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CAT

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This first issue is dedicated
to the memory of Tony Ryle (1927-2016)
creator of Cognitive Analytic Therapy.

Foreword

I very much welcome this new international journal which seems to me timely and appropriate. It is a source of great pleasure to have seen the gradual spread of CAT and its increasing acceptance around the world not only as a model of therapy but also increasingly, it seems, as an approach to more organisational and even social problems, of which there are many. This development has seemed to reflect in many ways the early origins of the model in concerns for individual patients in a general practice setting, as well as in their social context. My own work has also reflected, and been inspired by, the clinical work of my father stressing detailed observation, and evaluation of the treatment, of individual patients, along with my own life-long political passions, frustrated for the most part as they have been. It is heartening therefore to see such a range of contributions embodying this range of interest and concern. It is hard not to be depressed and maddened by the apparent trajectory of humankind despite our collective best efforts. Perhaps the energy and commendable commitment of those now using and developing the model, and relational approaches in general, may serve to address and challenge this pessimism and to offer some clinical and political hope for the future. I wish it well.

Tony Ryle
August 2016

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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 Hong Kong and United Kingdom. We look forward to more countries joining in.

What does ICATA aim to do?
Develop knowledge and use of Cognitive Analytic Therapy internationally. Support training and supervision internationally. Oversee national accreditation programmes and procedures.

Where has CAT developed?
Cognitive Analytic Therapy is most established in the UK where it has developed from the work of Dr Anthony Ryle and colleagues since the 1980's supported by the work of the Association for Cognitive Analytic Therapy. There are 900 members of ACAT. Follow this link to find out more www.acat.me.uk In Finland CAT has also developed very strongly over the past twenty years through the leadership of Professor Mikael Leiman and now through the FINCAT association (web www.fincat.net) which has a membership of 200. CAT has also developed over many years in Greece, Ireland, Spain and Australia.

Who are the members of ICATA?
There is an executive made up of two delegates from each member country with established or newly developing training programmes in CAT. The executive have bi-montly meetings by telephone conference and meet annual for an executive meeting. Every two years there has been a conference beginning in Krakow in Poland in 2011, Malaga in Spain in 2013 and Patras in Greece in 2015. Each conference has been co-hosted the national association and ICATA. The next international conference will be in Nottingham in the UK in September 2017.

CAT around the world

What's on

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Legacy of Tony Ryle – one day celebration
10th March 2017 in London

The Association for Cognitive Analytic Therapy would like to invite you to join us at a one day conference in memory of Tony Ryle, and to celebrate his contribution of Cognitive Analytic Therapy. A variety of speakers and contributions. For booking and more information go to.

http://internationalcat.org/legacy-tony-ryle-one-day-celebration/

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7th International CAT Conference
20th to 23rd September 2017in Nottingham UK

A warm welcome to those interested in CAT and relational mental health from other countries.
'New Frontiers in CAT Understanding and Practice'
hosted by ACAT and ICATA.

For booking details and more information go to

http://internationalcat.org/7th-international-cat-conference/

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Editorial

STEVE POTTER
IAN KERR
KATRI KANNINEN

IT IS WITH GREAT PLEASURE that we offer this first issue of the new *International Journal of Cognitive Analytic Therapy and Relational Mental Health.* The journal has taken a while to develop but represents the shared view among the representatives of the International CAT Association (ICATA) that its creation is needed. The journal offers a platform for the growing body of work emerging from the CAT model and relational and integrative approaches more broadly. These come from many different theoretical and clinical contexts as well as different countries and cultures. The newsletters and journals of national associations have been doing a valuable job in publishing excellent material but it was felt that there was a need now for a formal, peer-reviewed journal to carry more of this interesting work.

The perhaps rather lengthy title of the journal reflects a further view that, although it has emerged from ICATA and its interests and activities, it will be important to maintain a wider perspective and dialogue with others and to promote further research in the field of 'relational mental health' more broadly. This echoes the historic aim of CAT to be integrative and to be in dialogue with other relevant disciplines.

We hope this relational and integrative focus is reflected in the encouraging array of diverse contributions in this first issue. These include detailed studies of individual cases with common symptoms such as encopresis (Bernardy-Arbuz) or using formal approaches such as Leiman's dialogical sequence analysis (Gersh et al), through to more systemic applications to developing a culture of reflective and relational practice such as forensic mental health services (Kemp, Bickerdike and Bingham) and social settings such as schools (Bonfield and Crothers) or in work with refugees (Melville and O'Brien). The contrast between using CAT as a relational framework for work with young people

(Barnes) and CAT with older adults (Williams and Craven Staines) indicate the range of CAT practice across the lifespan.

We are pleased and fortunate indeed that this first issue is launched by a weighty and masterful review by Colwyn Trevarthen of the field of infant psychology and its intersubjective and relational underpinnings. He takes us through the radical changes that have occurred within the field over the past few decades. He then considers the implications of these developments for concepts of mental health and well-being and for therapy. Colwyn Trevarthen has been one of the leading and innovative figures in this field for many years and we are privileged that he has taken the time to contribute this piece.

A common thread in all these pieces is a relational conceptualisation of individual and systemic mental health problems.

A common thread in all these pieces is a relational conceptualisation of individual and systemic mental health problems, its implications for more 'joined-up' ways of working, and for treatment provision.

The journal also includes book reviews over a broad range of relevant literature. We welcome correspondence on matters arising, and intimations of forthcoming events internationally. We also welcome suggestions for future commissioned pieces or special issues. We are currently aiming to dedicate part of the next issue to the concept of psychological 'trauma', broadly conceived, within a relational context.

The focus of this journal could be seen to be at odds with much of the dominant individually-focused, cognitive-behavioural or biomedical approaches to mental health in the Western world at present. We consider that it is therefore even more important to offer a platform for relationally-informed work that is scientifically-based as well as humanitarian in its ethos.

All of this very much reflects the aspirations of Tony Ryle, the founder of CAT. Sadly, as we go to press, we have learned of his death at the ripe old age of 89 years. His death will be a considerable absence in many ways to us all. Obituaries have already been published elsewhere and a memorial event to celebrate his work is taking place in London in March 2017. We wish to note here the extraordinary scientific and humanitarian achievement

embodied in Tony's life's work, culminating in the creation of the CAT model. This continues to develop and to be applied by others in many various ways and settings, and in the light of emerging findings in a range of fields as diverse as neurobiology, developmental psychology and sociology.

This is very much in the spirit of the model and what Tony wished to occur. It reflects also the aspiration of this new journal. We are very fortunate that we managed to solicit a brief foreword for the journal from Tony a few months before his death. He did express considerable pleasure and pride in the growth of CAT through the work of various colleagues, and the establishment of this journal, despite his frustration and anguish at the very evident human conflict and suffering still going on the world, and at our apparent inability to do anything more effective about it.

The focus of this journal could be seen to be at odds with much of the dominant individually-focused, cognitive-behavioural or biomedical approaches to mental health in the Western world at present.

We hope that the broader CAT and relational approach of this journal offers a source of inspiration for a more kindly, optimistic yet realistic vision of individual and, inextricably, collective human life as well as of psychological disorder.

We are committed to a journal that is scientifically rigorous and peer-reviewed, but also one that is in the spirit of the CAT approach. Whilst a minimum charge will be made for print copies in the first instance to cover costs, the journal will then be open-access and 'copy-left' with regard to authors' rights. Science depends upon a collaboration among communities of practioners, across national borders, languages and cultures.

We hope the journal will be as creative and collaborative as possible in terms of style and content. And we hope our readers will enjoy and benefit from the various pieces included here and look forward to receiving further contributions in the coming years from colleagues both within the CAT communities internationally, and beyond. □

March 2017

The Affectionate, Intersubjective Intelligence of the Infant and Its Innate Motives for Relational Mental Health

COLWYN TREVARTHEN

Abstract
Radical changes in developmental psychology in recent decades have important implications for the theory of mental health and the practice of psychotherapy. In particular, the fundamentally relational basis of the well-being and development of infants has been made clear. We are not born to thrive either as self-satisfied individuals, or only dependent on maternal holding, protection and feeding.

The change of understanding has come from careful observational and experimental studies of real (as opposed to speculative) infant consciousness, and its intimate and creative engagement with affectionate and playful parent-companions. Modern televisual and audio recording has aided discoveries made by analysis of spontaneous dialogues and games. The impetus for this body of work, for which a considerable prehistory may be traced, was led some fifty years ago by three inspiring practitioners – Jerome Bruner in education, T. Berry Brazelton in paediatrics, and Daniel Stern in child psychiatry – who believed that the motives, curiosity and emotions of infants with trusted companions had not been perceived correctly. Their new science describes infants as persons who, from birth, and indeed before birth, are inherently social, interactive, playful, collaborative and meaning-making in human ways, the motives of which are recently described in terms of a fundamental 'communicative musicality'. The newborn child displays a need for the rhythms and tones of an innate 'intersubjectivity', a term abstracted from the phenomenological philosophy of Edmund Husserl.

Although initially controversial, this view of the extraordinary human ability of an infant is becoming widely accepted as the essential foundation for cultural intelligence, and its neuro-biological underpinnings are currently being mapped out. This capacity includes a life-long need for a human person to

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experience a proper, healthy enthusiasm and sense of 'pride' in the company of appreciative others. Healthy, mutually-engaged social involvement with others, recollected as each person's life story, constitutes the growth, development and learning of a relationally constituted self, or personality (Trevarthen and Delafield-Butt, 2015). Deprivation or adversity in relations and transactions with others may lead to serious psycho-developmental distress and damage to the life spirit, and thus loss of enjoyable and productive participation in society.

Misleading preconceptions lead to belief that infants are prone to be anxious or destructive as helpless organisms instinctively seeking intimate physiologic contact with their mothers for her care. They are believed to begin life as asocial and individualistic creatures that wait to grow and learn how to behave in social relations, a 'training' that requires 'conditioning' of reflex reactions by elders. Failure to recognise the inborn powers of affectionate communication and playful collaboration stands in the way of clinical understanding and care of troubled human intentions and feeings which need affirmation in companionship. An understanding that accepts the social genius of the infant has major implications for a richer appreciation of the relational basis of mental health and for the effective practice of psychotherapy.

Especially in Western cultures, there remains, it must be said, a curious paradigmatic resistance in much of the medical profession, in psychology and in education, predicated on mechanistic and individualistic neuro-cognitive or biomedical paradigms, to these changes, which inhibits scientific understanding of the foundation for human well-being. We need to comprehend, and correct, the justifications for this resistance.

IN THE LAST FIFTY years there has been a change in the scientific appreciation of innate human motives and feelings, and the forms of consciousness and memory they generate and regulate in sensations of body movement. We can no longer accept the theory of the newborn is an unconscious and unsocial 'Id' able only to give physiological or organic reactions to beneficial or harmful stimulations. The baby has a human mind seeking to learn how to live with meaning that is shared (Trevarthen and Delafield-Butt, 2015).

Change of understanding has grown by studying the efforts that infants make to share feelings and invent meaning with loving parents (Trevarthen, 1979, 1980, 2015a; Stern, 1985/2000; Bråten, 1998), and how acts of imagination of young children are developed in fun with a growing circle of playmates of all ages (Chukovsky, 1968; Bjørkvold, 1992). The

evidence has proved that our awareness of the world and of its cultural interpretation does not begin as a cognitive learning of facts about an impersonal reality by an individual thinker. Nor that it starts with instruction in how to articulate purposes and experiences in words.

The human primate is born with unique powers for sensing the intentions and feelings in other individuals' purposeful and inquisitive movements, and for elaborating stories with them. We are innately cultural. In affective engagements of interests between adults and children as they participate in stories and games, ideas are passed on from previous generations, and precious beliefs and rituals are recognized. The self-confidence and happiness of every adult and child with their family and in their habitual community depends upon this history of consciousness with feelings in intimate and trusted relationships that a child is seeking from birth.

There were earlier explorations of this life-story-making in good company. The convivial awareness of the infant mind had been appreciated in the eighteenth century, by Dietrich Tiedemann, and by Hutcheson, Hume, Smith and Reid in Scotland; and in the nineteenth century by Charles Darwin and James Mark Baldwin. But scientific confirmation of the importance of innate intersubjective awareness for a healthy lifetime came from developments in the use of film and television in the mid twentieth century. These tools enabled us to measure details of the rhythms and qualities of spontaneous performances and narratives of infants in recordings of play with attentive adults who love and admire them.

The New Inter-Disciplinary Approach to Meaning

The findings demanded a different kind of 'cultural social psychology', developed by Jerome Bruner from the 1950s to oppose the mechanistic learning theory of behaviourism. Bruner underlined the innate capacities of the child for sharing intentional life with emotions to create a personal narrative, and to take part in education for an interpersonal cultural world (Bruner and Goodman, 1947; see Bruner, 2003, chapter 3, 'The Narrative Creation of the Self'). The anthropologist Clifford Geertz likewise transformed thinking about the symbolic forms that humans invent to create and sustain the community life of their culture, and to define 'public meaning' in that culture (Geerts, 1973).

Bruner devoted his long life to comprehension of the acquired cleverness of a 'person-in-relations', a being who has acquired command

of language. He did not directly study the innate 'self-as agent' of a baby who is seeking recognition of his or her purposes in the affectionate companionship of innocent play, without words, from birth. I am using the titles of two influential books by the Scottish Professor of Moral Philosophy John Macmurray (1959, 1961). The developmental psychologist Margaret Donaldson, who was inspired by Bruner's work, made a comparable distinction in her studies of early childhood consciousness and its learning in communication (Donaldson, 1978). A pre-cultural or pan-cultural 'human sense' of life in affectionate relations of infancy is expanded in the playful preschool stage to become the foundation for all that is acquired of the 'common sense' of knowledge that sustains a particular culture. Donaldson applied her findings to develop a theory of the natural 'modes of the human mind', and how they grow to master and transcend immediate practical demands (Donaldson, 1992). Anthropologist Victor Turner (1982), like Geertz who wrote about 'deep play', celebrated the innate source of creativity with research on theatrical rituals, which he called 'the human seriousness of play'.

A Sociopsychobiological Account of the Early Development of Human Consciousness

Around 1970 three independent research projects gained evidence from micro-analysis of film of intuitive abilities that young infants use to share life in creative face-to-face play with their mothers (reviewed by Trevarthen and Panksepp, 2016; Trevarthen and Delafield-Butt, 2016, in press).

An anthropologist and linguist Mary Catherine Bateson, who had studied universal gestural principles of human 'kinesics' or 'body language' described by the anthropologist Ray Birdwhistell (1970) as the origin and support for all spoken languages, worked with Margaret Bullowa in the Speech and Communication Group at the Massachusetts Institute of Technology to trace the early development of language (Bullowa, 1979). Bateson, shortly before the birth of her daughter, made the following detailed description of films of an infant 7 to 14 weeks of age in spontaneous interactions with the mother:

> '. . . the mother and infant were collaborating in a pattern of more or less alternating, non-overlapping vocalization, the mother speaking brief sentences and the infant responding with coos and murmurs, together producing a brief joint performance similar to conversation, which I called 'proto conversation'. . . These interactions were characterized by a sort of delighted, ritualized courtesy and more or less sustained attention and mutual gaze.

> Many of the vocalizations were of types not described in the acoustic literature on infancy, since they were very brief and faint, and yet were crucial parts of the jointly sustained performances.' (Bateson, 1979, p. 65).

Bateson was convinced that the infant was sharing ideas with a subtle grammar of movements without symbols, and that this is the motivation for learning language and for developing self-confidence in an oral or literate culture.

In New York, Daniel Stern a young psychiatrist studying psychoanalysis, who was also inspired by Birdwhistell's 'kinesics', found that three-and-a-half-month-old twins were not just responding to directives but actively directing their mother in exchanges of mutual attention by precisely timed engagement of expressive movements (Stern, 1971). This interest in the life of mother-infant communication (Stern, 2002) led Stern away from conventional ideas of child psychiatry to path-finding studies of *The Interpersonal World of the Infant* (Stern, 1985/2000), and to elucidation of the dynamic principles of 'affect attunements' (Stern et al., 1985) and *Forms of Vitality* in body movement (Stern, 2010).

In 1968 Bruner made a comprehensive review of new evidence on the origins of infant intelligence and learning, and he redirected the work of the Centre for Cognitive Studies at Harvard in a project called *Processes of Cognitive Growth: Infancy*, taking inspiration from ethological work on the cleverness of non-human primates (Bruner, 1968). With the support of the pediatrician T. Berry Brazelton, he set up a richly equipped research facility for the use of a variety of recording devices and high-speed film to observe motor patterns and selective attention in young infants.

As Dr. T. Berry Brazelton demonstrated to parents in sensitive encounters with the baby immediately after birth, a newborn is not, 'helpless and ready to be shaped by his environment' (Brazelton, 1979, p. 79). Rather he or she makes delicately organized actions as a person with a 'state of consciousness', and can be immediately responsive to corresponding actions expressive of impulses and feelings in another person's consciousness in movement. With this approach Brazelton revolutionized pediatric care of infants, and established principles for support for all ages through periods of developmental change, which he called 'touchpoints' for responsive care (Brazelton, 1993). We are born to take part with companions in intentional movements that we care about. Advanced science of animal brains confirms they build consciousness out of 'affective phenomenal experiences' mediated by 'sub-

neocortical networks of emotions and other primal affects' (Solms and Panksepp, 2012, p. 147). The human brain inherits this resource as the spirit for life in a meaningful culture.

With Brazelton's advice, and with Martin Richards, a zoologist interested in maternal behaviour of mammals, I set up a private film studio in Bruner's Centre to record natural spontaneous communication between two- to three-months-old infants and their mothers, and to observe actions that the infants directed to objects. I used high resolution film techniques developed to observe intelligent manipulation of objects by baboons, to track the earliest consciously directed behaviours of humans. With a single camera, the behaviours of the infant were observed from directly in front, and the mother's behaviours were recorded from a large front-surface mirror placed beside the infant. Four important observations were made by frame-by-frame microanalysis of infants' movements in free activity with the mothers, or in response to objects they found interesting (Trevarthen, 1974, 1977, 1979): (1) In the first month the movements of the newborn were delicately coordinated to move many parts of the limbs, face, head and eyes to direct actions of selective attention to nearby objects; (2) The movements showed the same rhythmic patterns as similar actions of adults to explore experiences; (3) Movements two- to three-month-olds made with visual attention to perceive objects were different from those directed to have a dialogue with the mother. The latter included face expressions of emotion, 'pre-speech' movements of the lips with demonstrative gestures of the hands, and selective eye movements aimed to see expressions of the mother's eyes and mouth; Finally, (4), in proto-conversations at this age the infants were usually leading, with the mother mirroring or shadowing the infant's expressions and their manner or tone.

All these findings were evidence of prenatal development of adaptive intentional imagination of a moving Self who is guided by subjective consciousness of surroundings, and who felt special interest in inter-subjective engagement with the movements of another person (Trevarthen 2015a). I described this early form of perceptuo-motor intelligence with its special adaptation for communication and co-participation interests and feelings as 'primary intersubjectivity' (Trevarthen, 1979).

Richards and I called the different actions of the infants 'doing' with things, and 'communicating' with a person. In dialogues that were supported by the mother's expressions of affectionate interest the babies took the initiative. For most of their 'conversations' the mothers were

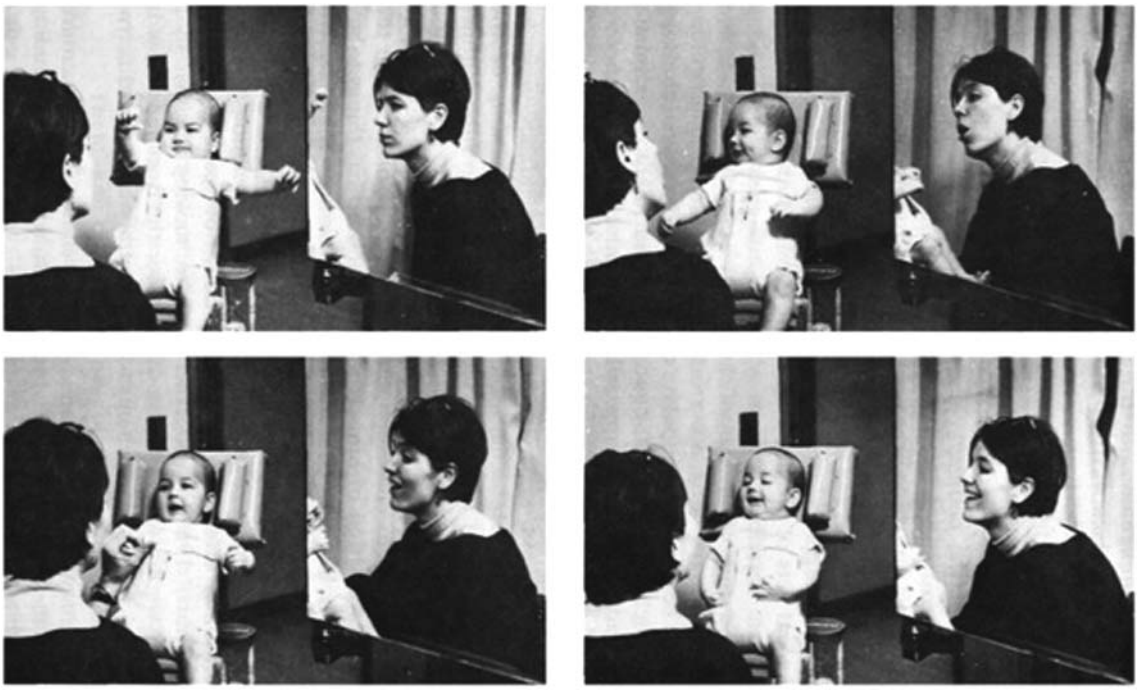


Figure 1:

'Photographic samples show how a mother may adopt postures and expressions to closely mirror what her baby does. The intense mutuality or harmony of the behaviour comes initially from the infant responding to the mother's friendly behaviour in kind. Then the development is principally due to the mother accepting the expressions of the infant as models for her expression, or, rather, as indicative of an emotion which she may both share with her infant and express in like manner.' (Trevarthen, 1977, p. 241).

