was that psychotherapies have clinically relevant 'effect sizes', comparable in most cases to the effects of psychiatric medication. Indeed, more refined recent re-analyses show *better* overall results for psychotherapy than were described in the original paper, whereas critics had predicted the effect sizes would melt away with more rigorous analyses (*op cit*. pps. 91-92). So, we are reassured by the book that psychotherapy generally shows respectable 'effect sizes' when it is treated as a medical treatment, so we can hold our heads high, before going on to criticise the assumptions behind meta-analysis.
- Various research designs have been used to test whether it is the *techniques* that differentiate therapies which are responsible for positive therapeutic outcomes. In general, this book summarises the evidence that 'techniques' at this level of abstraction are only weak predictors at best. In any case in complex therapies, such as CAT, it is almost impossible to isolate one technique, as though it were a specific drug, and test its efficacy (using strategies like'dismantling' the therapy). So, the book encourages us to adopt a more holistic view of change in psychotherapy research with attention to aspects such as the therapeutic relationship as key to the change process.
- As an alternative to technique-defined therapies, there was a trend starting around thirty years ago to look at heuristics or 'clinical strategies' that are applicable across models of psychotherapy. For example, the two clinical strategies identified by Goldfried (1980) as generally common to all psychotherapeutic approaches are *providing corrective experiences and offering direct feedback*. (*op cit*. p.45). These approaches cross traditional therapeutic boundaries and provide a framework for eclectic practice within a generally relational framework. (See Society for Exploration of Psychotherapy Integration [SEPI] for fuller discussion (SEPI, 2021))
- Rather than focus on medically defined outcomes, Jerome Frank, who developed the idea of 'common therapeutic factors', called for a redefinition of what psychotherapy intends to do:

> 'The aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby

transforming the meanings of experiences to more favorable ones' (Frank and Frank, 1991, cited on p. 30).

- Despite the dominance of the 'medical model' there has been great interest in understanding these 'common factors' as can be seen, for example, in the way that therapies that are not primarily relational have incorporated strategies for maintaining a positive therapeutic bond (Castonguay, *et al*, 2010).

Adherence versus alliance

As part of the homogenisation of psychotherapy the authors comment on some of the problems associated with 'Psychotherapy Treatment Manuals' (*op cit*. p25), and other ways of reducing variability between different therapies purporting to deliver the same 'dose' of the same 'treatment'. One of the most interesting aspects of the book is in disentangling the very complex interplay between 'adherence' to a manual, therapeutic alliance, and outcome. For example,

> 'Barber *et al* (2006) found that when the alliance was high, adherence was irrelevant [to outcome], but when it was low, moderate levels of adherence were most effective.'

This book puts the interplay between therapist and client at the centre of the psychotherapy process. The authors suggest that the medical model would predict that *adherence* to a well-defined, empirically sound therapy is more important in predicting outcome than the *alliance*, and show that adherence in fact has a complex but relatively weak link with outcome, whereas alliance, however measured, seems to be reliably associated with outcome. However, the picture is more nuanced than that. When a client 'resists' treatment efforts (in alliance terms having low agreement about the goals and tasks of therapy) therapists often increase their attempts to adhere to the protocol as though persuading the client to comply. But, this is shown to be detrimental, suggesting that adherence needs to be in the Goldilocks zone – not *too much* adherence and equally not *too little*.

Comparatively little scrutiny is given to a similar 'Goldilocks zone' paradox concerning the alliance, however. Whichever school of therapy we may be from, it is important to recognise a breach or failure to develop the alliance, but it is equally important to spot an *over*-positive (idealising) alliance as this can also lead to decidedly poor outcomes and treatment failure (as noted in the psychodynamic literature for well over a hundred years) (Hall, 1995).

Adherence and Competence

Adherence and competence are components of the medical model that are used to interpret the results of clinical trials. Adherence measures the extent that therapists do *what* the model predicts they should do, whereas competence specifies that it is done *to an agreed standard.* The argument is that to draw any conclusions about the

effectiveness of a treatment, the therapy must first be delivered as specified in the protocol (adherent) as otherwise you are not actually testing what you say you are testing, and it must be delivered skilfully (competently). Together, these two aspects are referred to as the *integrity* (or fidelity) of the treatment, using tools like the CCAT (Parry *et al*, 2021)

> 'It is now virtually required that clinical trials of psychotherapy assess and report adherence and competence' (*op cit*. p.232).