From a film made at the Centre for Cognitive Studies, Harvard, in 1968. The infant is three months old. These pictures were first published in Trevarthen, 1974

imitating the infant's expressions of vitality and their emotions of pleasure, displeasure, interest or disinterest. Rarely did the infant imitate the mother. (Figure 1)

None of the three above studies used psychological testing according to an experimental protocol. All relied on detailed recordings that were studied later to measure their rhythms, serial ordering and intentional or affective forms and targets.

In his summary of the work at Harvard, Bruner emphasized that,

> 'As the joint efforts within the Center have turned more toward infancy, there has occurred a gradual change toward the viewpoint of a naturalist exploring a new species, and away from an exclusive emphasis on the testing of specific hypotheses derived from a general theory of infant development. The objective of the research is much as it has been in the past: to elucidate the processes by which human beings achieve, retain, transform and communicate information.' (Bruner, 1968, p. ii).

In that project, and in further work with young infants I made in Edinburgh, both the subjective self-regulations of the infant, and the inter-subjective patterns that sustained the 'dialogues of movement' were recorded in photographs and drawings traced from films. They supported the theory that the young infant has strong abilities for sharing intentions and feelings of an intimate intersubjective awareness with a responsive adult, using special actions of hand gesture, facial expression and movements of tongue and lips that had meaning for a partner. I identified these as preparation for speech.

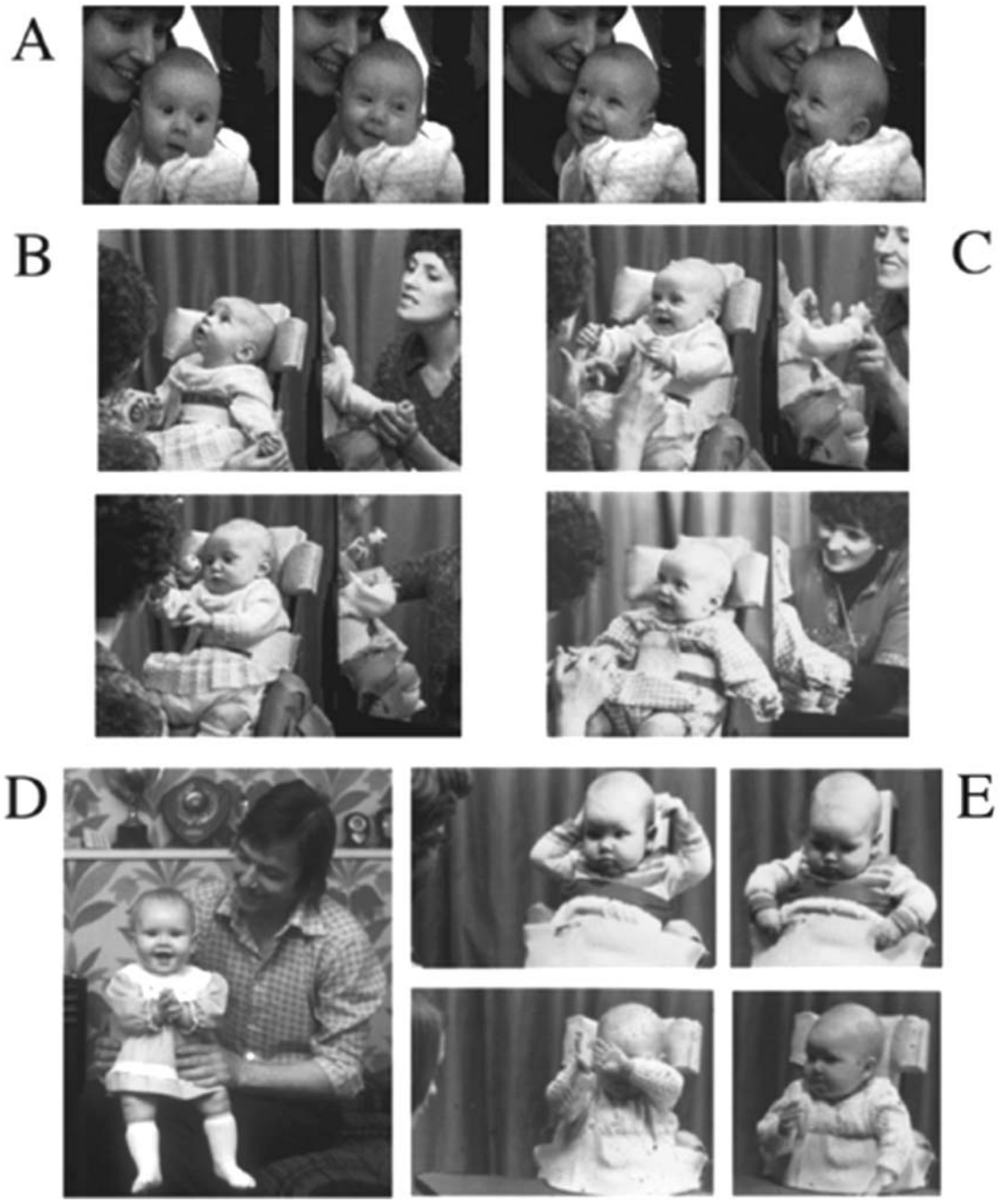
> 'We have found activity which is best called 'prespeech' because both the context in which it occurs and its form indicate that it is a rudimentary form of speaking by movements of lips and tongue. These distinctive movements are often made by young infants soundlessly. At other times young babies are very vocal, making a variety of cooing sounds as they move mouth and tongue. We note a specific pattern of breathing with prespeech even when sounds are not made.' (Trevarthen, 1975, p. 66).

Figure 2: After 3 months infants' bodies become stronger and their second person consciousness is more complex.

A. An 11-week-old shows a classic 'coy' reaction when her mother holds her up to a mirror (Reddy, 2008). (Reproduced with permission of Vasudevi Reddy)

B. A four-month-old infant is curious about the room and concentrates her attention on an object presented by her mother.

C. When her mother starts a rhythmic body game, the baby is both interested and pleased. At five months she is ready to participate in a 'ritual' action game, 'Round and round the garden', a rhyming four line stanza with a lively iambic pulse. The infant has learned the song and vocalizes at the end in synchrony with the mother and matching her pitch.



D. A six-month-old sitting on her father's knee smiles with pride as she responds to her mother's request to show 'Clappa-clappa-handies'.

E. The same six-month-old shows her uneasiness and withdrawal in front of two strangers, a man and a woman, who attempt to communicate in friendly but unfamiliar ways. The infant appears to experience shame as well as distress.

These expressive movements of face and hands, special to humans, are now being observed in 4-dimensional ultra-sound moves of foetuses inside the mother's body (Reissland and Kisilevsky, 2015).

With an intense interest in the arts, especially dance and choreography, and after forty years' experience expanding his awareness of the innate capacities of infants and their mothers for being in affective connection, Daniel Stern, in his last book, *Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy and Development* (Stern, 2010), defined a science of 'vitality dynamics'. With information that relates the new research on movements of foetuses, and that on actions of infants and their mothers, to the principles studied by performing artists, Stern's concept of life in movement enriches our understanding of the nature of well-being and learning for human beings of all ages and of the appreciation of music as natural communication.

All our arts and sciences, our literature, and the projects of technology, grow in communication which is dependent on the expressive impulses of infancy: the *pulse*, *quality* and *narrative* of gestural and vocal story-making in good, responsive, affectionate, sympathetic, and playful company. The stories we share educate the special human capacities for manipulating objects with skill, using delicate touch, sight and hearing to confirm the impulses of the body to make and value new things.

Internally Motivated Maturation of Infant Social Intelligence

Work that has traced the development of the intelligence and communication through the first year established age-related changes 'growing' in the child, which affected their interests in both objects and persons, and coordinated these two (Trevarthen and Aitken, 2003). As an infant gains in perceptuo-motor abilities, especially the rapid development of high acuity visual awareness in the first 6 months, there are changes in their willingness to take part in sustained face-to-face proto-conversations with the mother, who is stimulated by this change in the infant's initiatives to be more active and playful, introducing seductive or teasing actions directed to capture the infant's interest (Trevarthen, 2011a).

From 4 to 6 months there are 'person-person games' in which the mother engages directly with the infant's expressive movements by making exaggerated performances to be seen and heard, or making solicitations to play with touching and manipulation of the infant's hands and feet (Figure 2). After this stage, as the infant becomes skilled at

reaching for, grasping, and manipulating objects, the mother uses the objects the infant finds most attractive as 'toys' in 'person-person-object' play. Commonly, from 4 months, mothers sing poetic nursery songs with particular patterns of timing that are independent of the language used, and they make action games, using rituals such as clapping or bouncing with the infant, also with regular timing. These patterns of behaviour share creations that are characterized by strong aesthetic feelings that measure the energy and elegance in movements, and regulation by these of narrative episodes that capture the infant's attention and participation with expressive vocalizations and gestures (Stern, 1999; Trevarthen, 1999; Gratier and Trevarthen, 2008). These efforts to gain engagement with another's interest are expressive of emotions of infectious joy in cooperation, or of earnest opposition (Trevarthen and Malloch, 2002; Trevarthen, 2005, 2015a).

There are significant elaborations of emotional behaviour from the middle of the first year that give the infant a stronger and more varied personality or presentation of a social self (Figure 2). A six-month-old boy or girl may typically act like a show off, and be eager to play vigorously, or he or she may usually be more timid and withdrawn, or absorbed in their private curiosity. In games inviting the infant to perform a learned action a lively baby often shows joyful pride directed to others' attention. Conversely, at this age, between 6 and 8 months, infants display anxiety or shame if approached by a stranger. The moral emotions of proud showing of skill, and of shame that withdraws or hides from another's attention, are beginning to define the boundaries of companionship with special companions and the shared meanings they value and repeat.

At the end of the first year a transformation in the infant's acceptance of a partner's actions to offer and animate objects leads to imitation of purposeful use of objects as instruments. Penelope Hubley, working with me to trace the changes in curiosity and motivation of a girl Tracey through her first year in her play with her mother led us to identify a 'secondary intersubjectivity', where the two of them were engaging intentions in a more equal and cooperative 'technical' way (Trevarthen and Hubley, 1978). They began to make complementary moves to share tasks, because at around 40 weeks of age the baby was eager to pick up instructions and to complete small projects that required selecting and displacing designated pieces so they became complementary parts of a single task set by the mother. For example, the mother was asked to invite Tracey to place small wooden dolls in a toy truck, not by showing the completed activity as a demonstration, but by making indications or directives with

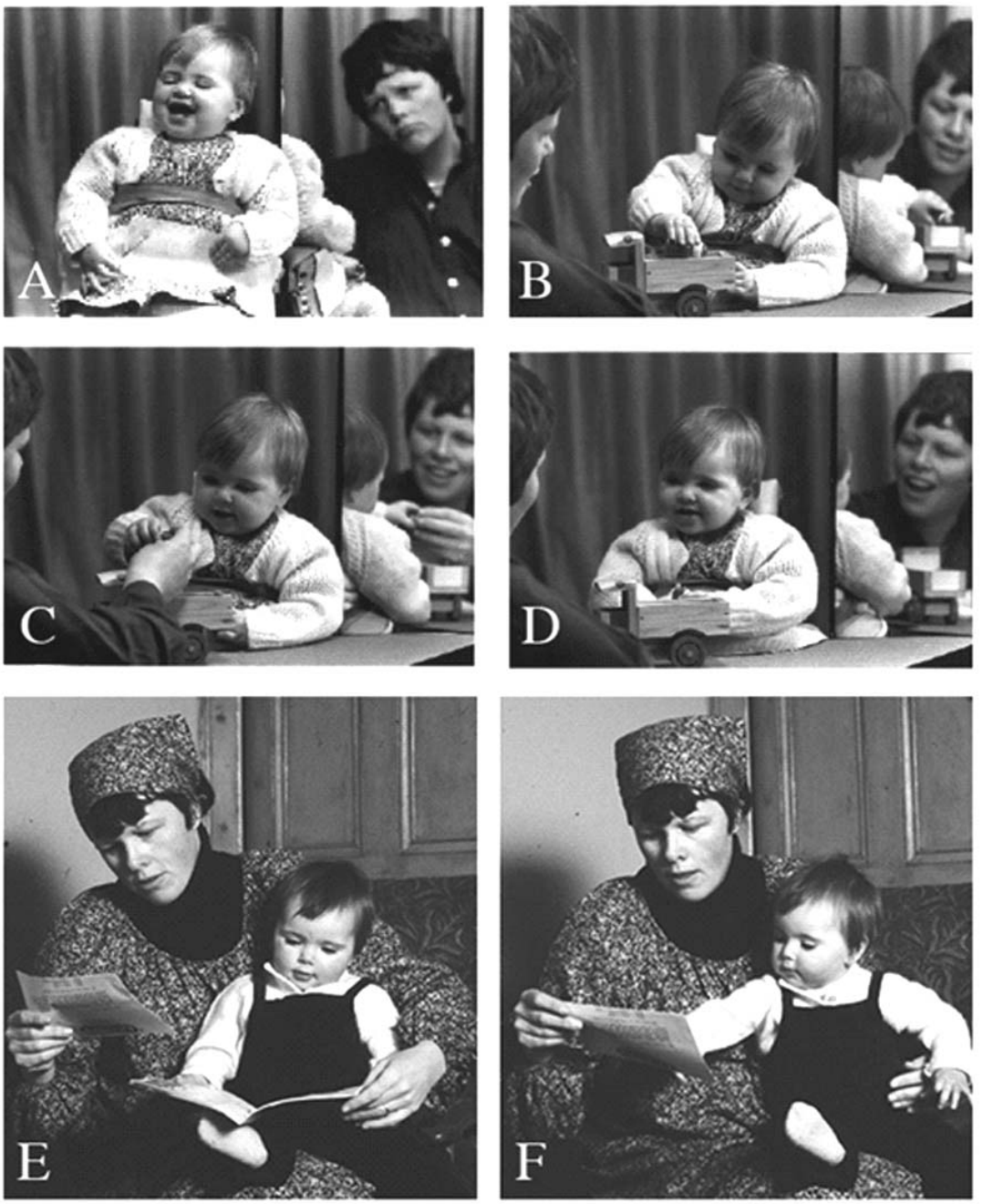


Figure 3: A one-year-old shows her talents (see opposite)

A. In the recording room, Basilie enjoys the comedy when her mother pretends to be sad.

B., C. and D. Mastering a task. She takes the wooden figure offered by her mother, with a request 'Put the doll in the truck'. Basilie carefully puts it in the

speech and gesture (Figure 3). Hubley repeated this simple observation with five baby girls, and all began to follow indicative actions at the same age, between 46 and 54 weeks (Hubley and Trevarthen, 1979).'

*Play With Others is Felt To Be Meaningful **If** They Respond and Cooperate Intimately*

The process of enculturation that gives conventional purposes to a baby's movements is necessarily playful. It is inventive and pleasurable, especially when eagerly shared. Before a human being can reason in language and communicate experience symbolically, he or she has to exercise natural abilities for experimenting with purposes and feelings of an imaginative and creative Self with intense enjoyment of intricate compositions of vitality in body movement that others too enjoy in the moment of their invention (Stern, 1999, 2010). The intuitive human spirit of play for fun is the source and monitor of relational well-being and enjoyable life times (Trevarthen et al., 2014; Trevarthen, 2016; Meares, 2016). It is one principal resource for therapy when fears and hardships of life lead to retreat from discovery and from relationships (Stern, 2004). Nothing serious or satisfying can be achieved without play with actions and ideas supported by appreciative company.

Confirmation of the young infant's sensitivity for precisely contingent response and for the affective quality of the messages of a partner has come from experiments that deliberately interrupted or dissociated the responses of a mother in proto-conversation with a two-month-old. Distressed and withdrawn reactions of the infant to the mother when she was instructed to go 'blank faced' or 'still faced' and silent while she kept looking at her baby proved the infant's expectation of live feelings of being in relation (Murray and Trevarthen, 1985; Trevarthen et al., 1981; Tronick, Als, Adamson, Wise, and Brazelton, 1978). The infant's reactions (removal of gaze from the mother, and expressions of agitation,

truck (C): then (D) looks with a self-satisfied expression at her mother who says, 'What a clever girl!'

E. At home Basilie and her mother read. Basilie is studying her book, the mother is intently occupied with a document, perhaps a telephone bill.

F. Basilie drops her book and points to the mother's paper, with a critical vocal comment, 'jargon' without words, but with intense prosody communicating criticism. This appears to be a response to the concerned expression of her mother.

confusion and distress, then withdrawal into a depressed state) resembled the sequence of emotional states that John Bowlby (1958) and René Spitz (1945) had described for older infants separated from their mothers in hospital. Observations of young babies' reactions to strangers also indicated that a specific emotional attachment to the mother exists much earlier than had been expected (Trevarthen, 1984).

A more stringent test by Murray of the infant's sense of the timing or contingency of the mother's expressions when there is no change in the feelings expressed, employed communication mediated by a Double Television link between mother and baby who were watching the other person on the screen in separate rooms. Switching to a replayed televised recording of the mother as she had been talking in an attentive and friendly way to her baby in preceding minutes, frustrated the motives of a two-month-old infant for a live and sympathetic response 'in the moment' (Murray and Trevarthen, 1985). The replay situation, like the blank face test where expression stopped, caused the infants to become withdrawn and distressed, or depressed. Immediate, intimate and emotionally sensitive companionship is, from the first weeks after birth, an essential mediator of the developmental process that leads to symbolic communication of shared knowledge (Trevarthen 2015a).

From Proto-Conversation to Proto-Language and Language: Sharing Meaningful Projects, Then Symbols

Michael Halliday, a socio-linguist and expert in phonetics, learned about the nature of the child's attention to conventions of language by watching and listening to his infant son Nigel in vocal and gestural play with his mother from nine to twenty-four months (Halliday, 1975, 1979). He called it 'learning how to mean' and said that a 'child tongue' or 'proto-language', that caretakers understand, precedes the 'mother tongue'. The child achieves this by combining two modes of directed action, addressing (a person) and acting on (an object), into a single act in which the one is the representation of the other – 'an act of meaning'. The more active interpersonal functions are conveyed by gestures with vocalizations, while ideational functions of signs expressive of the infant's state of experience are purely vocal. Nigel enriched his protolanguage after 16 months by imitating expressions taken from the English language, and from two years he was using the language well.

Protolanguage requires that the child have clear differentiation of an integrated 'self' (with cognitive and affective processes) from the world

of 'others' (things and persons), but especially it must see persons as conscious, effective and interested partners in the giving and taking of meanings. The success of the child's expressive efforts depends upon an appropriate complementary expression of acts of meaning from the other, the significance of which, in turn depends upon this reliable participation. Both persons must work with a dual representation of 'self and other' (Buber, 1937). This is the core component of a mental system that motivates human intersubjectivity (Stern 1985/2000; Trevarthen 1986).

These extraordinary ways that the human animal develops 'languaging' as a 'consensual' way of life (Maturana et al. 1995) can be related to the intricate preparations of body and brain for such ingenious and sociable intelligence that give serial ordering to actions with a purpose. They are formed 'autopoetically' before birth (Maturana and Varela 1980). These lay the imaginative strategies for the serially ordered movements of verbal narrative, or logical thinking (Lashley, 1951). The evidence of early stages of the development of autism suggests that a root problem that the child is struggling with is a disorder of the formation of these prenatal developments in motives for sharing imaginative projects in movement (Trevarthen and Delafield-Butt, 2013).

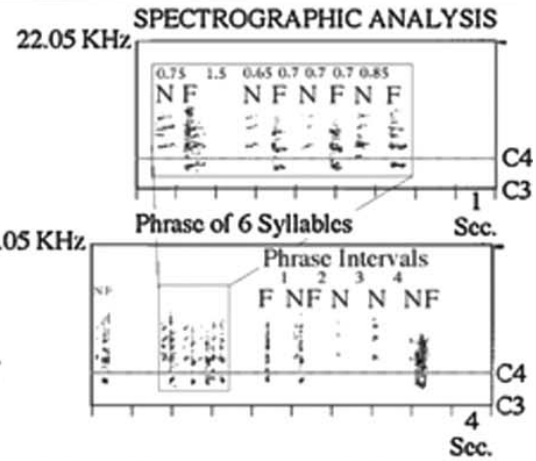
Neonatal Awareness and Imitation in Dialogue: Seeds of Personality Seeking Recognition

The original generative sociopsychobiological impulse in the infant, which so strongly attracts and directs the interest and pleasure of another person leading to the development of a human sense for the meaning of life with others, remains a mystery. No topic has been more revealing, or more contentious, than the ability that a baby may show in the first hours after birth, to imitate – to 'mirror' expressive movements of other persons in discriminating, purposeful dialogical ways open to negotiation and emotional appraisal (Kugiumutzakis and Trevarthen, 2015).

A newborn human body is very immature, and its brain, though distinctly human, is small. It must adapt to the new environment outside the mother's body (Nagy, 2011). For many months the infant's life will depend on maternal attention, support, and care. Nevertheless, within minutes of an easy birth, while accepting gentle and affectionate responses in intimate contact, a baby may focus its gaze with intense interest at the eyes or mouth of other human being, making delicate hand gestures and sharing smiles or small vocal sounds, sometimes by direct imitation (Maratos, 1973; Meltzoff and Moore, 1977; Kugium-

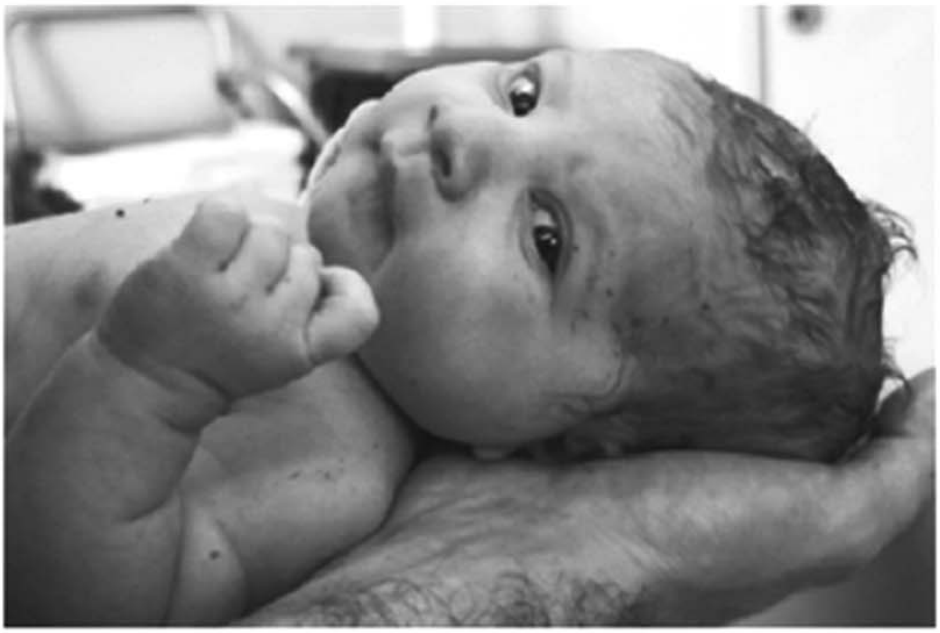
A

B



N= Nasira F=Father

C



utzakis, 1998, 1999; Butterworth, 1999; Nagy and Molnàr, 2004; Reddy, 2008). The baby's postures, gestures, face expressions, and voice sounds are expectant of sharing experience and emotion in human company (Trevarthen, 2011b). The emotional exchange of parent and child is one of an instinctive reciprocal, playful 'sympathy' with complementary and constructive feelings, not the one-sided pickup of feeling now being identified as 'empathy' (Reddy and Trevarthen, 2004; Kugiumutzakis et al., 2005).

Recognition of the inborn self-other awareness that is essential for every kind of cooperative purpose has been difficult for medical doctors, psychologists and philosophers in their thinking about it, and writing explanations. This is an ancient problem. According to Plato and Aristotle, neonates cannot imitate. We are born in a state of 'initial adualism', unable to 'know' what is outside, separate from us (Kugiumutzakis, 1998). The Platonic neonate cannot recognize the other, or imitate. Aristotle agreed that at birth we are unable to distinguish the self from the other. Because the baby lacks memory and cannot discriminate similarities and differences, it has no positive emotions to express to a loving parent. Two hundred years later, in the second century AD, the Stoics taught that human newborns possess innate impulses of affection, an affinity for being an organism with self-perception that may be shared. Hierocles was the first to oppose the Aristotelian view with a thesis of innate social dualism or self-other awareness, for humans and for other animals.

Hierocles' insight was ignored by science for 2000 years. Ideas of initial 'adualism' prevailed until the last quarter of the twentieth century, with notable exceptions among philosophers of the Scottish Enlighten-

Figure 4: The human intelligence of newborn infants

A. Two newborns in a hospital in India. Shamini, two days old, imitates her mother's tongue protrusion. A boy, within an hour of birth, tracks a red ball moved in front of him to tease his interest gently. He tracks the ball with head and eyes, two hands and one foot.

B. Naseera (N), born three months premature, now 2 months premature, exchanges short 'coo' sounds with her father (F) who is holding her close to his body, 'kangarooing'. They share, with matching precision, the tempo and rhythm of syllables (0.3 seconds in duration, and separated by 0.7 seconds) grouped in a phrase (of 4 seconds). Then they make a sequence of single sounds separated by phrase-length intervals.

C. Ava, 57 minutes after her birth, resting on father's arm. Photograph taken by her mother to whom she looks intently and makes a left hand gesture.

ment, Frances Hutcheson, David Hume, Adam Smith, and Thomas Reid, who believed we relate by 'innate sympathy'. Charles Darwin, James Mark Baldwin, Martin Buber and John Macmurray also rejected Cartesian Dualism and opened the way to a new interest in innate relational or dialogic awareness, now supported by both psychological studies of infants (Reddy, 2008; Stern, 2010), and research on the brain mechanisms of self-regulation and other-awareness (Nagy, 2011; Ammaniti and Gallese, 2014). From the perspective of a modern relationally-based therapy model Ryle and Kerr have more recently re-stated this position aphoristically suggesting that *'We interact and communicate – therefore I become'* (Ryle and Kerr 2002).

Jacqueline Nadel became a leader in work on children imitating one another. Inspired by the theory of interpersonal communication as 'affective symbiosis' of Henri Wallon, she developed an ingenious play situation where toddlers too young to speak can discover joy in imitative games, trying imaginative negotiations about what to do by matching actions with familiar objects presented in multiple copies (Nadel, 2014). She developed ways to study the use of imitation of expressions and actions from birth through infancy to expand consciousness as the child's movements and senses of sight and hearing gain new powers. In everyday life, preverbal children often imitate familiar actions with identical objects, which become vehicles of social interest. By reproducing actions they already know well they explore and enjoy 'interaction', and this 'boosts development'. Her findings inspire her to study the benefits of sensitive imitative engagement with autistic children, testing their sensibilities and disabilities in ingenious ways. The success she achieved with this treatment has fundamental importance for educational and therapeutic theory and practice.

The other aspect of shared purposefulness and enjoyment is the timing of actions that are intended and imitated. Intelligence is by nature both intentional and rhythmic, and it is communicated with synchrony in movement.

Motor Intelligence With Feelings In the Shared Pulse of a Hopeful Life

All animals have a prospective control of movement in time, a 'model of the future', which is the foundation of all the knowledge and skills they can acquire (Bernstein, 1967; Feigenberg and Meijer, 1999). Large ones must imagine the consequences of excitation of contractions in hosts of muscles within their heavy and complex bodies, and direct their

integrated selves to act well in the spaces and media of the environment. Automatic 'reflex' response to stimuli, with no prediction, is too slow for efficiency and pleasurable grace. It is used to recover or escape from errors of judgment or ignorance. We share a particularly rich inborn human sense of time in the flow of motor activity, and this makes possible doing and thinking in cooperative ways, and sharing meaning by movements adapted to be story-telling signs for others (Trevarthen and Delafield-Butt, 2013; Trevarthen, 2009, 2015b). As veterinary psychologist and phenomenologist Barbara Goodrich says, reversing Descartes' principle, 'we do therefore we think' (Goodrich, 2010). Thought is about projects in movement of the body in its functional timing.

The collaboration of the senses in self-created movement was explored by the pioneering physiologist Charles Sherrington, who presented his findings as *The Integrative Actions of the Nervous System* in 1906. An intelligent animal has an inquisitive and experimenting brain that lives in the prospects of moving – performing actions that are monitored inside the body by *proprio-ception,* 'self-feeling' with information taken from joints, tendons and muscles, and which are made useful by *extero-ception* with inquisitive deployment of clever senses to test and taste the world outside the body. Compositions of awareness are not just 'filled in' by learning and remembered. In his Gifford Lectures of 1937-38, published as *Man on His Nature,* Sherrington, reflecting on his lifetime of research on the central nervous system as the integrative organ of an animal being in movement, made an interesting appraisal of the process of evolution and development from a fertilized egg of 'the man John Brown, or the woman Mary Smith, whose exact like never was yet':

> 'All that has come within the experience of that ancestry has been the launching from generation to generation of that side-adventure which now terminates in fully completed man. An explanation once offered for the evolutionary process traced it to 'memory' in the ancestral cell. But such an explanation rests, even as analogy, on a misapprehension of the actual circumstances. It would be imagination rather than memory which we must assume for the ancestral cell; memory could not recall experience it never had.' (Sherrington, 1955, Chapter 4, *The Wisdom of the Body*, pp. 103-104)

This imaginative life-story-making is estimated and regulated by *viscero-ceptive* feelings of organs that sustain inner vitality, including the gut, heart and lungs, which evaluate satisfaction of achievement in comfort, or fear of misapprehension and pain. These are sensations that

monitor the active body of the self, its dynamic creativity and social personality (Varela, Thompson and Rosch, 1991; Lakoff and Johnson, 1999; Damasio, 1999; Goodrich 2010; Gallese, 2016). An emotional brain beneath the impressionable cerebral cortex generates deliberate narratives of hopeful purpose and guards against misfortune, and expresses these joys and fears as emotions to be felt by other persons in sympathetic engagements (Panksepp and Biven, 2011; Porges, 2011). This core organ of the Self projects motive guidance in measures of 'life time' into the vocal articulations of knowledge and skills acquired by ancestors (Lieberman, 2006).

Nikolai Bernstein (1967; Feigenberg and Meijer, 1999) used film to accurately trace the regulation of forces in the moving body of a workman using tools. He proved their skilled movements are always rhythmic, smoothing out the forces through planned steps of time. He also measured the movements of toddlers beginning to walk, and showed they play with the forces in running, hopping, jumping, creeping – exploring 'degrees of freedom' of their actions. They were moving in risky ways enjoying anticipation of what would happen, not making mistakes. David Lee, with his 'tau' theory, has confirmed by mathematical analysis that all goal-directed animal movements express prospective regulation by the brain of actions in a single space-time field monitored by all the senses (Lee, 2009). He has neonates sucking for milk, and their arm movements to touch or hold parts of the body, which are soon elaborated to make good use of objects grasped, before the movements of speaking are learned.

Protecting the Impulses for Making Up Life Stories and Sharing Them In Movement

Various forms of health care for a depressed and damaged human spirit, a Self, that has become threatened by persistent anxiety resulting from thwarted life-seeking, needs to reflect on how an infant is born capable of communicating intentions and feelings in serially ordered body movements. How efforts of proto-conversation lead to creation of meaningful knowledge in affectionate dialogues with intimate companions offers a model of the natural process of personal change that may guide therapy. Daniel Stern, a psychiatrist who was inspired to create a new more positive theory of psychotherapy by his research on infants sharing play with their mothers (Stern, 2002, 2010), explained his changed ideas of *The Interpersonal World of the Infant* in a response to appreciation by his readers as follows:

> 'One consequence of the book's application of a narrative perspective to the nonverbal has been the discovery of a language useful to many psychotherapies that relies on the nonverbal. I am thinking particularly of dance, music, body, and movement therapies, as well as existential psychotherapies. This observation came as a pleasant surprise to me since I did not originally have such therapies in mind; my thinking has been enriched by coming to know them better.' (Stern, 2000, p. xiv).

The 'composition' of a harmonious and sometimes thrilling life combines the values of moments in sequences of action or thought that resemble melodies, as the philosopher Susan Langer observed.

> 'There are certain aspects of the so-called 'inner life' – physical or mental – which have formal properties similar to those of music – patterns of motion and rest, of tension and release, of agreement and disagreement, preparation, fulfilment, excitation, sudden change, etc.' Langer (1942, p. 228).

Research on dialogues with infants has brought to light the poetry or music of the shared patterns of relating that build affectionate, playfully creative and trusting relationships that benefit both child and adult wherever they may be (Trevarthen, 1999; Schögler and Trevarthen, 2007; Gratier and Trevarthen, 2008). A musician Stephen Malloch helped me understand this meeting of minds between an innocent and inexperienced infant and a parent. By studying recordings I had made of spontaneous proto-conversations, and nursery games and songs shared by mothers and infants two or three months old, and applying his training as a skilled musician and researcher in the physics of musical acoustics (Malloch, 1999). He observed that the primary intersubjectivity of human dialogue has delicate regulations of 'pulse', 'quality' and 'narrative' that shaped sounds of the human voices in beautiful duets. 'Quality' identified the physical dimensions of loudness, pitch and harmony or timbre. 'Narrative' is the transitory enjoyment of story-making movements made in collaboration between two human spirits sharing their awareness of moving. Stephen's theory of 'communicative musicality' has proved attractive and illuminating for anthropologists, developmental psychologists, linguists and clinicians (Malloch and Trevarthen, 2009). It helps us conceive a different approach to psychotherapy (Trevarthen and Malloch, 2000, 2002).

Constructive Teaching Is Collaborative: Education as Play With Meaning in Relationships

I have recently collaborated with two musicians and a developmental psychologist, educators who have very wide intercultural experience, in two reviews of the principles and practice of early education (Trevarthen, Gratier and Osborne, 2014; Trevarthen and Bjørkvold, 2016). The purpose was primarily to give an account of how the passing on of Carl Jung's 'collective unconscious' or the acceptance of 'received wisdom' for a particular history of community has been understood as a process that cultivates a collective creativity of human nature. In this education two processes compete for recognition: one in which learners animate their progress with teachers' help; or one that prescribes an artificial transformation of the pupil's awareness by instruction to fit institutional requirements (Donaldson, 1992, Chapter 15, *Other and Better Desires: Prospects for a Dual Enlightenment*)

We refer to the work of a nineteenth century Lecturer in Education at Cambridge University, Robert Hebert Quick, who published *Essays on Educational Reformers* (1894) on the lives of experienced and dedicated teachers who, since the sixteenth century, have opposed practices of schooling restricted to instruction in religious doctrine and in academic skills of literacy and mathematics. Supporting a philosophy of humanism, one that cherishes the natural abilities of young children and their learning of both cooperative skills and social responsibility in joyful play, they inspired what Quick called 'a growing science of education'. This was intended to help parents and teachers welcome the initiatives of all children to share interests and feelings about the world, as they strive to appreciate and use it in playful ways.

The Jesuits in the sixteenth century, with François Rabelais, criticised the restriction of teaching to book learning, and 'pouring in' formulated knowledge, and said children need to exercise their bodies as well, and to feel 'love for the teacher' as a companion. In the seventeenth century, Jan Amos Komensky, or Comenius, became famous in Europe and in America for his appreciation of the life powers of young children and was invited to reform schools in Sweden, to advise the English parliament in 1641 and to be principal of Harvard, the last of which he could not accept. In his *School of Infancy* Comenius described the best principles for bringing up children for birth to the age of six (Quick, 1910, pp. 144-145). His ideas are now supported by scientific information on early communication and the growth of knowledge and understanding.

Johann Heinrich Pestalozzi and Friedrich Froebel, who at the beginning of the nineteenth century, followed Comenius in their efforts to reduce misfortunes of young children and promote their enjoyment of learning, inspired Quick's 'growing science of education'. They anticipated the support Jerome Bruner gave to the work of Loris Malaguzzi who, created an early education philosophy after the second World War that seeks to encourage the 'hundred languages of children'. There is currently an intense world-wide debate about how to reconcile methods of instruction to promote early mastery of language and mathematics with the fundamental needs of children as enactive discoverers of meaning who seek responsive teachers as they master ways of creating images of their understanding and mature symbolic communication of formal literacy and computation.

Jerome Bruner and his colleagues at Harvard and Oxford defined three systems by which a developing child motivates the discovery of knowledge and shares its meaning, all of which remain active through a lifetime of education. Learning is 'enactive' when the child uses action to explore or manipulate objects; it is 'iconic' when mental images, usually visual, recall ideas and purposes; with practice of shared conventions it becomes 'symbolic' reasoning with language and other systems of meaning.

Relational and Creative Therapies Offering Companionship To Heal and Build Confidence of a Meaningful Social Self

The understandings emerging from the body of work described above are clearly important in relation to our concepts of healthy development and mental health, and also for treatment approaches in general to the distressed or damaged self (Trevarthen 2015a). As such they represent a radical challenge to currently-dominant individualistic and mechanistic paradigms of mental health. In this section I will aim to reflect, from the perspective of infant and developmental psychology, on the ways in which these understandings are currently incorporated in various, more relationally-based, treatment models and modalities, and also on how they might inform future thinking about mental health and contribute to a new meta-perspective on treatment and how it is conceived more broadly.

It is clear from the psychotherapy literature that, despite the extra-

ordinary and confusing proliferation of 'brand-name' approaches, certain common factors are largely responsible for most of the variance in treatment outcome. This remains the case notwithstanding the jargon and rhetoric about effective components of treatment of the various models, whether or not they purport to be relationally-based. This results in the so-called 'equivalence paradox' whereby all approaches that embody certain 'common factors' are likely – depending also on patient and contextual and social factors – to be helpful and effective. The best recognised of these would be the strength of the so-called 'therapeutic alliance' – notwithstanding that this appears to mean significantly different things for different writers. At times this appears to refer simply to patient engagement with and regular attendance at therapy, or the performance of prescribed tasks – through to a patient experience that their therapist is empathic, validating of their story, and collaboratively involved in meaning-making and problem-solving with them. This 'equivalence paradox' is well-documented by leading outcome researchers (e.g. Wampold (2001), Gabbard, Beck and Holmes (2005).

Given the emerging understandings from infant psychology described above, it seems likely that this variance can be accounted for in terms of the extent to which the relational underpinning and origins of patient problems and distress are explicitly acknowledged and accurately described, and the extent to which treatment is authentically relational, benign and collaborative, or sympathetic from the patient's perspective.

These understandings would also predict that obstinate and rigid adherence to manualised protocols or didactic prescribing of tasks, which appear increasingly to bedevil psychotherapy, would be likely to undermine engagement with, or the effectiveness of, treatment.

Many treatment models and modalities have adopted a predominantly relational approach to the understanding and treatment of mental health problems over recent years albeit in different ways and with different ostensible emphases (for an overview see Gabbard et al. 2005). These would include more relational ('object-relations') modifications of psychoanalysis, Kohut's self psychology, group analytic models, family therapy and systemic approaches, narrative and dialogically-based approaches, as well as numerous more integrative and 'creative' approaches. It would be futile and unhelpful to attempt to address all of these individually in the light of the above considerations. Rather I shall attempt to highlight some significant features of a few models I am more familiar with and that appear of interest and relevance, and that illustrate some of the issues in challenging ways.

Music Therapy: Intimate Sharing of Feelings in Movement With Sound

Improvised music therapy seeks to make a creative partnership of a patient with a musician who has been trained in the responsive performance of sounds of movement with feeling, with or without words. In one-to-one sessions or in group sessions the aim of the therapist is to strengthen self-confidence and to explore and enable the resolution of feelings that shut out happiness and sense of achievement. The performance has been compared to mother-infant communication and jazz improvisation (Schögler and Trevarthen 2007), both of which are based on reference themes and intuitive rules of variation, predictability challenged with chance accidents and discoveries, which 'play' with or 'tease' a partner's anticipation and pleasure in sharing (Ansdell 1995; Gratier and Trevarthen 2008). As with other therapies, music therapy requires a sensitive and sympathetic 'contract' between therapist and client, or in a group, in intimate communication (Meares 2005; Wigram and Elefant 2009).