This mainly focuses on the treatment being evaluated, but it is important that the comparison treatment is delivered as effectively as possible too. Comparing a well-supervised treatment where researchers, supervisors and therapists are enthusiastic (i.e show an 'allegiance bias') against so-called 'treatment as usual' [TAU] hardly makes for a fair comparison. Nevertheless, there are many published studies where TAU is hardly specified at all. So, it is important to minimise false positive results for new treatments by carefully supporting and nurturing treatment as usual, with agreed structure and supervision to allow a fair comparison. This is sometimes referred to as *Optimised* Treatment As Usual [OTAU], (e.g.Zipfel *et al*, 2014) but the ways in which standard treatment is quality-controlled must be specified.

Even when control conditions are optimised, there is an even more questionable assumption being made

> '. . . that adherence and competence are therapist characteristics. When Waltz *et al*. (1993) rigorously defined adherence and competence, they realized that the *context of therapy* – characteristics of the client and what was happening in therapy – were important: '*When clients like their therapist and improve substantially, it is easier for therapists to look competent'*. (Waltz *et al* 1993, p. 624 cited *op cit*. p. 236)

This problem is well recognised when assessing a therapist's competence in a teaching setting – and equally it is hard to look competent when a therapy is going badly (unless observable skills to address an alliance rupture are used skilfully), but when things are going well there is a 'halo effect' that is hard for an observer to discount. Hence, adherence and competence may also be a *consequence* of a good therapy rather just a cause.

For all its faults, assessment of treatment integrity must retain some utility, however, otherwise we end in a very strange world where words are not anchored to their common meanings:

> 'When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean – neither more nor less.'
>
> 'The question is,' said Alice, 'whether you can make words mean so many different things.'
>
> 'The question is,' said Humpty Dumpty, 'which is to be master – that's all.'
>
> Lewis Carroll:
> Through the Looking-Glass

Quality improvement

The implication from traditional 'Medical Model' outcome research is that to improve the outcomes of care we should disseminate evidence-based treatments into routine psychotherapy practice.

> 'According to this perspective, therapists are achieving relatively poor outcomes because they are not using faithfully evidence-based treatments, and if these therapists began to use such treatments, outcomes would improve'. (*op cit.* p268)

Wampold and Imel (2015) are right to be sceptical about this over-simple account: therapists are unlikely to engage as fully if they and the clients do not have some expectation that what they are discussing is helpful, and to force therapists to adopt a model that they feel is alien is likely to be counterproductive.

In contrast, the Contextual Model focuses more on the therapist actively engaging the client – so the focus should be on therapists choosing the appropriate approach for each client and using ongoing measurement of progress to optimise outcomes:

> 'According to the Contextual Model, a variety of different treatments will produce benefits as long as the treatments are given by effective therapists. . . [with] each therapist responsible for achieving commendable outcomes, regardless of the treatment they choose to use. This perspective leads to the use of 'practice-based evidence', which uses data about the progress of clients in practice to improve the quality of care (*op cit*. p.270 for fuller discussion and references).

Lambert and colleagues demonstrated that giving feedback about progress to a therapist *during the therapy* improved outcome as it helped the therapist to know when things were not going well and helped a therapist to engage in a discussion about when to end the therapy (Lambert, 2010).

Treatment Choice

The book concludes with some points to consider about treatment choice, commenting there is insufficient evidence to privilege one approach over any other. However, they still impose some exacting standards:

> 'therapists must deliver a treatment that is coherent, explanatory, and facilitates the patient's engagement in making desirable changes in their lives . . . [rather than] incoherent eclecticism. . . [Secondly], therapists are responsible for the outcomes achieved by their patients. Of course, some patients will have poorer prognoses than others, due to a number of factors outside of the control of the therapist, but overall therapists should achieve reasonable benchmarks for the types of patients being treated. . . [and thirdly] there should be]. . . a limit to the range of therapies that should be provided. . . which should have a reasonable and reasonably defensible psychological basis' (*op cit*. p.273)

This raises some important issues that are not fully explored in the book.

The authors do examine integrative therapies, firstly focused on integration between two distinct models (e.g., Wachtel,1997), and, secondly, on other integrative approaches derived from a common factors approach (e.g., Garfield, 1995), before moving on to their Contextual Model. However, they do not give full weight to the growing category of therapies that have inbuilt methods for integrating different approaches through structured reformulation in the initial stage of therapy, as is the case with CAT but also other formulation-based approaches.