For example, a confused and self-absorbed child can discover confidence and joy in company through self-expression in carefully managed steps of intimacy with an adult who is skilled at using imitation and creative extension in melodious sounds in a way that the child can anticipate in 'playful' dialogues that lead to a fuller participation in a flowing musical collaboration, expressing mutual affection in melody (Nordoff and Robbins, 1977/2007; Bruscia, 1987; Wigram et al., 2002; Wigram 2004; Oldfield 2006; Zeedyk 2008; Bond 2009; Osborne 2009; Wigram and Elefant 2009).

Group music therapy, dance therapy and drama therapy inspire collaboration among performers, strengthening different ways of being, different personalities and different talents. Experimental and non-experimental case studies confirm the therapeutic value of improvisational music therapy (Nordoff and Robbins, 1977/2007; Wigram et al., 2002; Oldfield, 2006; Wigram and Gold, 2006; Wigram and Elefant 2009). Stages of the process of music therapy in groups can be measured to demonstrate how confidence and shared experience may grow (Pavlicevic and Ansdell, 2009) to heal disorders of autonomic regulation that may harm essential functions of the body.

Nigel Osborne, who has spent twenty years helping young people severely traumatised by war in Bosnia-Herzegovina, uses a 'biopsychosocial

paradigm' that integrates understanding of the physiological, psychological, and social needs in a single model, 'in which practitioners may feel confident in the potential of their work to effect positive change, and where the development of practical methods and methodologies may take place with the general support of current scientific research' (Osborne 2009, p. 335). Music therapy with this breadth of understanding can help a child who has been abused deal with both the psychological and physiological symptoms of mental trauma (Robarts, 2009). Music can directly modulate brain systems to reduce both psychological pain and physical pain (Bernatzky, et al., 2011).

Beyond Psycho-Analysis

Classical Freudian psychoanalysis followed the rational medical practice of searching for a diagnosis of emotional disorder in an individual patient, a single subject with a 'personal unconscious'. It presumes there is a developmental physiological change in a component life system of that person that regulates stimuli that excite pleasure and pain. In consequence of this 'neurotic' change, he or she has been unable to build self-confident habits for dealing with life or, especially, for communication in affectionate relationships or attachments. The primary assumption is that a proactive and adaptive Self is acquired through the successful negotiation of (speculative) psychosexual developmental stages. Successful treatment was understood to be achieved through the 'interpretation' of these (unconscious) conflicts by a detached, uninvolved analyst. Some later versions of Freudian theory (e.g. 'object relations') have stressed the developmental importance of internalisation of caring (or malign) relationships. But recognition of the spontaneous development of a thriving, relationally-formed Self with an imaginative and imitative consciousness through a process that imitates the playful activity of a young infant, who is alive in normal intimate and loving relationships that create meaning joyfully, looks beyond this reductive clinical philosophy. That new understanding is what Daniel Stern achieved in *The Interpersonal World of the Infant* (1985/2000).

Various other practices of therapy developed in recent decades from unprejudiced reflection on the process of therapeutic change have evidently been inspired by the new infant psychology, and by consideration of dynamics of life of individuals in families and communities. The observations have led to the adaptation of practice to events arising in live interpersonal relationship with the client, or between

members of a family receiving psycho-social care, require deep modification of the psychoanalytic model because they give primary importance to an intuitive human need for reciprocal or sympathetic support of shared imagination in embodied activity which is playfully creative and enjoyable. All regard the patient-therapist experience as a consensual system animated by consilience between autopoetic processes of intentional agents seeking cooperation (Maturana and Varela, 1980; Maturana et al., 1995). All have been advanced by attention to the findings of micro-analysis of motor activities and emotional expressions between healthy infants and adults in early months after birth, and age-related developments that follow.

The Conversational Model

An English physician and psychiatrist Robert Hobson, working in the Maudsley and Bethlem Royal Hospitals in London, used audio and video recordings in clinical supervision to check on the limitations of a therapist's oral or written recollections of their work and attempts to specify explanations according to psychoanalytic theory. He found that these descriptions 'after the fact' miss subtle and rich details in the human encounter of emotions conveyed by changing attitudes and gestures and by the intonations of speech, with which the patient shows their sense-of-self or personal being, and how this grows strong or weakens in conversation. With his colleague Russell Meares he also published a controversial challenge to the predominantly 'withholding' and 'inscrutable' therapeutic practice of the time, arguing that this would likely be actively harmful (Meares and Hobson 1979).

Hobson developed a Conversational Model based on a set of principles for listening and learning, by which patient and therapist seek both self-confidence and mutual appreciation (Hobson, 1985). He clarified the poetic powers of metaphor by which the patient regulates their feelings in intimacy with the therapist, how the effort they make to become recognized and understood can enable them to abandon emotional defences and regain a sense of personal well-being. These principles of a more authentic and receptive communication of feelings were adopted by Hobson's colleagues in Manchester and developed as a Psychodynamic-Interpersonal Therapy (Guthrie, 1999). This method has been successfully used for various presentations including self-harm and psychosomatic disorders (Hamilton et al. 2000).

Hobson's colleague Russell Meares, who became Professor of

Psychiatry in Melbourne and in Sydney, has developed the model further, in particular for patients with 'borderline personality disorder', conceptualising this as essentially a disorder of the integrity of the self. (Meares, 2004). His writings, including *The Metaphor of Play: Origin and Breakdown of Personal Being* (Meares, 2005) and *The Poet's Voice in the Making of Mind* (Meares, 2016) explore deeply the philosophical and psychological principles of the art and practice of relationships that are brought out by the conversational approach to the live expression and reception of emotions of hope and discovery in therapy.

Cognitive Analytic Therapy

A similar relationally-based but more collaboratively pro-active and structured therapy, Cognitive-Analytic Therapy (CAT) developed by Anthony Ryle (1990), has proved highly effective in practice (Ryle, 1995; Ryle and Kerr 2002). Ryle worked initially as a doctor in general practice in London with large numbers of families suffering emotional distress. Together with colleagues seeking ways to support a new National Health Service with limited resources unable to cover expensive individual psychiatric treatment over long periods, he sought a more immediate response to emotional needs by listening and talking to patients, and he carried out an enquiry responsive to special psychodynamics of families in his care. He made considerable use of the 'personal constructs theory' of the psychologist, therapist and educator George Kelly who developed a comprehensive method of assessing individual characters and needs in social relations, the 'repertory grid' (Kelly, 1955).

Ryle developed a psychotherapy model – based largely on theories of object relations – but adapted psychoanalytic theory to incorporate the findings of the repertory grid and of early cognitive psychology to create a research project and a new practice of psychotherapy. This uses joint descriptions (reformulations) created by the therapist and patient to recognise and help control damaging ways of acting, and to guide the therapist to avoid reinforcing these patterns. This is undertaken in a constructive and collaborative enquiry with the patient who is encouraged to be an active participant in treatment. CAT aims to identify and work with problematic reciprocal roles (RRs) occurring *between* people in their emotional life together (including in therapy), as well as those earlier, internalised, formative reciprocal roles *within* the patient. Besides the epidemiological approach of Kelly, CAT is supported by the cultural and bio-social development theories and philosophy of language of Vygotsky and Bakhtin, and the constructs of the 'zone of proximal

development' and 'scaffolding' to explain competent mastery of learning and fluent communication in cooperative life. The reformulations, diagrammatic and written in letter form, are conceived of in CAT as Vygotskian 'psychological tools', which are used to enable a collaborative understanding, as well as narrative validation, of a patient's problems and their early relational origins, and also to work on revising them, in sometimes overtly 'practical' ways. In CAT, the 'Self' is seen as the underpinning 'organising construct' and to be fundamentally relationally-constituted. More complex, 'borderline' type, disorders are seen, as in the conversational model, and based on consideration of recent infant psychology, as essentially highly distressing, dissociative disorders of the Self, with resultant impairment of self-reflective capacity and of interpersonal function (Kerr et al. 2015).

Video Interaction Guidance

In the mid 1980s, a psychologist Harrie Biemans in the Netherlands and a team of colleagues were searching for more effective approaches to child welfare practice. They were inspired by the findings of descriptive research on the emotional communication between infants and their mothers, and how the mother's responsiveness to her baby's initiatives developed intersubjectivity, or shared understanding, as the basis for communication, interaction and learning.

Biemans extended these principles to achieve success with a group of youth in a residential facility in the Netherlands by study of video recordings of interactions and the use of video feedback to develop awareness of subtleties of interaction (Van Rees, S. and Biemans, H. 1986; Biemans, 1990). The methodology has evolved from an application developed by SPIN (an Association for the Promotion of Intensive Home Training in the Netherlands) created to direct service to families, and adopted in many countries as Video Home Training (VHT), to a second application for all other settings, called Video Interaction Guidance (VIG) (Kennedy, Landor and Todd, 2011). This has proved effective in improving teachers' communication with pupils in schools, in assisting shared experience with people with special educational needs, such as autism, and in strengthening working groups of many kinds (Trevarthen, 2011c).

The Boston Change Process Study Group (BCPSG)

The BCPSG was created in 1995 by a small group of practicing psychoanalysts, developmentalists, and analytic theorists, to promote

discussion of how recent developmental studies as well as dynamic systems theory can be used to understand and model the process of change in normal development and in psychoanalytic therapies (Stern et al, 1998; Boston Process Change Study Group, 2010). It is motivated by a conviction that, in the light of the new knowledge of how the infant observed in natural engagements regulates intimate affective engagements in collaboration with a parent, psychoanalytic developmental theories are in need of drastic revision. Following this understanding, the group has set out to explore in depth how knowledge of developmental process could creatively inform psychoanalytic therapies and understanding of change in treatment.

This project for a new psychotherapy is more recent than the others I have considered, but it has the closest relationship with the path-finding work on the perceptual abilities of infants and their use in affective regulations of mother-infant communication in which Daniel Stern was a leader in the 1970s. In 1971, aged 37, he was Chairman of the Department of Developmental Physiology of the Department of Psychiatry, College of Physicians and Surgeons, Columbia University and New York State Psychiatric Institute, and beginning psychoanalytic training at Columbia. That year he published in the Journal of the American Academy of Child Psychiatry in 1971 a paper entitled 'A micro-analysis of mother-infant interaction: Behaviors regulating social contact between a mother and her three-and-a-half-month-old twins'. He discovered dynamic patterns of expressive movement that were coordinated between the mother and her infants to communicate interests and emotions, and he proved that efforts of the mother which appeared to be controlling the infant were in fact also controlled by how the infant acted towards her. Stern began to seriously question the theory that the infant's emotional self is 'constructed' by maternal actions. He also became intensely interested in experimental studies that were proving infants had more intelligent control over their actions and awareness than had been assumed.

When fifteen years later Stern summarized the fruits of a new approach to understand the infant as a developing person with natural social intelligence in *The Interpersonal World of the Infant* he wrote these words in the Preface: 'This book attempts to create a dialogue between the infant as revealed by the experimental approach and as clinically constructed, in the sense of resolving the contradiction between theory and reality.' (Stern, 1985, p. ix, reproduced in the 2000 edition on page viii). In referring to 'the experimental approach' he is not giving

full credit for the knowledge gained by observation of spontaneous behaviours measured by microanalysis of spontaneous activities recorded on video. What happened was not compatible with the infant 'clinically constructed' by psychoanalytic interview.

For the rest of his life Stern was developing a new understanding of the innate dynamics of human body movement and the power of their rhythms and affective attunements in interpersonal communication. And this work culminated in a brilliant synthesis entitled *Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy and Development* (Stern, 2010). In the practice of the BCPSG, critical moments that arise in clinical treatment of patients who have trouble controlling their anxieties and emotional responses to perceived threats offer a therapist 'moments of meeting' in the rhythmic flow of attentive communication, which can bring 'a new way of being with the other', and change the implicit story, without explicit interpretation (Stern et al., 1998, 1999).

Whilst recognising this position as of fundamental importance, and of effective therapy, Ryle, from a CAT perspective, has cautioned that in addition, for more damaged patients, explicit collaborative reformulation of presenting problems and their relational origins may also be necessary, as well as more proactive assistance with changing and revising unhelpful patterns of coping and of interpersonal relating (Ryle 2003).

Conclusion: A New Way to Understand Both Intimate Relationships of Attachment and the Companionship of Cultural Awareness as a Meaningful Self-In-Relations Has Profound Implications for Appreciation of Mental Health and Well-Being

By carefully observing rhythms of movement and their purposes we have gained a wealth of scientific evidence confirming that we are born with mastery over the vitality dynamics of what our own complex bodies can do, and with an innate ability to share these with expressions of vitality in other persons. The motor skills of a newborn baby animate affectionate attachments with loving parents, and they cry for care and comfort to protect their vitality. The newborn can also show a playful sense of pleasure with smiles at 'moments of meeting' that promise adventurous companionship. This develops as musical proto-conversations composed in intimacy.

In the next few months a seductive playfulness flourishes, and by three or four months it draws attention from growing curiosity about the 'objective' world, which may be looked at and handled, to joy with companions in games that become favourite rituals.

The transition from self-conscious play with friends to the end of the first year where things people use become conventional tools leads to games as tasks that combine objects according to rules. In the second year the baby becomes a toddler, who is beginning to be attracted to words that name meanings in a common sense of what the world affords for sharing (Trevarthen and Delafield-Butt, 2015).

When asked to summarise these changing motives by VIG therapists I came up with the description of the developmental plan as LOVE comes before PLAY, which is followed by WORK (Trevarthen, 2011c). I now see it as describing the contrast between Freud's 'personal unconscious' and Jung's 'collective unconscious' (Trevarthen, 2005, 2013). Collective feelings are implicit or artful urges that direct the growth of a human consciousness that becomes more articulate and explicit or effective, and that may become distressed and alone in elaborate self-related thinking conceived as a defence.

Early in childhood, before mastery of language, a child shows interest and pride in performance of rituals that known companions appreciate as meaningful, and shyness or shame when faced with an unknown person who does not 'understand'. Shared meaning depends on a different set of affections and enjoyments from those of 'attachment' expressed as love for those who give care and who are 'cared for'.

The different forms of relational therapy attend to both intimate and communal affections, recognizing that the feelings of implicit awareness of others' presence and sympathy cover a great range between passionate attachment to proud satisfaction in enjoyment of collective symbolic creations, the ceremonial habits and language of our culture revealed by Geertz and Turner. There is a developmental process that guides the elaboration beyond infancy. Erik Erikson (1950, 1968) traced 'Ego' development and the changes of moral emotions in relationships, postulating a number of stages beyond a mother's protection from confusion in infancy, through early childhood, adolescence, maturity and old age.

These stages of the maturation of the self-in-relations are clarified by Brazelton's identification of 'touch points' where changes occur in collaboration and trust between individuals, or between organisations

and their management (Lester and Sparrow, 2010). They explain why therapies to support regaining of confidence and confiding and enabling of psychological healing need to attend to both the sympathetic feelings of personal affections in family relations of the past and present and the personal stories about them. They also need to attend to the responsible and rewarding participation of human actors in a complex collaborative world where each has to find a role with pride in others' recognition and appreciation.

Collectively these, by now detailed and extensive, understandings of the quintessentially relational character of early human development illuminate a new perspective on the convivial life of the human spirit and helpfully challenge current, dominant, highly individualistic and mechanistic conceptualisations of mental health and well-being, and, correspondingly, all therapeutic approaches that rely on them. □

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Working with Refugees: A CAT-Based Relational Perspective

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Abstract: In the context of the Syrian refugee crisis this paper explores how the relational framework of Cognitive Analytic Therapy (CAT) can be applied to working with refugees. Having a relational and contextual understanding of, and response to, the refugee experience is critical in responding humanely to the needs of refugees. This paper takes a look at an existing trauma recovery framework, utilising a relational perspective, focusing on four core adaptive systems that dominate the refugee experience: safety, attachment, meaning and identity, and justice. The narratives of survivors, professionals and services are drawn upon to illustrate the dominant reciprocal roles in each domain. The intention of this paper is to stimulate dialogue about how the CAT framework can enable services and professionals to feel more empowered when working with refugees.

Keywords: Refugee, Asylum-Seeker, CAT, Relational Mental Health

THE SYRIAN refugee crisis has highlighted how the public and political responses to the refugee phenomenon are often polarised. The tragedy is that these responses reinforce the themes already dominant in the narratives of refugees, that is, vulnerability, disconnection, discrimination, disempowerment and being devalued. Concomitantly, health and welfare sectors in countries of re-settlement struggle to engage and meet the complex set of psychiatric and psychosocial needs (Centre for Multicultural Youth (CMY), 2015; Colucci, Minas, Szwarc, et al., 2015; McColl, McKenzie, & Bhui, 2008). As a consequence services and professionals in countries of re-settlement often feel overwhelmed, pressured and powerless and refugees continue to feel misunderstood, alienated and disempowered and, as a consequence, may not seek help for their difficulties.

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It is generally accepted that responses to refugees require an integrated approach that not only targets individuals but also the wider refugee communities (CMY, 2015; Miller & Rasmussen, 2010; Williams & Thompson, 2010). Traditional, conceptual frameworks and models of care, however, have focused on the psychiatric symptomatology of refugees, with an emphasis on post-traumatic stress disorder. These approaches have been widely criticised as being too reductionistic and neglectful of the importance of the relational and sociocultural context both in terms of the resilience to and recovery from traumatic experiences (Bhui & Bhugra, 2002; Eades, 2013; Kirmayer, 2005; Silove, 1999; Summerfield, 2000). Subsequent research highlighted the role of pre migration and post migration variables and the need to bridge the gap between psychiatric symptomatology, psychosocial and resilience frameworks (Eades, 2013; Miller & Rasmussen, 2010).

Most countries of re-settlement have a range of specialist and mainstream services. Mainstream services still tend to be dominated by the psychiatric paradigm. Concomitantly, critics highlight that while specialist services have made efforts to develop more holistic and integrated approaches they still tend to focus on interventions that are linked to individual recovery frameworks (Eades, 2013; Summerfield, 2000). These approaches do not adequately consider the socio-cultural context (and systems) or explore the relational aspects that reinforce (or protect from) the experience of trauma and themes of vulnerability, disconnection, discrimination and disempowerment (Eades, 2013). In the current political and economic climate the challenge is for professionals, services and indeed society to respond in ways that enable the inherent adaptive resilience of refugees and their communities; the relational context being critical to such.

In this paper we provide a preliminary exploration of how the CAT relational framework can be used when working with refugees. There is a growing literature describing the use and principles of Cognitive Analytic Therapy (CAT) with different populations including people with personality disorders (Kerr, 2006), psychosis (Kerr, Birkett, & Chanen, 2003) and learning disabilities (Lloyd, J & Clayton, P., 2013). While there is some literature on CAT and working cross-culturally (Brown & Msebele, 2011; Emilion, 2011; Toye, 2003) there is a scarcity of discussion on working with refugees (Brown, 2011).

In this paper we focus on advocating for a better understanding of the socio-cultural context of the refugee experience and the incorporation of a relational perspective that takes into account the individual's

developmental narrative (and reciprocal role patterns) and patterns enacted by the refugee experience currently in the very core of intervention frameworks and recovery processes. In doing so we map a CAT relational framework onto an existing trauma-recovery framework (Silove, 1999; VFST, 1998) by providing a relational 'mirror', which highlights the dominant reciprocal role patterns in the refugee experience. It is the aim of this paper to stimulate further dialogue about using CAT to meet the needs of refugee populations.

The refugee experience and refugee trauma frameworks

In responding to the complex needs of refugees and their communities it is important to stop and reflect on the refugee experience and the existing field of literature. Refugees are forced to flee their country of origin due to war, mass trauma, torture, and other human rights injustices. Many have – individually or collectively – been subject to violence and persecution, lost support networks (family and socio-cultural), been subject to human rights abuses and lived in environments of deprivation. Refugees and asylum seekers make the perilous journey to new countries seeking refuge. If refuge is granted they have to contend with the challenges that arise from the process of re-settlement.

It is acknowledged that the experience of people from refugee backgrounds is heterogeneous and most are resilient and adjust 'successfully'. Reports indicate, however, that there is a higher risk of psychological difficulties, such as depression, anxiety and somatoform disorders, substance misuse and social isolation compared to the general population (Burnett & Peel, 2001; Fazel, Wheeler, & Danesh, 2005; Reed, Fazel, Jones, et al., 2012).

The refugee experience brings to the fore the complex social, cultural, economic, political and familial context that influences distress, resilience, wellbeing and help seeking (Kirmayer, 2005; Summerfield, 2000). The distress for refugees is both personal and social; it is about displacement and disruption to these social, cultural, economic, political and familial realities. Central to the refugee experience is the erosion of interpersonal trust yet trust is fundamental to help-seeking, engagement and recovery. The rebuilding of positive relational and social contexts is pivotal.

The literature on the health and wellbeing of refugees indicates that post-migration factors clearly compound the difficulties experienced by refugees (Carswell, Blackburn & Barker, 2011; Porter & Haslem, 2005).

System of adaptation (Theoretical domain)	Violence and persecution	Social and psychological effects	Core components of trauma reaction	Recovery goals
Security and Safety	Killings, assaults, life threats, threats of harm to family, friends, 'disappearances', creation of uncertainty	Chronic fear, alarm	Anxiety, feelings of helplessness, loss of control, unpredictability, inescapability	Restore safety Enhance control Reduce the disabling effects of fear &anxiety
Attachment and loss	Death, separation, isolation, dislocation, prohibition of traditional practices	Disruption of connections to family, friends, community and cultural beliefs	Relationships changed, grief, depression	Restore attachment and connections to others who can offer emotional support and care
Identity and meaning	Deprivation of human rights, killings on mass scale, boundless human brutality on mass scale	Destruction of central values of human existence	Shattering of previously held assumptions, Loss of trust, meaning, identity and future	Restore meaning and purpose to life
Sense of justice	Invasion of personal boundaries, no right to privacy, impossible choices, insults	Humiliation and degradation	Guilt and shame	Restore dignity and value Reduce excessive shame and guilt

Table One: Conceptual framework of understanding and working with the impact of trauma and torture in refugees (adapted from Silove, 1999; VFST, 1998)

Post migration challenges include socio-economic adversity, racism and discrimination, government policy (especially aspects of the asylum system), social isolation, language acquisition, negotiating new cultural, educational and employment systems and concern for absent family. Some groups are at greater risk, for example asylum seekers, and the literature clearly documents the long term psychological toll of chronic uncertainty, discrimination, socio-economic adversity, adverse government policies and detention on asylum seekers (Robjant, Hassan & Katona, 2009; Steel, Momartin, Silove et al., 2011). Another factor critical to the recovery process is the re-building of social networks; highlighting a process of 'collective' rather than just individual recovery (Eades, 2013).

The Victorian Foundation for Survivors of Torture (VFST, 1998) has developed the 'Recovery Framework' with the aim of providing a therapeutic intervention that attempts to integrate psychiatric and psychological approaches highlighting the impact of the refugee experience and implication of mass trauma on four fundamental systems of adaption: 'safety', 'attachment', 'meaning and identity', and 'existential justice' (Silove, 1999; VFST, 1998). This framework shifts from a purely psychiatric paradigm and highlights the complex psychological and social manifestations of the 'refugee experience' on individuals and communities. It assumes that individuals and communities have an inherent capacity to survive and adapt and that psychosocial recovery is a central goal.

The value of using CAT when responding to the needs of refugees

We argue that the CAT framework could be a valuable therapeutic and contextual framework when working with refugees. CAT provides a relational approach and, unlike other models, considers not only the 'socio-psycho-developmental' but also socio-cultural processes that are internalised and contribute to the formation of self – relational patterns, distress, vulnerability and resilience (Kerr, 2009). This allows the recognition of the socio-cultural, socio-economic and relational determinants of mental health and wellbeing and not just locating the 'problem within the individual'. It provides tools to allow the exploration of a contextual reformulation of the refugee journey as well as the individual's developmental narrative so that professionals and services can create a more informed understanding of the relational patterns that impact on (or enable) the refugee recovery journey. Furthermore, the framework

and tools can also be used flexibly for individuals, communities and applied to the professionals and services that may also be impacted by the work.

Several core tenets of the CAT framework are, in our opinion, particularly useful when working with refugees. In particular the explicit use of a relational lens, the focus on a collaborative shared reformulation and the concepts of the 'observing eye' and zone of proximal development.

While the importance of the sociocultural and relational context may be implicit within the psychosocial literature, this is not necessarily *fait accompli* among services and professionals within the broader health and welfare sectors (Chowdhury, 2012; Kirmayer, 2005). In fact, one of the core critiques of conventional psychiatric models is the neglect of socio-cultural (and historical) context and values when working with anyone from a different cultural background (Ben Ezer, 2012; Bhui & Bhugra, 2002; Bracken, Giller, Summerfield, 2000; Chowdhury, 2012; Kirmayer, 2005). A lack of awareness or capacity to reflect on the socio-cultural background and refugee experience in countries of re-settlement lead to stereotypical assumptions and misunderstanding that can undermine appropriate and effective responses (Brown, 2011; Brown & Mseble, 2011; Ruiz & Bhugra, 2010).

The creation of a collaborative, shared reformulation is a specific process in CAT, which, is about recognising the impact of the sociocultural and historical context (Ryle, 2010; Ryle & Kerr, 2002). The socio-cultural context is a critical determinant of the formation of self, identity and meaning-making, both from a macro level (institutional and social patterns of country of origin and resettlement) and in terms of the psychosocial development of individuals. The socio-cultural context and refugee experience is crucial in developing an adequate understanding of individuals from refugee backgrounds, their needs, and potential reciprocal role procedures.

The CAT relational perspective, through contextual reformulation, can enable one to explore and understand how pre-existing childhood reciprocal role patterns and the patterns enacted throughout the refugee journey can interrelate and co-occur. Developmental narratives and pre-existing reciprocal roles can contribute to our vulnerability and resilience and longer term mental health. Many refugees come from communities that have been discriminated and been displaced for generations and it is important to consider not just familial realities but the broader historical

socio-cultural-political context when understanding and identifying the 'sources' of an individual's reformulation and subsequent reciprocal role patterns. The themes identified in this model may reflect both formative and contextual reciprocal role patterns.

Inherent in the function of torture, the impact of mass trauma and the refugee experience as a whole is the breakdown of positive reciprocal relationships. We also know that positive relationships are protective factors in the process of resilience (Eades, 2013, Reed et al., 2012). Incorporating a relational lens (both individual and collective) at the core of the recovery process, therefore, can allow the survivor to recognise, reformulate and create new relational processes empowering them to successfully integrate pre and post migration experiences. It also allows professionals and services to develop a greater depth and understanding of how potential unhelpful reciprocal roles and procedural patterns play a role in pre-disposing, precipitating and perpetuating the survivor's current functioning.

At the core of the recovery process is the shift from enactments that perpetuate the destructive reciprocal relationship of 'powerful, superior to powerless, inferior, worthless', which dominates the refugee experience. The emphasis of the recovery process should be that of 'accepting, welcoming to accepted, belonging'. At the core of intervention frameworks, therefore, is the need to involve the experiential modelling of alternative reciprocal role relationships, which take an observing eye from the physical environment, to survivors, communities and service responses.

CAT's emphasis on maintaining a reflective, dialogic observational position is critical in creating the capacity to step out of these unhelpful patterns (the '*observing eye*', Ryle & Kerr 2002). This also applies to professionals and services who, in a fragmented and under-resourced health and welfare system, often feel overwhelmed and disempowered when working with refugees, characterised by a sense of hopelessness, cynicism and powerlessness and some describe increased experiences of vicarious trauma (Ruiz & Bhugra, 2010). As a way of coping, professionals and services appear to oscillate between either 'backing off', minimising care efforts (even discriminating against) or entering into such patterns as 'rescuing and striving' (see the 'Helper's Dance'; Potter, 2015).

Vygotsky's, 'zone of proximal development' (ZPD) is another central tenet of CAT and concept that reinforces the idea of being person-oriented

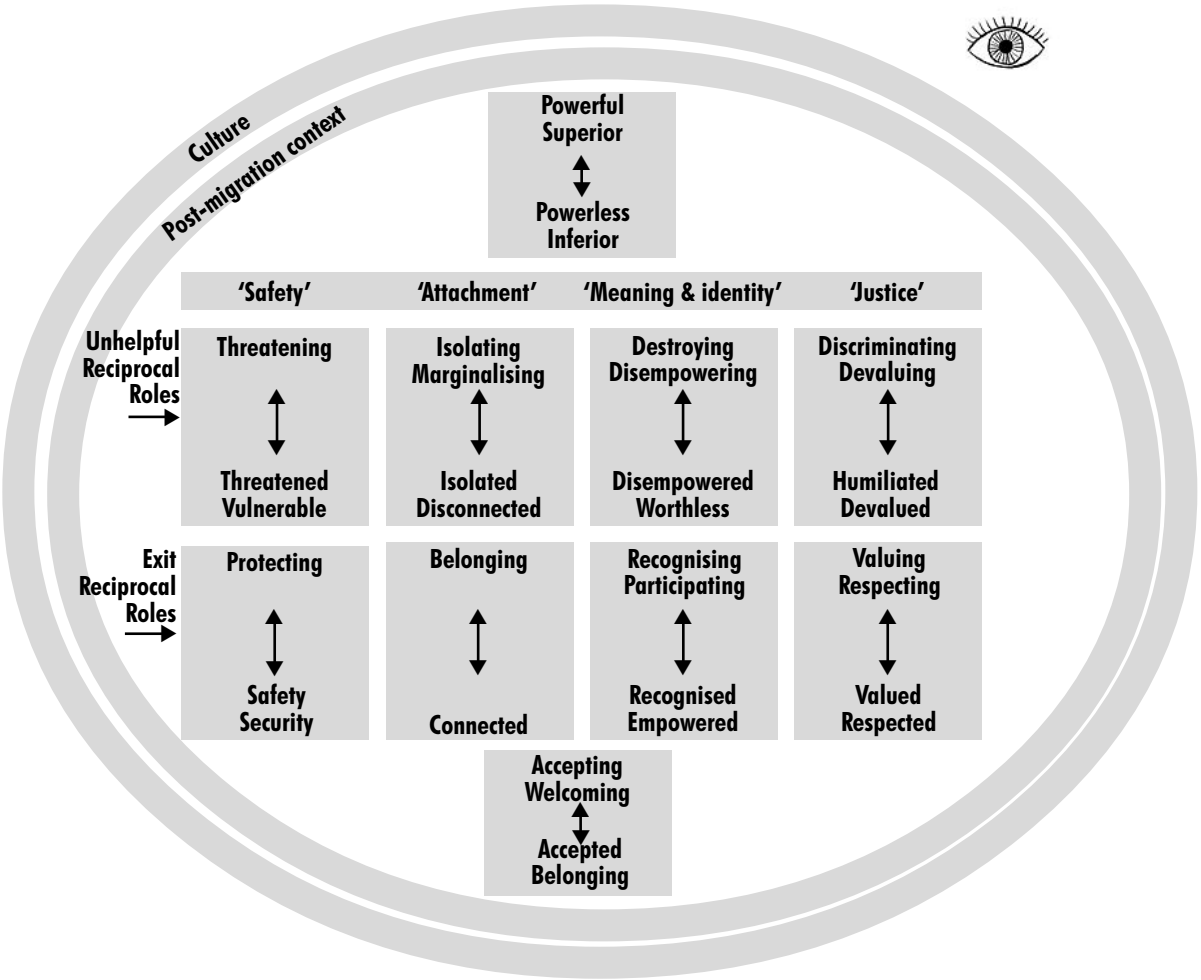

Figure One: Diagramatic Reformulation

and increases the likelihood of maintaining an awareness of context (Ryle & Kerr, 2002). When working with refugees, for example, it is important to consider the role of socio-cultural values regarding disclosure, the sociocultural manifestations of distress and expectations about 'intervention' (BenEzer, 2012; Brown, 2011). Critically, it is important to assess when it is safe to work on trauma related symptoms or to consider if an inpatient psychiatric setting is going to be 'therapeutic'.

The remainder of the paper will describe the four core adaptive systems, which form the basis of the Recovery Model with examples of the reciprocal roles that dominate each adaptive system (see Figure One for a diagrammatic representation of this relational framework).

Adaptive system: Safety (Threatening to Threatened)

One of the core strategies used by persecutory regimes in oppressing and destroying individuals and communities is to 'create a state of terror' and insecurity (VFST, 1998: 29). This domain is well recognised in the trauma and anxiety literature and in the very definition of post traumatic stress disorder (DSM-IV, American Psychiatric Association, 2000). In the refugee literature, however, there is emphasis on the broader definitions of 'threat' to include threats of mass violence, incarceration, displacement and general intimidation in order to oppress and create a sense of 'not being safe' (Silove, 1999; VFST, 1998). It keeps individuals and communities in a state of precariousness, focused on maintaining safety, existing in the present rather than re-directing attention to the future.

These acts of oppression and terror can be described in relational terms as a reciprocal role of 'threatening to threatened, vulnerable'. Individuals, families and communities exist in a state of anxiety, vulnerability and uncertainty regarding their safety and future. It reduces their sense of control over the present and future.

The impact of such may be internalised (by individual and community systems) and manifest in various survival patterns (reciprocal role procedures) ranging from anxiety-fear responses, a pervasive mistrust and paranoia and withdrawal and avoidance. There are ethno-cultural variations in psychosocial responses and coping patterns, including psychosomatic presentations and dissociative-like experiences (BenEzer 2013, Chowdhury, 2012; Kirmayer, 2005). This state of anxiety, insecurity and vulnerability regarding safety can persist for a long time after the trauma and can be reinforced by post migration stressors in countries of resettlement.

> Survivor story ('threatening to threatened, vulnerable, no control'): A man was a survivor of detention and torture in his home country. He is now detained by the country from which he seeks protection. He feels powerless, threatened, criminalised and humiliated. When others put their hands on his shoulders this triggers flashbacks; windowless interview rooms create a threatening environment that remind him of being trapped and powerless; lack of information leaves him feeling precarious. He feels fearful and withdraws from professionals. He is plagued by tightness of chest, headaches and 'tension' and hopelessness. He doesn't want to engage with the services available to him.

An alternative reciprocal role that services and professionals can enhance is 'protecting to safe'. This can be enhanced through measures

ranging from physical environment, system processes, modelling predictability and continuity and by being a *'witness to'* to the narrative.

> Professional Story ('protecting to safety, control'): 'In order to help create a sense of safety and control I leave the doors open for him and let him know he can sit in reception and come when he is ready. The stance of staff at reception is a core intervention in providing a 'welcoming – protecting' position. When he withdraws I don't press or push rather I let him know that I am available and I will often just sit alongside him until he is ready. This allows him to again feel some control, respect and be in an environment that feels safe.

Adaptive system: Attachment (Isolating to Disconnected)

Another strategy used by persecutory regimes is the 'systematic disruption of basic and core attachments to families, friends, religious and cultural systems' (VFST, 1998: 30). Disruptions to attachment systems include forced disappearance, destroying connections to the land or to ancestors, banning cultural traditions and language and systematically inducing a climate of mistrust within communities (Silove, 1999). The destruction of attachment systems aims to destroy the sense of self and identity (individual and community) and reduce any sense of individual or collective connectedness and therefore empowerment.

These acts, the loss of meaningful attachments, can be described as 'isolating, marginalising to marginalised, disconnected'. This disconnection threatens not only the sense of attachment and belonging with others but also a sense of identity and can endure for years (VFST, 1998). The sense of disconnection can be perpetuated in countries of re-settlement, for example, through government policy restrictions on family migration, detention, restrictions on the right to work and racism and discrimination (McColl et al., 2008). There is ample evidence that a sense of disconnection is one of the core risk factors in perpetuating mental health difficulties (Burnet & Peel, 2001; Miller & Rasmussen, 2010; Williams & Thompson, 2011). This reciprocal relationship can result in numerous responses that vary from being passive through to rebellion and substance misuse. The following is a quote from a young man who arrived in a country of resettlement when he was an adolescent.

> Survivor story ('isolating, marginalising to isolated, disconnected'): '. . . I am always struggling, always an outsider-misunderstood, inferior. . . my community has always been outsiders. . . but now

> my community excludes and looks down on me because I don't conform. . . no one understands me… where do I fit in?. . . I have my 'bros'. . . we hang out, and we will fight for each other. . . that's what my history has taught me. . .'

The adolescent describes feeling as if he isn't accepted by his cultural community or by the country in which he has resettled. As a consequence he rejects both cultures, which perpetuates the reciprocal role of 'isolating to disconnected'.

An alternative reciprocal role, 'belonging to connected', can be promoted by professionals, services and systems. A participatory, inclusive framework both by services and professionals can enhance resilience, acceptance, belonging and sense of empowerment, for example, advisory groups, consumer representatives and support for community initiatives (CMY, 2015).

> Professional story ('connecting to connected'): '. . . talking to some disengaged young men they described feeling misunderstood and disconnected. The young men acknowledged they wanted to re-connect with their community but also wanted to have their 'new' identities accepted. The goal of our community programme was to provide opportunities for community elders, church-goers and disengaged young men to re-connect. We helped the community organise a range of inclusive activities, including fishing trips (an activity that was important traditionally). As one elder said: 'When I got to know them (young men) more they weren't as bad as I thought'. This community program provided a bridge between the young people and the elders allowing a safe place for participants to practice enacting the reciprocal role of 'connecting to connected, accepted'.

Adaptive system: Meaning and Identity (Destroying to Disempowered)

Acts of mass violence and death, incarceration, torture and indoctrination erodes away at the 'central values of human existence' (VFST, 1998: 30). The aim is to erode an individual's (and community's) sense of identity, agency, trust, faith and meaning in self and the world (Silove, 1999). This can leave individuals feeling inferior, worthless, helpless and disempowered. The re-settlement process can perpetuate this relational experience as individuals and communities negotiate new systems, language and expectations that challenge the sense of self, identity and mastery.

The impact of these acts on the systems of meaning and identity could be described in relational terms as 'destroying, disempowering to worthless, disempowered'. Policies such as temporary protection visas, detention, denial of access to work and health care leave asylum seekers disempowered, powerless and feeling 'less worthy' than other citizens. Discrimination in the country of resettlement is also destructive to sense of identity and meaning. There is a greater sense of powerlessness, which can result in increased passivity, patterns of absence of care and neglect or resistance and aggression.

> Survivor story ('destroying, disempowering to disempowered, worthless'): '. . . I have been separated from my children because I had to seek safety from the regime. Now government policy won't let me reunite with my wife and children. This is tearing at my heart. How can I help and protect them when I'm not there? I feel guilt, anger at the world. Who am I without my children? I contact them over Skype. . . but it is difficult to feel close to them.'

This father attempts to remain connected with his children. He feels disempowered and questions his role as a parent. He becomes unmotivated, depressed, begins to give up and reduces his contact with the family. He is left feeling disempowered and worthless.

The alternative reciprocal role that can be drawn upon when working on improving meaning and identity is 'recognising, participating to recognised, empowered'. Re-establishing socio-cultural structures and systems is an important source of creating connections, belonging, identity, meaning and empowerment for refugee communities. Taking a curious stance, and providing experiential interventions, allow the individual to find experiences that develop their own personal meaning. Community based interventions from socio-cultural projects to mental health provision have been proven to be of value (Williams & Thompson, 2011).

> Professional story ('recognising, participating to recognised, empowered'): 'As part of our school support program we wanted to develop a resource to support schools to strengthen their engagement with families. We established a parent advisory group (PAG) comprised of refugee-background parents. We realised that if we were to be genuine about participation and empowerment then we would have to relinquish some control. The PAG process allowed an opportunity for parents to give direct feedback to the school and so feel more involved with the school, and their children's education. The parents felt they were heard and both the school and the parents reported that parental engagement had been strengthened'.

Adaptive system: Sense of justice (Discriminating to Devalued)

Torture, rape, violence and the witnessing of such are not only about threats to safety or identity but are also examples of human rights violations. A denial of human rights is an active strategy to humiliate and dehumanise that destroys any sense of justice (Silove, 1999). Persecutory regimes also induce guilt and shame by leaving individuals and communities with 'impossible choices', for example, being put in the position of 'passive witnesses' or being left with the belief that 'you could have acted differently' (VFST, 1998).

These acts can be described in relational terms as 'humiliating, devaluing to humiliated, devalued'. Loss of dignity, humiliation, shame, guilt, sense of weakness and betrayal are all associated experiences of extreme injustice: the act of being devalued. As highlighted by those who work with the impact of interpersonal trauma, the shame, the sensitivity to injustice, betrayal and feeling 'let down' may result in self destructive patterns or an underlying sense of 'rage' (VFST, 1998; Herman, 1997). Some describe feeling caught in a struggle either trying to suppress their emotions or losing control and 'angrily exploding' when confronted with perceptions of injustice and shame, for example;

> Survivor story ('discriminating to humiliated, devalued'): 'My worker gave me a food voucher. I went to the supermarket but they told me it was for another shop. I felt humiliated, ashamed, stupid. I called the worker and was angry at them. They were out to get me, humiliate me, just like everyone else. . . me a poor black guy, they tricked me'. The professional felt abused and frustrated and a 'dismissing, blaming to blamed, dismissed' relationship pattern was enacted. The man disengaged from the service. The professional was not assertive in follow up. The young man later ended up in an inpatient psychiatric unit with untreated psychosis.

The above example highlights the need for services and professionals to find ways to enhance the 'participating, valuing, empowering' reciprocal roles of both survivors and professionals. Support and collaboration, such as, supervision and reflective processes can enhance the empowerment of professionals (Gardner, 2009; Robinson, 2013; Ruiz & Bhugra, 2010).

Future Implications

This is an exploratory article only and it would be of value to further develop and refine the CAT-relational model for working with refugees. A key limitation is that there has not been a process of evaluating the framework's application, and feedback thus far is limited to qualitative and anecdotal accounts. It will be critical to evaluate which CAT tools and processes are of most value when working with refugees and, the adaptations required when working with anyone from a different cultural and linguistic background. Another area to explore is the adaptation of the CAT framework to group, school, service and community based contexts, either as a direct intervention or through a process of secondary consultation.