Regarding supervision, the book raises some apparently troubling issues:

> 'To help the supervisee progress, the supervisor assesses the present skill level of the supervisee and compares that to the ideal or desired skill level, keeping in mind of course the developmental level of the trainee. Using the discrepancy between present and ideal skill level assumes that the supervisor's ideal skill level will result in better outcomes for clients than the current level. [However], we presented evidence that adherence and competence ratings were not [well] correlated with outcomes. This suggests that the supervisor's assessment of the competence of the supervisee may have little to do with the supervisee's actual effectiveness and much to do with the supervisor's own implicit model of competence. (p.276)

This raises important conceptual issues about the nature of psychotherapy supervision. Pedder cites Fleming in his description of supervision as 'jug, potter, or gardener' models: Is the supervisor's task to fill the jug of the supervisee's mind with knowledge; being a potter shaping the supervisee in the supervisor's idealised image; or a gardener cultivating and promoting the growth and maturity of the therapist? (Pedder, 1986, citing Fleming, 1967). I suspect most relational therapists will favour the gardener analogy but might also think that it is going too far to think we have *no* valid knowledge to impart. But, there is clearly a risk of a supervisor simply imposing their *'own implicit model of competence'*.

Having contrasted The Medical Model with The Contextual Model, and predictably favoured the latter, it is unfortunate that there is not more of an attempt to see how the two models can co-exist. I think the medical model, for all its failings, has focused on real concerns about what is effective, and how to make those treatments more widely available, and how we can faithfully describe commonalities between disparate presentations. But following that approach without being aware of the contextual factors would also be a serious disservice.

The book is both readable and broad in scope and I recommend it for beginners in research who need a good overview of the psychotherapy debate over the last forty years. For experienced researchers it is a salutary reminder of the enormous breadth of approaches that have already been taken to the questions why and how psychotherapy works.

How does CAT fit with the analysis of Wampold and Imel (2015)?

In this final section we can reflect where CAT research fits into the overall picture presented in *'The Great Psychotherapy Debate'* with particular attention to the CAT recent special issue.

Taylor and Hartley (2021, p. 1) comment in the 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.'

They address many of the key issues raised in 'The Great Psychotherapy Debate' commenting as below:

> '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' (Taylor & Hartley, 2021, p.1).

The special issue demonstrates that CAT research uses a wide range of methods, and this plurality enriches our field. Papers in the recent special issue are embracing psychotherapy research in all its diversity and often address issues of the client-therapist relationship.

The *client perspective* is central when Balmain and colleagues, (2021a) focus on a service user perspective using systematic review and a qualitative approach, and in a separate paper service user experience of CAT in complex secondary care is reviewed (Balmain *et al* 2021b).

There is also a *qualitative study* on mapping using the 'Torchlight' method (Jefferis, Fantarrow and Johnston, 2021). In contrast, other papers are *quantitative and outcome-focused*. There is a variant of *single case design* for borderline personality with an innovative twist: the response to the therapist withdrawal during the period where psychotherapy is not occurring is used to test a theory-specific outcome variable of resilience to separation (Kellett, Gausden and Gaskell, 2021). In addition, there is *pilot service evaluation* of a CAT-derived approach to self harm (Taylor *et al*, 2021).

CAT is now used in diverse contexts and settings, and examples here are an *exploration of group CAT* for anxiety and depression, (Martin *et al*, 2021), and a report on a new *hybrid approach* using CAT with a digital support tool (Easton *et al*, 2021). Just prior to the publication of the special issue the context of perinatal mental health problems was the subject of a pilot study (Hamilton *et al*, 2020) again showing that CAT is an acceptable and potentially effective approach in a wide range of contexts, and there is a

further recent *single mixed methods case study* on obsessive morbid jealousy (Kellett & Stockton, 2021), that demonstrates the usefulness of this approach as a way of developing a research base with modest funding.

Finally, when *adherence and competence* need to be assessed, whether in a teaching or a research context, there is a well-developed competence framework reported (see Parry *et al*, 2021). This examines the key issue that

> 'an adherent but incompetent CAT therapist could produce a narrative reformulation that was outside the patient's zone of proximal development, so rendering it meaningless to them',

and describes the elements that constitute competence as a CAT therapist. As discussed earlier, *The Great Psychotherapy Debate* suggests that adherence, competence and treatment integrity are outdated concepts, but for all the problems of reification of concepts having these measures available adds something of long-term value as treatments develop over time.