There is a very real potential for the CAT framework to be of value in supporting existing frameworks and services in better understanding, assessing, engaging and supporting refugees in a manner that enables professionals and services to step out of unhelpful patterns and enhance reciprocal relationship patterns that support the recovery process.

Conclusion

CAT provides a relational framework that allows services and professionals to hold the intrapersonal, interpersonal and social contextual dynamics that shape the experience of refugees. Compared to other models this allows a shift in focus of 'responsibility' from the individual to the relational context and having a shared responsibility. CAT is also explicit in not only advocating for the importance of socio-cultural context (past, present and future) but it is also part of the very structure of the approach enabled by use of various tools such as contextual reformulation. The CAT approach and tools can also be used to work collectively as well as individually and draws attention to the power of relational positions in the recovery process for survivors and their communities.

> Survivor quote ('welcoming, accepting to accepted, belonging'): 'soldiers don't smile. . . the local people didn't smile at us. . . When we re-settled here. . . it was like. . . people smiled at you. . . it was like. . . yes I am a person worth smiling at. . .' This survivor was then able to internalise the 'accepting to belong' reciprocal role and in turn began to feel that they could accept that this could be their new home. □

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The relationship between formulation, self-observation and the alliance process in psychotherapy for borderline personality disorder: A dialogical sequence analysis

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Abstract: In psychotherapy for borderline personality disorder (BPD), there is evidence supporting the importance of the therapeutic alliance, having a theoretical model for formulating the client's problems, and development of self-observation as mechanisms of change. This case study involved a 22 year-old female with BPD who received five sessions of Cognitive Analytic Therapy. Quantitative measures demonstrated improvements in symptoms and stability in functioning across time. Therapist and client alliance ratings indicated a deterioration in the alliance across time in therapy. Qualitative analysis was performed using Dialogical Sequence Analysis (DSA). DSA is a theory driven method of psychotherapy research that analyses utterances according to their author, addressee and referential object. Results highlight the relationship between the technical and the relational in

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psychotherapy. Specifically, there was evidence that case formulation may be used to try to pre-empt ruptures in the alliance. Additionally, in this case, the open sharing of the formulation was used as a framework for resolving alliance ruptures where they did occur in a manner that promoted improved self-observation. This study suggests that therapists should aim to tentatively hold a case formulation in their minds, checking it with the client and consistently attending to fluctuations in the therapeutic alliance, so as to maximize their flexibility and effectiveness in working with individuals with BPD to improve the client's self-observation.

Keywords: Alliance, borderline personality disorder, dialogical sequence analysis, case study, process research

THE FIRST description of 'borderline personality' emphasized the difficulty in treating clients with this disorder due to their tendency towards projective defences and deficits in interpersonal functioning (Stern, 1938). Ensuing research has underlined the difficulties in treating such clients, as BPD involves prominent deficits in interpersonal functioning (Jeung & Herpertz, 2014; Lazarus, Cheavens, Festa, & Rosenthal, 2014; Skodol et al., 2002), high levels of suicidality and self harm (Black, Blum, Pfohl, & Hale, 2004; Pompili, Girardi, Ruberto, & Tatarelli, 2005; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994), as well as high levels of affective instability (Carpenter & Trull, 2013; Nica & Links, 2009). These features make treating BPD a significant clinical challenge for mental health professionals (Bender, 2005; Paris, 2005; Vaillant, 1992).

Despite these challenges, a number of novel and effective treatments have been developed to treat BPD, without clear evidence of superiority of one treatment (Stoffers et al., 2012; Zanarini, 2009). Given that these treatments differ in theory and practical implementation (De Groot, Verheul, & Trijsburg, 2008), one parsimonious approach to developing a deeper understanding of their effectiveness is to focus on describing the mechanisms of change that might be common across approaches. These have been described as 'principles of therapeutic change' and importantly, account for the inter-related nature of techniques, client characteristics and the therapeutic relationship (Castonguay & Beutler, 2006; Castonguay, 2011; Goldfried, 1980). By clarifying the elements of treatment that might be responsible for therapeutic change in different disorders, this approach might help focus research and improve clinical practice.

In terms of BPD, a number of key elements of effective treatments

have been identified. The first of these is that treatments are structured and clearly defined (Bateman, 2012; Clarkin, 2012; Livesley, 2012; Weinberg, Ronningstam, Goldblatt, Schechter, & Maltsberger, 2011). This is likely to be helpful in assisting therapists to make sense of complex presentations and also to manage potentially difficult countransferential responses, which are demonstrably more negative with BPD clients when compared with depressed clients (Bourke & Grenyer, 2010; Brody & Farber, 1996). Additionally, a treatment structure offers the theoretical framework through which to develop a formulation of the client's difficulties. Formulation provides a working model of the different factors that might contribute to a client's problematic recurring patterns and is fundamental to all therapies (Johnstone & Dallos, 2006). It can assist in providing a basis for effective collaborative work (Macneil, Hasty, Conus, & Berk, 2012; Ryle & Kerr, 2002).

The second important mechanism of change appears to be developing the capacity of the client to reflect on their own thoughts and feelings, as well as those of others (Livesley, 2012). Terms used in the psychotherapy research field include metacognition (Semerari et al., 2005), mentalization (Bateman & Fonagy, 2004), reflective functioning (Clarkin, Yeomans, & Kernberg, 2006), mindfulness (Linehan, 1993) and an observing position (Ryle, 1997). This is perceived as particularly important, due to the impaired and fluctuating capacity for self-reflection that is evident in BPD (Fonagy & Bateman, 2006; Jennings, Hulbert, Jackson, & Chanen, 2012; Semerari et al., 2005). While improved reflection is the explicit focus in treatments such as CAT (Ryle, 1997) and MBT (Bateman & Fonagy, 2006), it appears that all treatments assist the client in improving the quality of their self-observation (Livesley, 2012).

The primary vehicle through which this is achieved is through the therapeutic relationship (Norcross, 2011; Wampold, 2001), which is widely accepted as a fundamental cornerstone of BPD treatment (Gunderson, 2008). One element of the relationship is the therapeutic alliance, or the degree to which therapist and client can work collaboratively and purposively (Bordin, 1979). Ruptures in the therapeutic alliance can occur frequently when treating BPD (Bender, 2005; Cash, Hardy, Kellett, & Parry, 2013; Daly, Llewelyn, McDougall, & Chanen, 2010) and there is preliminary evidence that the extent of resolution of ruptures is predictive of positive outcome in therapy (Daly et al., 2010; Safran, Muran, & Eubanks-Carter, 2011). It is also clear that both therapist's characteristics and technical skills can contribute to fostering a strong alliance (Ackerman & Hilsenroth, 2003).

In summary, three fundamental mechanisms of change have been identified in psychotherapy for BPD. Namely, a model that clearly formulates the client's problems, an improved capacity for self-reflection and the use of the therapeutic alliance. These three elements can be combined to postulate that therapeutic change in BPD is partly contingent on the quality of the therapeutic model in developing a formulation of the client's problems and in using this model to assist the client to develop improved self-reflection within the context of a therapeutic relationship. This suggests that there is an interactive effect of case formulation, improved reflection and the therapeutic alliance in bringing about therapeutic change (Bateman, 2012; Clarkin, 2012; Livesley, 2012).

While this account is not original (Bateman, 2012; Clarkin, 2012; Livesley, 2012), there is only limited evidence to support it. The complexity of the therapeutic encounter suggests that simple linear models might not sufficiently account for the responsive (Stiles, Honos-Webb, & Surko, 1998) and transformative nature of psychotherapy (Leiman, 2012). As such, a case study approach offers the first step towards an explication of the inter-relationship between numerous variables and can offer findings that might be clinically relevant and theoretically meaningful (McLeod, 2001; Stiles, 2007). This study aims to examine the relationships between case formulation, self-observation and the therapeutic relationship in the treatment of BPD. More specifically, it will use a case study design to explore how case formulation and therapist technique are used to improve self-reflection in BPD and repair ruptures in the therapeutic alliance.

Method

Case description

'Jenny' is a 22 year old female, living in a rental property with her partner 'Tim', 'Bec' her infant daughter and 'Luke' her toddler-aged son. She provided written, informed consent to take part in an RCT examining treatment for young people with BPD. On assessment the Structured Clinical Interview for DSM-IV (SCID-I & SCID-II; First, Gibbon, Spitzer, & Williams, 1996; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) was administered by an independent research assistant and Jenny was assessed to have Major Depressive Disorder, Panic Disorder without agoraphobia, BPD and Antisocial Personality disorder.

Jenny consented to take part in a randomized controlled trial (Chanen

et al., 2015) and was randomized to receive 16 sessions of CAT as well as access to all the services of the Helping Young People Early (HYPE) specialist early intervention programme for BPD in Melbourne, Australia (Chanen et al., 2009). This included case management integrated with individual psychotherapy, general psychiatric management, access to a psychosocial recovery programme and family support. She attended five sessions of CAT before treatment was discontinued after she moved houses and was unable to attend sessions. It is important to note that this should be considered an incomplete treatment due to its short duration, and the outcomes should be interpreted within this context.

Measures

The *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989) is a 36-item questionnaire that is widely used, with parallel therapist and client versions and reported high internal consistency (Horvath & Greenberg, 1989; Tyron & Kane, 1993). Responses are made on a 7-point likert scale and can be divided into 3 subscales corresponding with Bordin's (1979) tripartite view of the tasks, goals and bond. Overall alliance score was used and values can range from 36-252.

The *Borderline Personality Disorder Severity Index IV* (BPDSI-IV; Arntz et al., 2003) is a semi structured interview that yields quantitative ratings that assess BPD severity. The measure demonstrates strong internal consistency as well as discriminant, concurrent and construct validity (Giesen-Bloo, Wachters, Schouten, & Arntz, 2010). Overall scores range from 0-90 with higher scores indicating greater severity of BPD symptoms.

The *Social and Occupational Functioning Assessment Scale* (SOFAS; Goldman, Skodol, & Lave, 1992) is a widely used measure of global functioning, that is a single rating made by the interviewer. It integrates a rating of symptoms as well as a focus on level of adaptive functioning in social and occupational domains. Higher scores correspond with better social and occupational functioning.

The *Montgomery-Asberg Depression Rating Scale* (MADRS; Montgomery & Asberg, 1979) is an interviewer rated 10-item questionnaire that is scored on a 7-point likert scale and measures depressive symptom severity. It was designed to be sensitive to change and demonstrates high inter-rater reliability (Kørner et al., 1990). This study used the *Structured Interview Guide for the Montgomery-Asberg Depression Rating Scale* (SIGMA; Williams & Kobak, 2008), which offers clear anchor

points and a structured interview guide that was designed to maximize inter-rater reliability. In a study of 81 rater pairs, the intra-class correlation for total score was r=.93 indicating excellent inter-rater reliability (Williams & Kobak, 2008).

Dialogical Sequence Analysis (DSA)

DSA (Leiman, 2004, 2012) is a theory driven psychotherapy research approach that is rooted in Vygotsky's (1978) theory of sign mediated activity, object relations theory (Leiman, 1992; Ryle, 1991), and Bakhtin's (1984) dialogical theory. Rather than offering a narrowly prescribed set of steps, DSA provides a set of theoretical concepts that can be used to analyse relational and dialogical components of therapeutic discourse. The methodology assumes that there are meaningful relationships between psychic processes, external actions and verbal expressions. DSA examines utterances in therapy in terms of three elements. The first is the *author* of the statement who is always positioned. Against this there is a counter-positioned *addressee,* to whom the speech is addressed, which might include the therapist, a part of the client or another person who is not present. The third element, is the *referential object*, which is the content or topic of the speech. These relationships are illustrated in Figure 1.

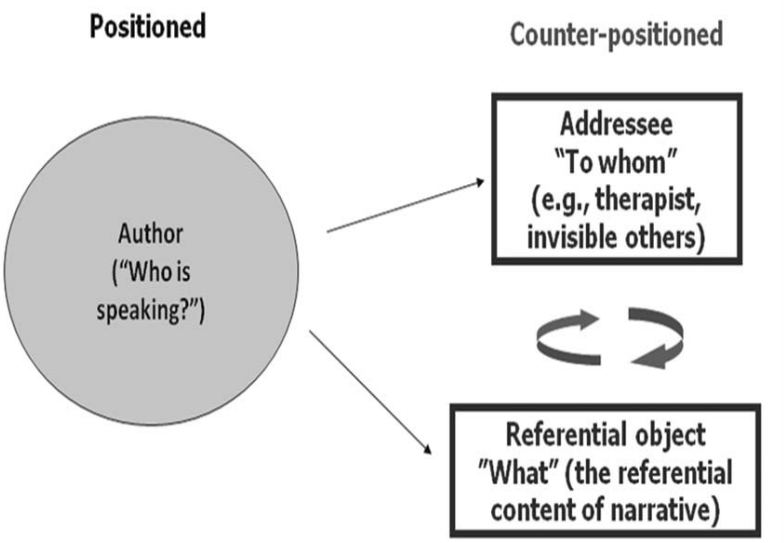

Figure 1 Illustration of DSA conceptualisation of positioned utterances (from Leiman, 2012)

Bakhtin's (1984) theory emphasizes the *double directedness* of utterances, in that they are addressed towards someone and also have a topic or referential object. Depending on the referential object of speech, or the topic, the speaker's position to the addressee can be quite different. For instance, if the addressee is perceived as rejecting, disclosing personal themes to the therapist can become difficult. DSA is a group based approach that is particularly suited to microanalysis of psychotherapy transcripts in that it is able to explore patterns of dialogue in therapy and elucidate the subtle relational dynamics that evolve over time in therapy. It has been used to examine impasses in the context of a network meeting (Tikkanen & Leiman, 2014).

Analytic procedure

The first two sessions of Jenny's CAT were transcribed by the first author, who is a psychologist. The data analysis group included two clinical psychologists and experienced CAT therapists, one of whom was the therapist in the case described. The group also included four experienced psychotherapists. Data analysis sessions occurred through web video conferences and involved large and smaller group discussions and a consensus based approach. The opening exchanges of the first session were utilized to develop a research based DSA formulation of the client's problematic pattern. This formulation (see Figure 3) was then used as a conceptual tool in order to examine the quality of the alliance and self-observation during the first two sessions of therapy.

Ethics approval was provided by the Melbourne Health Research and Ethics committee. Written informed consent was provided by the client for the therapy sessions to be recorded and used for research purposes. Therapy transcripts have been de-identified by using pseudonyms and all identifying details have been altered.

Results

Jenny's psychometric results are presented in Table 1 and demonstrate a decline in the severity of her BPD and depressive symptoms with six month scores remaining in the clinical range (Arntz et al., 2003; Montgomery & Asberg, 1979). Results indicate stability of social and occupational functioning over six months at a level of moderate impairment. The working alliance scores for therapist and client are presented in Figure 2 and demonstrate a reduction in the quality of the

Table1 : Outcome data across 6 months of assessments

Domain	Measure	Baseline	3Month	6 Month	Effect size Cohen's d
Borderline Pathology	BPDSI (total)	44.05	23.35	33.24	d=.91
Depression	MADRS	26	17	17	d=.78
Global Functioning	SOFAS	60	55	59	d=.13

alliance during the course of treatment. In the following section, excerpts will be provided to examine the inter-related nature of reflection, formulation and the alliance.

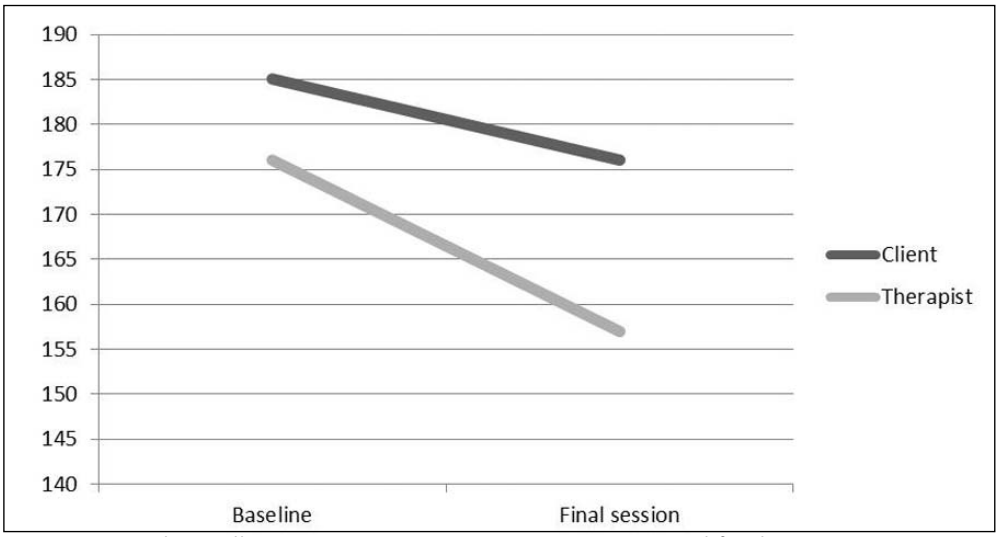

Figure 2 Working alliance inventory scores at session one and final session (session 5)

Session One: Developing the formulation

The following excerpt begins with the fourth speaking turn of the first session of CAT. T signifies therapist speech, C, client speech, square brackets indicate cross talk. Words are emphasized with bold font where they are used for further analysis.

C4: Me and Tim have been **fighting** a lot the last couple of days.

T4: Mhmm

C5: Like bad fighting.

T5: Ok, is that usual or a bit out of the ordinary [for you]?

C6: [Um, every now] and then we have a really bad fight but I nearly **punched him in the face** again this time.

T6: Ok, that's a fairly significant fight.

C7: Yeh.

T7: What tends to get you into those really big arguments?

C8: Me being **pig-headed** pretty much. Um, I'm a **bit pissed off** because we're still not talking to Tim's family. My girlfriend went away and I've got no one to look after the kids. I couldn't even go and get my hair cut. I couldn't even go to the supermarket.

The excerpt opens with the referential object or topic of conversation being fighting. In C6, when discussing nearly punching Tim in the face, Jenny is very open about her anger and rage. Nonetheless, it seems there is something intolerable about the situation for the client. In T7 the therapist prompts reflection and for more detail about the antecedents to the fights and in C8 Jenny immediately moves to a self-critical position, characterizing herself as 'pig-headed' or stubborn. As if responding to her self-blame, Jenny begins to give external reasons for her uncontrolled anger. She then moves to an angry 'pissed off' position regarding the lack of support that she received. She expresses feeling dismissed and disregarded at having no one to help care for her children, and it appears that her intense anger might arise from feeling as though these needs are not being met.

Another element that helps to contribute to the development of the formulation occurs later in the session where the topic turns to drug use.

T73: Yeh, are you still feeling the cravings for the **ice**?

C73: Yes, I still want, if I think about it.

T74: Right.

C74: Definitely. Like I start to get the sweats and my heart races and I want it but I'm very **quiet** about it because I feel very **judged**. Especially by Tim who's an ex-addict and I tend not to say anything until he does. So.

T75: So **that's interesting** that he, 'cause he used with you, it was never only you but you feel **judged** by him for [the fact that]

C75: [I'm stronger] I'm supposed to be the **strong one**. I don't want him to think that I'm also **weak.**

T76: Right, ok.

C76: (5 second pause) (sigh).

T77: (sigh) **It**'s hard isn't it?

C77: Yeh, I still stand by the fact that out of every substance I've used the one I will never give up is my cigarettes. (laughs) I love my cigarettes. I can't get through my day without those.

The discussion has moved to Jenny's previous problematic use of ice (crystal methamphetamine). In C74 we see the counterpoint to the client's self-critical position, in which she is now feeling criticized and judged by others. In T75, the therapist avoids colluding with this criticism and takes a curious point of view, commenting 'that's interesting'. In C75 Jenny clarifies her underlying appraisal – the fear of being weak if she loses control and her perception of herself as 'strong' and capable. There is a 5 second pause, which is rare in this client's therapy and it appears that at this stage Jenny is reflecting on her vulnerability. In T77 the therapist empathically states that this reflecting process ('it') might be difficult. In C77 Jenny moves the topic to the safer ground of cigarettes. This supports the thesis that self-observation might be contingent on the emotional state of the person with BPD. That is, the client finds it difficult to maintain a coherent sense of self, especially under the emotional activation associated with reflecting on her drug addiction. She rapidly shifts to safer ground. Soon after, the therapist attempts to return to the client's vulnerable feelings.

Session One: Utilizing the alliance and formulation to stimulate reflection

T80: I imagine it's also hard to get your **needs met** when you always have to be the strong one. Because even having needs and letting people know of them might be weak.

C80: That's why I don't ask for help with the kids.

T81: Yeh, it might actually then leave you feeling really shit.

C81: Yeh.

T82: Because, yeh. People either **dismiss** what you want and need or **you kind of do it** in a way by not, by kind of holding on to it because otherwise you'll feel kind of weak and shit.

C82: **Yeh**, the only people that don't make me feel that way are my kids. And even they sometimes make me feel like I'm being **walked all over** but I'm **pretty good** with them these days. Like um, I don't, I used to, I could actually lose my temper and fly off with Luke. Now, I sound angry but I'm not actually feeling the anger that I'm projecting.

T83: So that you can be more controlled.

C83: Yeh it sounds scary, getting what needs to be done, done. But not actually start throwing stuff.

T84: Yeh, so that you won't fly off the handle.

C84: Yeh.

T85: So you'll be able to let him know that you're not happy but without going too far.

C85: If I do feel **that anger**, I take it out on Tim.

T86: Right.

C86: Like why do I have to get to this point? Why can't you step in and do something?

In T80, the therapist suggests that Jenny's experience of vulnerability as being a weak and dismissed position might lead to her having difficulties getting her 'needs met'. The client amplifies this understanding in C80. In T82 the therapist further develops this understanding by emphasizing that the dismissing can be experienced from others and can also take place at an intrapsychic level. This invites further reflection on this pattern and in C82 Jenny offers minimal agreement saying 'yeh' and then denies that this dynamic is in place with her children. However, she then notes that she can feel 'walked all over' or exploited by them. She then appears to move again into a somewhat defensive mode, explaining that she is 'pretty good' with her children and has reduced her angry feelings towards them. This might be accurate but might also reflect the client's sensitivity towards criticism in the therapeutic relationship and desire to appear competent. In T84 the therapist responds empathically and non-judgmentally, emphasizing that she understands that the client might need to sound 'scary' in order to avoid overwhelming anger. In C85 Jenny concedes that she does at times experience 'that anger' but that she takes it out on her partner, and in C86 she moves to the angry and blaming position towards Tim.

From the therapy transcripts, the DSA group developed a tentative formulation of the client's key dialogical sequences, which is presented in Figure 3. A key relational dynamic for Jenny, called a *reciprocal role* in CAT, involves a critical, blaming position in relation to a guilty and judged counter-position. Importantly, the client is able to take both positions, for example, being critical towards her partner or herself, as well as feeling very judged in terms of drug use. In the above excerpts we see how this leads to anger towards others, as well as a perceived anger in others that leads to a justifying position. This formulation can be revised through further analysis of transcripts however it can be especially useful both to make sense of complex interactions that are difficult to comprehend and in order to determine whether change is occurring in terms of positions taken or reflective capacity.

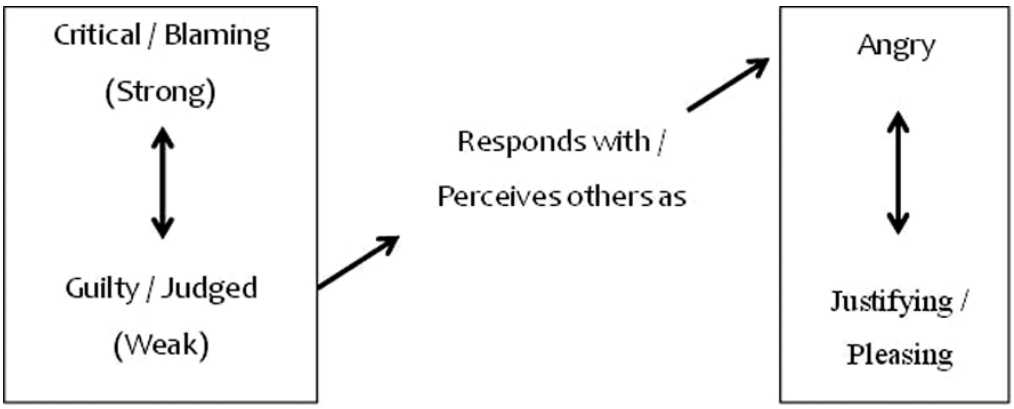

Figure 3 Case formulation of key dialogical sequences established from session one

Session Two: Using the formulation to assist in reflection and to maintain the alliance

This session presents examples of how formulation can be used in session to assist in fostering self-reflection and managing the therapeutic alliance. It is important to note that the DSA formulation was developed by the research team independently, yet it is clear that the therapist's formulation utilizes some similar concepts. This excerpt begins in the context of an exploration of the client's need to please others.

C115: Yeh I mean, you're here to help me and I want help. Like, this is where I want to be. Um, and I've got no reason to **lie** to you.

T116: Mhmm

C116: I don't really see a lot of point in lying. And I've got. . .

T117: I'm not talking about lying, I'm talking about maybe **not saying something** because you think I'll get angry at you, because you don't like people being **angry at you**. Or if I say that, that person, me included, might get angry at me so I won't say it.

C117: I suppose I could possibly be like that if I ever got on the drugs again. I don't think I'd want you to know about that. Um, otherwise, no. Not unless I did something **seriously stupid**. And I'm not real prone to doing seriously stupid stuff. Self-reckless, sure a little bit. But not seriously stupid stuff. (*pause 6 secs*). I just like to have fun like other people sometimes.

T118: **Why** do you think I'd get angry at you if you started using ice again?

C118: Because you've put a lot of hard work and time into helping me get better and I would just be **back-pedalling** on you. Or,

again it'd be a show of **weakness** um, I don't know. It's just something that my **brain assumes**. It's a good question, why do you think that person would be angry at you?

T119: Mmm

C119: 'Cause **I just think they will**.

T120: Because you've gotten to a point where you make an automatic assumption [that people]. . .

C120: [yeh and] I get angry at people doing that to me (laughs). Yeh.

T121: Yeh, so when people make automatic assumptions about you, you get angry.

In C115 Jenny denies a need to 'lie' and in T117 the therapist reframes lying in a less critical voice as 'not saying something' thereby avoiding reciprocating with judgement, as Jenny might anticipate. The therapist also alludes to the other being 'angry' at Jenny, which according to the formulation is an intolerable position. The client denies doing 'seriously stupid' things, pauses to reflect and states that she just likes to have fun. This is a potential example of *multiple addressees,* in that this statement appears to be justifying the client's behaviour and drug use both to the therapist and the critical aspect of herself.

In T118, the therapist offers an important intervention, asking the client to reflect on why the therapist might be angry at her drug use. This can be seen from a CAT perspective as improving the client's capacity for reflection. From the perspective of the formulation, it is acknowledging the central role that anger can play in causing strain in relationships and the therapist is seeking to prepare the ground for potential ruptures in the future. From a DSA perspective, the referential object or topic of conversation moves from drug use to the emotion itself, namely anger. The therapist takes a neutral, curious position.

In C118, Jenny has difficulty clarifying her reasons, suggesting that her drug use might be perceived by the therapist as being 'back-pedalling' or worthy of judgement or a sign of 'weakness'. She goes on to externalize the reasoning as something her 'brain assumes'. Finally, in C119, she loses all reflective capacity stating 'I just think they will'. It is evident that, in the context of the emotionally laden 'hot topic' of drug use, the client's self-observation capacities are diminished. Yet, her fundamentally self-critical positioning remains. The next excerpt follows immediately from the previous one.

C121: Yeh well it's like you say that I look like a pretty straight up and down person and I generally tell it how it is. Whether it's about you or about someone else. I just say it **straight up**. Nobody else is like that. Nobody else is like that. So all I can do is make an assumption about what someone is feeling or thinking because you know they're **never saying** what they actually think.

T122: Yep.

C122: So even you in your job where you're supposed to be not judgemental, you're supposed to be, and just you've heard it all before anyway. But there's got to be something going on in your mind that makes some sort of judgement at some point, because you're human.

T123: Sure.

C123: And, so when people say things to me, whether they be really nice or really nasty there's always a **hidden motive** behind it or there's always something else going on in their head. They just don't want to upset ya.

T124: Yeh, and I completely agree. I don't think this is a **judgement free zone**. And I don't think this is necessarily an **anger free [zone].**

C124: [No.]

T125: Or a disappointment free zone or whatever. I'm just wondering, what I'm hoping though, is that if something like that happens, like if you find yourself **not saying something** because you're worried I'll get angry or maybe if you do feel judged by me or I'm actually hoping that we can **find a way to talk about it**.

C125: [Yeh well.]

T126: [because I] don't think this is, like I agree with you, I don't think it is going to be free of all of that stuff.

C126: No.

T127: Because yes, this is separate from your life, but I think some of the stuff that happens in your life will also play itself out.

C127: Yeh probably.

T128: In a different way I think.

C128: If I felt **judged** or anything like that I would quite easily approach you about it. But if I thought you were **angry** at me I'd probably sus you out about it first and then make a [decision].

T129: [Ok yeh.]

C129: 'Cause I reckon I'd find it pretty quick. Whether I'd figure

out whether you were angry at me or not.

T130: And I don't think there is actually a problem with us getting angry.

C130: No.

T131: I think there's a problem obviously if we start yelling and I think we both need to feel safe here. But anger is, see that is what was interesting to me about when you said I'm kind of **afraid** of, in a way you're afraid of other people being angry at you. It's kind of like, that's really interesting because anger's gonna happen. You know because anger is one of the whole gamut of emotions that is going to happen. You are going to get angry and other people are going to get angry at you.

C132: Yeh.

T133: There's no way of avoiding it.

C133: I think it's the outcome of how that person handles the anger. I can't handle it when people shut off from me and don't tell me what the problem is.

C121 offers a picture of Jenny's view, where she is the only 'straight up' honest person and others 'never say' what they are thinking. In C122 she extends this, directly challenging whether the therapist is unbiased or also engages in judgement. In C123 she elaborates her suspicion that others have a 'hidden motive'. Throughout this early exchange, the therapist agrees with Jenny's assertions, culminating in T124 where she acknowledges that therapy does not necessarily exist without 'judgement' or 'anger' implying that these might be inevitable in therapy. This utilizes key themes in the formulation of Jenny's issues in a manner that seeks to foster the alliance and avoid ruptures. In T125, the therapist once again softens Jenny's idea of a 'hidden motive', similar to the earlier discussion of lying and reframes it as 'not saying something'. She argues that rather than avoiding these difficult states, the dyad need to 'find a way to talk about' these difficult areas.

Jenny's speaking turn in C128 is instructive in demonstrating that although judgement is difficult, she can communicate about this issue. By contrast, anger in others is intolerable and too difficult to discuss openly, unless she feels in control. In T131 the therapist uses this insight to explore the fear that is underlying the anger. In this way she seeks to assist the client to access these vulnerable feelings in the context of a strong alliance. In C132, the client does not access these feelings but does take a more nuanced and accepting position towards the anger, suggesting some limited therapeutic progress.

The next excerpt occurs soon after and the topic has returned to Jenny's drug use.

Session Two: Utilizing the formulation to repairing an alliance rupture and improve reflection

> C146: It's almost hurtful, you know the first time that **you** try a **drug** like that, you're taking a leap, you're taking a big chance. But then when you realize what it actually does to you, it's **not that big a deal**. It's not like I'm **incapable of looking after my kids** and then **when someone else judges you** on that, that **hasn't done it before** and then tells you that you're being **irresponsible** and that you're putting your kids' lives in danger and all that, it's quite **insulting**. Because I would never do that on purpose, I would never do it deliberately and I did a fair bit of research on the ice before I ever even took it.
>
> T147: Oh, and that would, and I think that, you know, I think that that's a **really good place** to kind of start from. I think if we ever, if **we** did **fall into** some of those **unhelpful patterns**, I don't think either of us have done it deliberately or **intentionally**.
>
> C147: [No.]
>
> T148: and therefore I think we can take the blame out of it and go 'Oh hang on a minute, we fell into something here'.
>
> C148: [Yeh.]
>
> T149: We both did it. And, you know, not feel that either one of us is to blame to for it but actually just talk about it and go 'well **what happened**?'
>
> C149: Yeh.
>
> T150: Because ultimately, and I don't say this to be dismissive, but ultimately at the end of this **you have a right** to do everything exactly the same as you already, as you always have.
>
> C150: Yeh.
>
> T151: Because it's **your life**.
>
> C151: Yeh exactly. And that's where I can sort of detach myself from you is the fact that yes you're involved in my life at the moment and you're trying to help me but you're not part of my life as such. If that makes sense. So the **emotional attachment** isn't as strong as it would be with Leigh or my mum.

This excerpt begins by discussing the 'drug' ice, from the depersonalized position of 'you'. Jenny describes feeling 'judge[d]' and 'insult[ed]'

regarding a perceived other who views something that is 'not that big a deal' as her being 'irresponsible' as a mother. The addressee might be an abstract other person or potentially the therapist herself, whom the client assumes 'hasn't done it [ice] before'. If the latter is the case, this might be viewed as a rupture in the alliance and a breakdown in the bond. There might be some element of the client projecting her judgemental perspective on to the therapist. Jenny then moves from the judged position to the justifying one, stating that she would never endanger her children 'deliberately' and that she researched ice before using it.

The phrase 'when someone else judges you' is an example of what Bakhtin calls a 'word with a sideward glance' (Bakhtin, 1984, p. 195), which is a 'hidden polemic' (p. 163), where the statement obliquely takes a swipe at and anticipates the addressee's objection. In this case it appears that Jenny is warning the therapist against any judgement about her drug use.

In T147, the therapist seems to intuit the challenge, struggle for the right words and then allies with Jenny's defences, characterizing her position as 'a really good place' to start. She then moves to strengthen the alliance with the client using the word 'we' and reframing the critical terms of judgements and irresponsibility as the more benign 'unhelpful patterns', that both parties can 'fall into' unintentionally. In this way the therapist seeks to offer the option for feelings of guilt and vulnerability to be explored within the therapeutic relationship without the need for a corresponding intentionally critical or judgemental counter-position. In T148 and 149, the therapist continues to expand on the same theme. In T149 the therapist seeks to encourage greater reflection, and in T150-T151 the therapist emphasizes the client's autonomy.

In C151 Jenny states the she does have some capacity to 'detach' and observe her own states within the context of the therapeutic relationship, which she might not have in family relationships. She states that this is due to the weaker 'emotional attachment' and this is consistent with her difficulties maintaining accurate self-observation when she is in a highly aroused emotional state. Nevertheless, the strength of the alliance remains somewhat precarious at this stage.

Discussion

This case study demonstrates the inextricably intertwined nature of therapeutic technique and the therapeutic relationship (Hill, 2005). It is evident that all technical interventions occur in an interpersonal context

and have relational meaning (Butler & Strupp, 1986). This is not to say that efforts to compare the relative importance of technique and the alliance are uninformative, but rather, that a comprehensive account of change processes in therapy necessitates a consideration of both.

The formulation, known as the *reformulation* in CAT (Ryle, 1997), is the basic shared understanding that guides the direction of the therapy. In Jenny's case, elements of her formulation, including the pivotal roles of anger and judgment, are evident from the earliest exchanges in therapy. This corroborates earlier findings regarding the considerable information that can be gleaned from a micro-analysis of the opening utterances of the first sessions of therapy (Stiles et al., 2006).

Importantly, and consistent with the CAT model, it is evident in this case that the formulation was actively addressed by the therapist in an open and collaborative manner. This case demonstrates that the formulation serves multiple functions in that it assists therapists to focus on the relevant referential objects (themes) that are involved in maintaining the client's problematic patterns. This helps to foster self-observation, known as the 'observing eye' in CAT (Ryle & Kerr, 2002). The formulation also assists in negotiating alliance ruptures, when they appear in the context of referential objects, such as Jenny's drug use.

The unstable sense of self, that is characteristic of BPD, is particularly evident in Jenny's case in excerpts where anger and judgment are the topic of conversation or where Jenny perceives judgment in the context of the therapeutic relationship. In these cases, Jenny experiences *state shifts* and reduced reflective capacity. This presentation is well accounted for by Ryle's (1997) Multiple Self-States Model of BPD. At the lowest level, this model posits a restricted and extreme repertoire of reciprocal roles, which are presented in the formulation and evident throughout Jenny's therapy. The second level suggests rapid switches in self-states that occur as a result of dissociative processes in response to early adverse experiences. In Jenny's case these switches are evident when topics shift to and from her problematic drug use. Finally, the third level of the model describes impaired self-reflection, which occurs for Jenny particularly under high emotional activation. It is important to note that the diagnostic label BPD covers a heterogenous set of personality traits and there is considerable debate about the appropriate nosology to capture this complexity (Skodol, Morey, Bender, & Oldham, 2013; Tyrer, 2009).

The therapist repeatedly prompts reflection in the client in a manner consistent with CAT. It appears that Jenny is capable of reflection, but

only under certain circumstances, and that more therapy was likely needed for her to continue to develop this capacity. This case suggests that an account of BPD that primarily focuses on emotional dysregulation (Linehan, 1993) might fail to account for the diffuse sense of self that has been emphasized in other models (Kernberg, 2012; Ryle, 1997). It appears that this understanding of sense of self in BPD can assist the therapist to negotiate the relationship successfully. It would be helpful for future research to also consider a more fine-grained analysis of the different facets that make up reflection and metacognition and how they manifest in therapy interactions (Semerari et al., 2005).

In terms of addressing ruptures in the therapeutic alliance, this case illustrates two points that might help to elaborate alliance theory. The first is that the therapist appears to be attempting to pre-empt and prevent ruptures by explicitly raising the potential that themes like anger and judgement will enter the therapeutic domain. This appears to be a productive strategy, but it is not one that has been specifically examined in previous research. Studies have found different rates of ruptures in different treatments (Muran et al., 2009), and that focusing on the alliance can improve treatment (Constantino et al., 2008). Yet, it remains to be seen whether attempting to pre-empt ruptures actually prevents their occurrence, reduce their impact or whether other pathways might be more important. In this case, despite active efforts to sustain the alliance, quantitative data suggest that the alliance weakened over the brief course of therapy.

The second element pertaining to addressing ruptures illustrated by this case is that the formulation offers a shared language that can be used as a means through which to negotiate ruptures in the alliance (Shine & Westacott, 2010). In Jenny's case the ruptures appear to be closely linked with her key dialogical patterns in terms of feeling dismissed or judged by a critical or angry other. When these manifest in the relationship, it appears that the therapist and client are able to work through them. However, it is also evident that the productive therapeutic work is only done when the client's level of emotional arousal is contained to a sufficient extent to allow some level of self-reflection. This is consistent with Fonagy and Bateman's (2007) account of the mentalization system being inhibited by arousal of attachment.

The quantitative alliance data suggest that both the therapist and client perceived a reduction in the quality of the alliance across time in therapy. One study of interpersonal microprocesses suggested that the early phase of therapy should be characterized by consensual engagement

and that successful therapists disconfirm clients expectations of negative complementarity or hostility (Altenstein, Krieger, & Grosse Holtforth, 2013). The active, non-judgemental and collaborative stance of the therapist in this case appears to be consistent with this finding. Another potential explanation is provided by Valkonen and Leiman (in submission), who examine 'active barriers' that might be present in people with BPD that might inhibit self-observation. From the perspective of Transference Focused Psychotherapy, primitive defences, such as splitting and projective identification, are seen to impair reflective capacities (Clarkin et al., 2006). These defences appear to be present in Jenny's perceptions of critical judgment from the therapist and it appears that the therapy did not continue for long enough to overcome these barriers, and any related damage to the alliance. It is also possible that Jenny felt judgement in her broader social context, and that this might have contributed to her moving houses.

This study has a number of limitations. The therapy for the case selected was terminated early by the client who moved too far away from the mental health service to be able to attend further sessions. Hence, it was not possible to follow up how these findings might have developed across time in therapy and it is possible that further sessions of therapy might have affected the alliance and outcome ratings that have been provided. The psychometric data point to a reduction in Jenny's BPD symptoms and also her depressive symptoms, yet both remain in the clinical range and as such the result could be considered 'improved but not recovered' (Jacobson, Roberts, Berns, & McGlinchey, 1999, p. 300). At six month follow up her level of global functioning appears to have remained stable and impaired across treatment. This is broadly consistent with the common trajectory for BPD, which involves symptomatic improvement concomitant with functional stagnation (Gunderson et al., 2011; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010). It is unknown how further sessions might have influenced this trajectory for this individual client.

Another shortcoming is that DSA is a qualitative analytic tool and as such does not conform to traditional definitions of reliability (Leiman, 2012). These shortcomings are addressed to some extent by consensual group-based analysis. However the extent to which the analysis provided is justified in light of the case material presented is left open to challenge. The approach is vulnerable to criticisms of disproportionate influence of individuals in the data analysis team, or that prior conceptions might influence the data analysis process. Additionally, in a single case study

design, it is unclear whether results will generalize to the broader population.