The Contextual Model approach shows a healthy approach to understanding the client perspective, resolving barriers to care, and developing CAT in a range of naturalistic settings. However, from the 'medical model' perspective there is an important meta-analysis by Hallam, Simmonds-Buckley, and colleagues (2021) that summarises the state of the art in *quantitative* research. They looked at the acceptability, effectiveness, and durability of change with CAT. They found twenty-eight relevant studies of reasonable quality of which 25 were analysed in the end. Just over a third of the 28 studies (10 [36%]) were *randomised control trials* .

The remaining eighteen (64%) looked at *change over time* but not in an RCT setting and where there was no comparison to another treatment. The latter point is technical but important as comparing the same individuals pre- and post-therapy gives much larger effect sizes than comparisons between one therapy and another or against a control (where the effect size can be conceptualised as the *additional* benefit derived from CAT). Nevertheless, the studies showed moderate to large effects sizes measured pre-post in global functioning, interpersonal problems, and depression and this is a small but important step in making a case for CAT as part of the funding of a larger RCT.

The studies showed that CAT is being offered to clients with complex problems, for example, long-standing and complex trauma, and most studies were in a public setting such as the NHS.

A fair summary of the state of play would be that there is still a clear focus on outcomes, using a variety of appropriate measures and respectable pre-post change demonstrated with CAT, but with relatively few RCTs being conducted. However, one of the main points from *The Great Psychotherapy Debate* was that we are at risk of idealising RCTs and need to keep a broad base of research methods

to support the Contextual Model.

However, the Contextual Model itself is not beyond criticism: it is no better than standard models in making refutable predictions; and at times there is a conceptual confusion. In criticising the use of adherence and competence measures the book overlooks the issue that one of the key competences in any relational therapy is to have the skills to repair a problematic therapeutic alliance, and to date there have not been large-scale research projects looking at the impact of recognising alliance breaches and repairing them on the eventual outcome.

When relational outcomes are individually agreed as relevant to a particular client the link between alliance and outcome may be mediated through specific skills in place in relational therapies (see for example Bennett *et al*, 2006 in CAT and Agnew *et al* (1994) in Psychodynamic Interpersonal therapy [PIT] on recognition and repair of alliance breaches.

Reflection

CAT research has a good range of strengths but some areas that are less strong, and one of the main 'weaknesses' is driven by structural factors in allocating research funding. There is no simple solution either through adopting the route of excessive preoccupation with RCTs, or by denying their importance, in the *realpolitik* of psychotherapy provision. CAT has so far managed to keep a questioning and at times critical conversation about our practice, and a varied research perspective is an important ingredient of that rich, dialectical dialogue.

So, rather than pose research questions as if 'winner takes all' we can look at establishing strength in diversity. We know that the main monoculture of CBT has absorbed ideas from many different approaches that started as distinct models (e.g., mentalisation, compassion-focused therapy, emotional regulation). So, rather than an existential threat we can take a broader view of developing psychotherapy as a sustainable culture within a complex ecosystem.

To gain large research grants researchers are pressured to move towards a unified way of doing CAT (in order to be replicable), and currently have to focus on diagnostically homogeneous groups (at the expense of real-life complexity). In doing so researchers risk becoming separate from practitioners. It is possible to negotiate through these two pressures, for example in the large scale RCT seen in the work of Chanen and colleagues (2021) in Melbourne, Australia, but in general it has proved difficult to develop large-scale outcome studies as fundable psychotherapy research becomes more narrowly defined.

It is hard to move from a simplistic diagnostic model where problems arise 'in the person's head' to a fully biopsychosocial model, open to change within a therapeutic relationship. Our

current research methods are not equipped to resolve questions at this level of clinical sophistication, even though case discussion and supervision can take in the whole picture.

The recent special issue shows that CAT research is certainly healthy in the sense of being methodologically diverse using pluralistic methods within manageable studies that can be conducted by small research groups. There are studies taking place outside major research centres and they ask questions that arise from the richness of everyday practice. The researchers are recognisably still clinicians and teachers, and the CAT being studied takes place in a wide range of settings, with a small number of larger scale RCTs complementing the range of approaches.

Earlier, we looked back twenty years to a placeholder editorial (Margison, 2000) commenting on the need for more systematic research. This in turn looked back a further twenty years to Anthony Ryle formulating the new CAT model as a way of integrating two apparently disparate approaches to psychotherapy. This position was summarised succinctly by Ryle and Kerr in a quote from *Introducing Cognitive Analytic Therapy* (Ryle & Kerr, 2020, p1):

> 'CAT evolved as an integration of cognitive, psychoanalytic and, more recently, Vygotskian and Bakhtinian ideas. It is characterized by a predominantly relational understanding of the origins of patients' problems. . . From the beginning it has emphasized genuine therapist-patient collaboration [offering] a respectful, whole-person, 'transdiagnostic' approach. . . The model arose from a continuing commitment to research into effective therapies and therapy integration, and from a concern with offering appropriate, time-limited treatment in the public sector.'

The special issue on CAT demonstrates that CAT researchers are still consistent with those values. In some ways CAT researchers have tried to adopt a transdiagnostic approach, less wedded to systems such as ICD and DSM. Moreover, the Wampold book takes each piece of research as frozen in time at the point of publication, for understandable reasons. But, 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. Or, we might see further amalgamation of models along more generic lines with all the relational therapies working from a shared set of values to sustain a larger research programme. If we look at the history of psychotherapy, there are strong forces keeping us within tribal boundaries, and even splitting us into smaller subgroups. But reviewing this book is a good reminder that CAT is one of a range of relational therapies drawing on expertise across psychodynamic, cognitive-behavioural, and procedural approaches enriched by a growing research base. It is here that the Contextual Model has its main strength – in providing a point on the way to developing 'a genuinely multidimensional and integrative biospsychosocial approach' for relational therapies (Kerr, personal communication). □

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Charting the Territory of Trauma

●**The Reckoning** Mary Trump (2021) New York: St Martin's Press

Steve Potter

Mary Trump's book *The Reckoning* details her analysis of the cruel psychology of her uncle in combination with the traumatising and divisive ideologies of racism, sexism, white exceptionalism and rugged individualism that lie unresolved among the founding narratives of the United States.

The Reckoning came out in May 2021; President Biden had just served his first 100 days and the second impeachment trial of ex-president Trump had floundered in the Senate. Previously Mary Trump has written one book *Too Much and Never Enough* about her uncle halfway through his presidency. Its subtitle: '*How My Family Created the World's Most Dangerous Man'* is further evidenced in the opening paragraph of her new book:

> 'The insurrection on January 6th, 2021, shouldn't have come as a surprise – my uncle Donald had been sowing the seeds of discontent for two months and promoting division and grievance for four years. It was a watershed moment – deliberate, planned, incited, yet another assault aimed squarely at everything I had always thought this country stood for. America is a deeply imperfect

country – a country that has never actually been democracy for all of its people, just for a privileged majority – but it always had the potential to become that hoped-for, more perfect union.'

The subtitle to *The Reckoning* reads *America's trauma and finding a way to heal.*

In CAT terms it offers a reformulation that looks inward and outward at the same time offering a personal and social perspective. Mary Trump is well placed to do this as a clinical psychologist and as a specialist in trauma work. Her starting point is her own trauma. She checked into a PTSD clinic shortly after her uncle was elected. In processing past and present personal wounds arising from her family across several generations, she extends her healing narrative to facing the trauma built into the deep structure of American society.

> '. . . this book couldn't simply address the trauma caused by the intersecting crises caused by COVID; it also had to address the trauma caused by the political crisis that exposed the long-standing fragility of our democracy.'

Mary Trump speaks clearly as she sees it. 'We are a traumatised society.' Cruelty is cruelty: for example, in separating refugee children from their parents. Fascism is fascism: the collusion with her uncle by the Republican Party is a courting of fascism. The cruelty incites violence and division.

> 'For four years the performative cruelty of the Trump administration and its message that we need to be tough and vindictive and punitive wore away at the fabric of our society We were pitted against one another and forced to choose sides.' p166

She links his political indifference to the tragedy of COVID to the family ideology.

> 'On August 3, 2020, a day before the United States surpassed 150,000 deaths from COVID Donald's interview with Axios reporter Jonathan Swan aired on HBO. "It is what it is," he said after Swan pointed out that 1000 Americans are dying a day. That was a popular expression in my family, and hearing it sent a chill through my body.' p81

Mary Trump berates her uncle for denigration of good authority, science and expertise and government and painfully notes it in a personal way when seeing her uncle triumphantly pulling the mask away from his face on returning to the White House from his hospital treatment for COVID.

> 'He clenched his teeth and jutted out his jaw, just as my grandmother did when she was biting back anger or clamping down on her pain. In Donald, I saw the latter.'

There are some startling and painful statistics and a call for healing the trauma in part through the payment of reparation to the descendants of those traumatised.

> 'By the time slavery was abolished in 1865 the numbers of people living in bondage in the United States had grown to four million. Every generation since has been shut out of the economic and educational benefits that were regularly bestowed on whites. There is no way to

> compensate for the loss of life or the destroyed potential or the fallout from the resulting trauma, but reparations will, as far as possible, return what has been stolen.'

Mary Trump links the cruelty of her uncle across a common narrative of contemptuous treatment of women, cruelty towards refugees, aligning with white supremacists, attacking climate change awareness and science and common sense in relation to COVID.

She gives a coherent account of how racism works to draw in the poor white migrant populations into an identification with the American dream. Mary Trump generously acknowledges her sources and those who have helped with the book. Anyone who wants to look America in the cold eye of its crisis through a personal and insider account will find the book a challenging but informative read.

What might we take from the book from the perspective of a relational view of mental health? That therapists need to also be historians and step outside of nationalism and be as careful in reformulating the workings of the society around them as they would be with the complex needs of a client. Whereas we have a language for not getting entangled in our own transference dynamics with the client, it is a different challenge to not be entangled with the society that partitions, positions and genders us with privileges in some cases and abuses and harm in other cases. I read Mary Trump's book at the same time as reading *Active Hope: how to face the mess we're in without going crazy* by Joanna Macy and Chris Johnstone. It was a book recommended by members of the ICATA climate crisis special interest group www.internationalcat/events and whilst it was written before the Trump era, it is equally part of a call to change the agenda. As Mary Trump stresses her uncle is only the symptom or presenting problem of a deeper structural crisis.

The focus of *Active Hope* is on a broad and activist relational awareness of the climate crisis and how changes comes from within us as well as around us joining together and doing things. Where Mary Trump looks the social structure and internalisation of trauma in the eye there is less on the pathways to change which is at the heart of the *Active Hope* book.

> 'We will have moments when the penny really drops that our world is in grave danger. When facing a challenge far beyond what we might normally think ourselves capable of dealing with, we need to move beyond the familiar and learn the art of seeing with new eyes. The next section of this book introduces four empowering shifts in perception. We like to think of these as the four discoveries: a wider sense of self, a different kind of power, a richer experience of community and larger view of time.'

What both books do is seek common cause to change the conversation, or rather initiate a thousand conversations about change.

Can CAT help? Can its capacity to use maps to hold in mind the complexity of

an individual client's attempts to change the conversations about themselves and re-work deeply embedded narratives be used to examine the societal narratives that oppress or free us? Well yes, we have more chance of being able to chart the push and pull of the political in the personal with a map making conversation than without one. Mary Trump says as much about her time at the trauma clinic in the Arizona desert.

> 'So, in the desert, I attempted to chart the territory of my trauma; I was a shoddy cartographer, and often lost my way, forced to detour by my desperate need to avoid the very thing that would help me get home – but facing the trauma was the only way to deal with it, so during the weeks in the desert, that is what I did.' □

Steve Potter is a CAT Psychotherapist, East London

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Recent published and forthcoming books on CAT

Potter, S. (2020)
Therapy with a Map:
a cognitive analytic approach to helping relationships
https://www.pavpub.com/mental-health/therapy-with-a-map

An overview of CAT therapy from the point of an active, relational, and conversational approach using the tools and methods of CAT co-creatively with the client

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

https://www.pavpub.com/mental-health/reflective-practice-in-forensic-settings

A collection of practitioners accounts of using CAT methods to develop reflective practice and teamwork in Forensic setting but with applications more widely

Brummer, L. Cavieres, M. Tan, R. (editors) (2022)
The Handbook of CAT Theory and Practice OUP

A multi-author compendium of the developments in and applications of Cognitive Analytic Therapy

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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.

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