This study has several implications for clinical practice and research. The first applies to the therapist's inner processes and stance during therapy. Classical conceptions argued for the therapist to offer an 'evenly hovering attention' in therapy (Freud, 1912, p. 111) as a 'participant observer' (Sullivan, 1953). More recent integrations have emphasized cultivating mindfulness in order to be able to engage in and reflect on the therapeutic process simultaneously (Harris, 2009; Safran & Muran, 2000; Siegel, 2010). The present study suggests that therapists should aim to tentatively hold a case formulation in their minds, checking it with the client and consistently attending to fluctuations in the therapeutic alliance, so as to maximize their flexibility and effectiveness in working with individuals with BPD to improve the client's self-observation.

Given the robust link between alliance and outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011), fostering a positive alliance might be seen as an evidence-based practice (Muran & Barber, 2010). This study extends beyond this, to suggest that it might be fruitful to use case formulation to assist in pre-empting ruptures in the alliance, as suggested by Ryle (1997). Therapists should also be aware of the effect of the context or topic of the session in mediating BPD clients' reflective capacities and use their formulation to inform their understanding of fluctuations in self-reflective capacity. Further studies are needed to examine how to effectively achieve this and to further clarify the relationships between reflection, formulation and the alliance and how they might best be utilized by therapists to enhance outcomes. □

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If I work with the mother will the child get better?

Harry Potter says to Draco : 'Love blinds. We have both tried to give our sons not what they needed, but what we needed. We've been so busy trying to rewrite our own pasts, we've blighted their present.' (Rowling ,J.K., & al. P 279 (2016).

Marie-Anne Bernardy-Arbuz

Abstract: Children with Encopresis are hard to treat (1998). The two children described here, had been through various therapeutic approaches (psycho-dynamic and psychoeducational) without benefit. Rather than family work, the author chose to work directly with each of their mothers using Cognitive Analytic Therapy with the idea that if the mother develops an understanding of her relationship with her daughter, the child's symptom of encopresis might be relieved. The focus of the therapy unexpectedly was more upon the mother's understanding of her own childhood trauma.

The paper explores how the relational dynamics of the mother's childhood trauma is re-created in her relationship with her girl child and how therapeutic understanding for the mother, allows the mother-daughter relationship to change and the encopresis in the child to be relieved. There are no clear answers theoretically either to the mechanisms of transmission of the trauma from one generation or one body to another nor in the mechanism of therapeutic change that lead changes in the mother to enable changes in her daughter. This paper is an invitation to colleagues to further explore the complex relational processes involved.

Keywords: Encopresis, symptom, mother-daughter relationship, inter-generational transmission, co-embodied, abuse, family secret, cognitive analytic therapy.

THIS ARTICLE describes two therapies with mothers seeking help for their daughters who show symptoms of secondary encopresis. According to DSM5 (2013) encopresis 'is essentially a repeated passage of faeces into inappropriate places, such as on clothing or the floor'.

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While typically the passage is involuntary in nature, it can be intentional in some cases, linked to oppositional behaviour. The French meta-analysis by Boige and Missonier (1998) points to relational difficulties in families when a child shows a symptom of encopresis. The authors recommend that contextual, family and environmental factors should be taken into account in an integrative, psychosomatic therapeutic approach, linking organic and psychological elements, rather than dissociating them (1999). For other clinicians, Interactive Parent-Child Guidance has shown its effectiveness (2006).

The purpose of the present paper is not to describe different approaches and show their effectiveness. The two CAT therapies we have been conducting with the mothers of girls showing symptoms of encopresis, were offered after psychoeducational work with parents and children as well as psychotherapy for the children had failed.

In our out-patient clinic in Paris (CAMHS) there has been an acceptance that sometimes the child might be 'symptomatic', but it will be the parent who directly needs our attention if we are to help the child. It is with this idea in mind that both mothers were offered and accepted sixteen sessions of CAT's relational approach to therapy. CAT is an open and versatile model and has a lot to offer to parenting with its particular emphasis on 'the relational', especially the parent/child relationship and its flexibility, allowing the movement back and forth between the child and the parent if needed, as Jenaway (2007, 2013) and Varela (2016) have already shown in their work.

As we shall see, the mother's own abuse was a family secret, kept within the family – in a 'protective bubble', without ever revealing anything to a professional or anybody else. The child psychiatrist invited the mothers to engage in individual psychotherapy in order to work on their difficult relationship with their children. Both mothers could get very angry, but the anger was always shown in the relationship with their daughters and rarely with the older boy siblings.

In both cases, the mothers revealed their own history of abuse and their suffering during the first sessions of individual CAT therapy. The children were seen a few times by a child psychiatrist in order to 'keep an eye' on their 'toilet training' during the mothers' therapy. We also wanted to observe any effects on the child of the therapy with the mother. In both situations the first child in the family is a boy. The boys in both families are doing well and it is the girls who are both suffering with encopresis.

We began the therapies with a series of open questions. How might the symptom of encopresis in the child be linked with the expression of the mother's suffering? Was there a transmission of suffering and pain through their bodies? For instance, could there be the repetition of a damaging pattern of bonding such as an insecure attachment arising from the experience of sexual abuse suffered by the child's mother in her own childhood? If so, why is this mainly with the girl children? If the mothers were protectively controlling of their daughters were they then able to rebel and be oppositional to the mother in ways that the mother could not be with her abusive parents? In sum, could the symptom of encopresis in children sometimes be related to a traumatic life (sexual abuse by parent or grandparent in these cases) experience of the mother when she was herself a little girl? Were both mothers unconsciously trying to protect their daughters?

A second range of questions concerns the mechanisms of therapeutic change. If therapy with the mother is successful what is it that changes in the mother that indirectly relieves the encopresis in her daughter? With these issues in mind I share description of two therapies with a mother of a daughter with secondary encopresis.

I offered sixteen sessions of cognitive analytic therapy (CAT) to both mothers. I chose CAT, for its relational capacity to link the interpersonal and co-embodied relation between mother and child past and present. I didn't realize until later that it could also show the relationship across three generations. CAT as a brief model of therapy is an asset in our CAMHS setting as it helps us get off the symptom hook and work with the family relationships.

We have developed CAT as our practice in France in the context of a strong psychoanalytic tradition in which the neutrality of the therapist/analyst in the relationship to the patient is emphasized. In our work we advocate what is called '*désir sur le patient*' in French. This translates as a willingness on the part of the therapist to have hope for the patient, to get involved in the patient's struggle. The collaborative work in CAT gives shape and a safe voice to this '*désir*'.

In order to respect the confidentiality, names, locations and some of the details of the patient's history have been changed.

First therapy: Sophie in relation to her daughter Lucy

Sophie's parents never listened to her needs. Very early on in the CAT sessions, Sophie starts talking of 'bizarre physical contacts' with her father, where he invited her to come and do 'play fighting'. It remained difficult for us in therapy to call what had happened to Sophie by its proper name of 'sexual abuse'. She needed time to feel confident, especially as we unpacked the weight of secrecy she had been carrying for years without telling anybody. Her mother did not protect Sophie from her husband's unhealthy and abusive treatment.

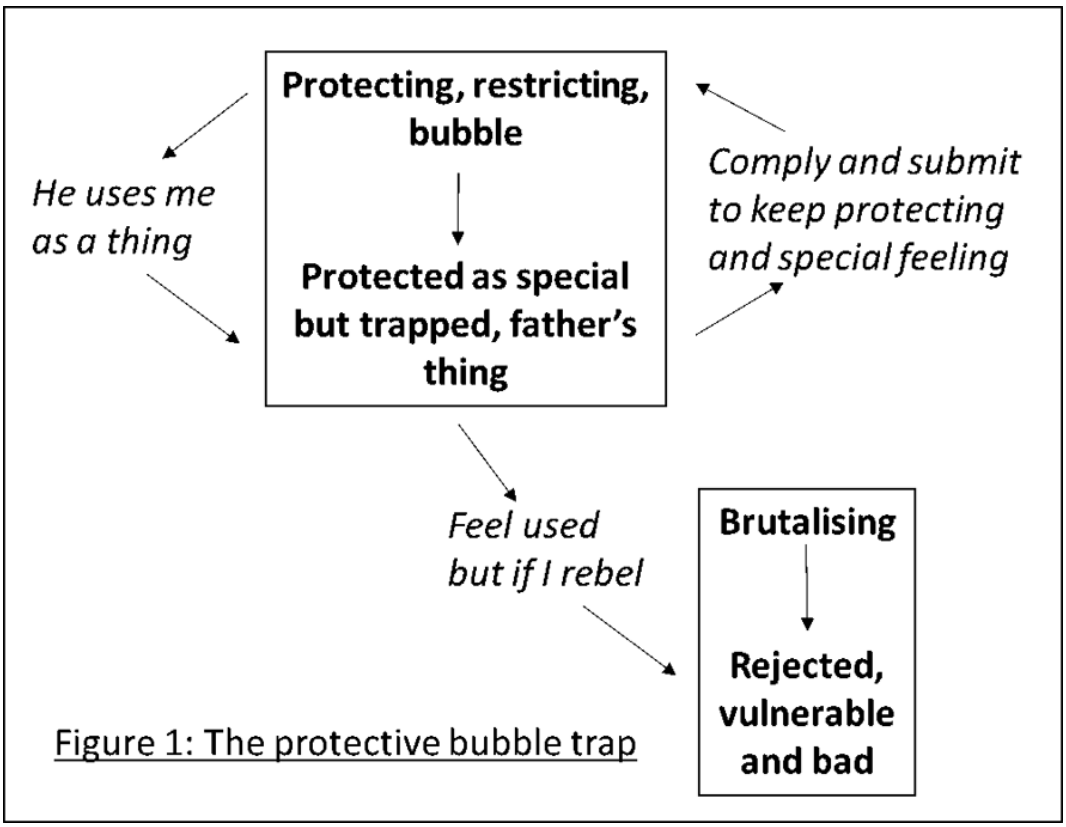

Figure 1: The protective bubble trap

As Sophie's therapist, I felt all the weight of these disclosures during the sessions, as if I were intruding into what had been kept secret for a long time, feeling the pain of this suffering, and holding her fear of what would happen 'if her father were to discover that she had disclosed this secret'.

After her parents divorced, Sophie was abandoned by her mother to the abusing father. She hardly ever saw her mother after the divorce and even when Sophie tried to commit suicide as a 'cry for help', her mother did not respond.

Sophie described how her father put her inside what she called a '*bulle de protection*' (tr. protective bubble), which turned out later as being a prison in which she was abused. When she rebels and refuses to be her 'father's thing', he becomes violent. Her dilemma was then in her words: 'either I am everything for him 'his thing', or if I rebel, he will become extremely violent, hurt me and reject me. And I will be nothing.'

The map of the 'protective bubble trap' helped us to contain her fears and anxiety as she understood gradually why she had not been able to escape this terrible trap. To calm herself, she would do relaxation exercises after the sessions and thus, put herself inside another 'protective bubble'. As she gradually felt safer in therapy, she stopped putting on this self- protective 'skin/coat'.

At the age of 16 years, Sophie tried to escape from this 'incestuous' relationship with her father by attempting to commit suicide. She described it as a 'call for help'. But nobody came to help her and when Sophie got back home it got worse. Sophie fled from the abusive home when she turned eighteen. But she had no qualification, no job and met in this context of vulnerability a man who repeats her father's abuse. She manages to escape from that abusing relationship, showing capacities of resilience and finds a man with whom she has a loving and stable relationship. He is the father of her two children. But Sophie carries the relational patterns of her abuse with her, causing her a lack of self-esteem and has an increasing number of panic attacks.

Sophie starts her first therapy after Lucy, her second child is born. Lucy as a girl child offers a mirror which re-activates the relational dynamics of her own unresolved sexual abuse. It is as if some of the repressed, unsolved conflicts, pain and suffering were popping up and abruptly forcing their way into the present.

Lucy triggers the reciprocal roles of her mother's childhood: over protectively controlling, to overly controlled. When Lucy is provocative and tries to control her, Sophie can feel her own anger growing. After the onset of anger, Sophie realizes her behaviour and feels guilty. She then wants to put her arms around Lucy and kiss her. This reminds Sophie of her childhood experience. After her father had hit her, he wanted to stroke her. We worked this out by mapping together what was happening in these particular moments and it helped her develop a compassionate observing reciprocal role in relation to herself.

As a child it was too dangerous for Sophie to show her anger. She learned to repress her feelings and cut off. This seems to be her core

problem, as she repeats the abusive configuration of reciprocal roles with Lucy. But Lucy has the possibility to rebel and this changes the outcome and the configuration of their relationships. In the process of naming this we were able to work more deeply on Sophie's childhood, where she could not rebel, as it was too dangerous. As an adult, she can change and, release herself from the 'compulsion to repeat' and find new exits.

The compulsion to repeat is one of Freud's earliest concepts appearing in a certain number of his writings. It is understood as a compulsion to resolve, connect with or escape from the relational character of the trauma. It fits well with the CAT understanding of the repetition of formative early relationships. J.D. Nasio, (2012) writes 'that which has not found a signification in our head, always comes back in our acting, whereas that which has found a signification, stops coming back.' In her troublesome interactions with her daughter Sophie was caught up in a pattern of reciprocation which she was compelled to repeat in search of a meaningful exit which never came.

Sophie feels controlled by her daughter Lucy's encopresis. Lucy seems to express with her symptom and in her body something of the mother's childhood trauma. Looking at trauma work, especially by Bessel van der Kolk (2014) and the way the Vagus Nerve reacts to trauma, there might be an explanation of the child's symptom in relation to the mother's sexual abuse, as an expression of co-embodied suffering.

In our work of mapping together, we identified moments where Lucy is opposing, refusing to do what her mother asks her to do, like getting ready for bed, cleaning up her toys, sitting on the toilet. Sophie, confronted with Lucy's anger, 'quits the scene', 'rejecting and abandoning' her daughter somehow, as she was herself abandoned as a child. Sophie's love towards her daughter appears conditional and demanding. There seems to be a repetition of Sophie's experience as a child. Sophie says that she wants to get rid of her anger through therapy and avoid spoiling her relationship to her children and especially to Lucy.

Sophie describes herself becoming a phantom or a fawn in dangerous situations, (figure 2) and we work on 'if I am a phantom, I cannot get caught and if I am a fawn I run away at the slightest noise'.

Reading the reformulation letter seemed to have a traumatic effect on Sophie. She is crying and says she is feeling dirty, oppressed, frightened, as if 'it had all come back', when she wanted to get rid of all these memories. Perhaps it is too exposing and she is not yet in the zone

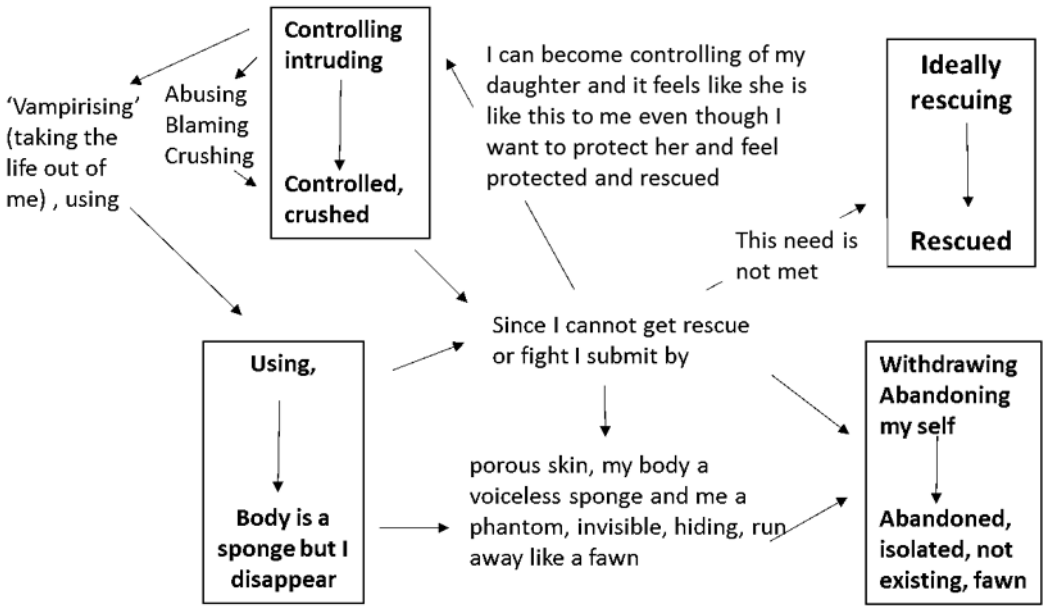

Figure 2: How the child's needs trigger the compulsive, unformulated, unconscious reciprocal role pattern arising from the mother's childhood abuse: for example when my daughter wants a cuddle it feels controlling and invasive and rekindles my body's memory of abuse. Since my body cannot hold her, she holds herself and I become invisible and she fights for care and I become angry and attacking which she copies.

to make use of it. At session eight, we explore Sophie's relationship with her father in a 'psychodramatic vignette'. She shakes and is afraid of what he could do to her. She becomes the little girl, a prey without any defence but as we talk, she realizes that she is no longer this little defenceless girl. We write a 'protective' sentence for her to take home, in order to fight this fantasy: 'Today, I can defend myself and nothing can happen to me'. Sophie also came to therapy with symptoms of somnambulism and nightmares which faded as the sessions went on. The decrease in these symptoms was for us an indicator of progress.

Sophie is gradually stepping out of the 'protective bubble' into a more open bubble with me in the therapeutic relationship. She can begin to look at what happened and how all this might be in relation to her

daughters' oppositional attitude which in turn makes Sophie feel controlled. More generally, this makes us reflect on how our defences can constitute a false protection to change and how we need a protective, secure environment in order to be able to change. As we get to the end of therapy, Sophie starts letting go. We can share her feelings of being 'abandoned' by me after such a 'short' period.

She felt able to acknowledge that she 'is an adult woman now and that her father can no longer harm her'. She has learned to stay with her daughter's anger and not run away 'like a fawn' and abandon her as her own mother did when she was a child.

Second therapy: Anabel in relation to her daughter Maya

Anabel came into therapy saying that she wanted to learn to 'manage her anger' which she was only expressing with her children. She did not want to behave like her mother who could be very impulsive, controlling, blaming and sometimes blackmailing her.

She explained: 'There was something that frightened me as a child and that I have not been able to digest'. Anabel described a 'merged relationship with her mother' and was kept inside a 'protective bubble', which oppressed her. All the family secrets were hidden in that same bubble. The protective bubble revealed itself as a false protection, filled with denial, anger and fear. It was where her mother imprisoned her. The only possible escape for her was cutting off.

The 'protective bubble' burst when Anabel was in her twenties, as her mother separated from her father and she was told that all five children, were from five different fathers. Nobody wanted to tell her why her father had been kicked out of the house. Years later, Anabel's father revealed to her that he had sexually abused her two stepsisters. He presented the abuse as a commonplace event to her and was never prosecuted.

The words 'anger, guilt and regret' are very important for Anabel as she talks about her past history. Guilt, because she did not cut the relationship with her father immediately. Regret, because she could never tell her mother all the wrong she did to her and because she could not blame her father any more for what he had done, as he started having signs of dementia.

Anabel's four year old daughter Maya suffers with encopresis. Anabel

was wondering in the first session, whether there might be a 'family heritage of bottling up'. She describes a difficult relationship with her daughter, for example, when Maya does not dress quickly enough Anabel can get very angry. Anabel is aware of her difficulties to control her mood when Maya is opposing her and says. 'Either I control her or I am lost'. Gradually, we could understand and name the way she was working through her own trauma in relationship with her daughter. She was confident and seemed relieved to be able to talk about her past, even if it was painful to recall what had happened.

Anabel described nightmares: 'where she tried to find a light, but the switch did not work'. In other dreams she is forced to have sex with a very strong and big person. Anabel is unable to find links in reality, as she has no memories of any special events in her childhood. We wondered whether Anabel could have been abused at a very young age before she was even able to speak. We also talked about the atmosphere of insecurity in which she was living from a very young age, with an impulsive and insecure mother. Anabel realizes that she behaves with Maya in some ways like her mother was with her.

At her last session, as she sits down, Anabel looks at me and says: 'I wonder whether I have let go of things because Maya has been to the toilet for the last four days and has declared that: she is a big girl now, she can take care of her faeces and go to the toilet'.

After sixteen sessions, Anabel had recognised what caused her controlling and sometimes aggressive behaviour towards the children and especially in the relationship with her daughter. She had managed to stop and revise this behaviour and Maya had stopped retaining her faeces. But Anabel had felt also that she was still kept a prisoner inside the family bubble, not allowed to get out and talk about what had happened. Considering the overwhelming feelings of anxiety which she is describing at follow-up, we decide to add eight sessions.

These additional sessions allowed her to disclose slowly, respecting the needs of her '*temps psychique*' (her own emotional pace). Only when she is ready does Anabel talk about her mother's sexual behaviour of inviting her into her bed whilst she was masturbating. Recalling these painful events, makes Anabel still feel dirty and ashamed. At the same time, she acknowledges that talking and feeling heard now, makes all the weight she was carrying gradually vanish. The CAT framework of collaborative work with the diagrams helped to enable and hold what was being felt and said.

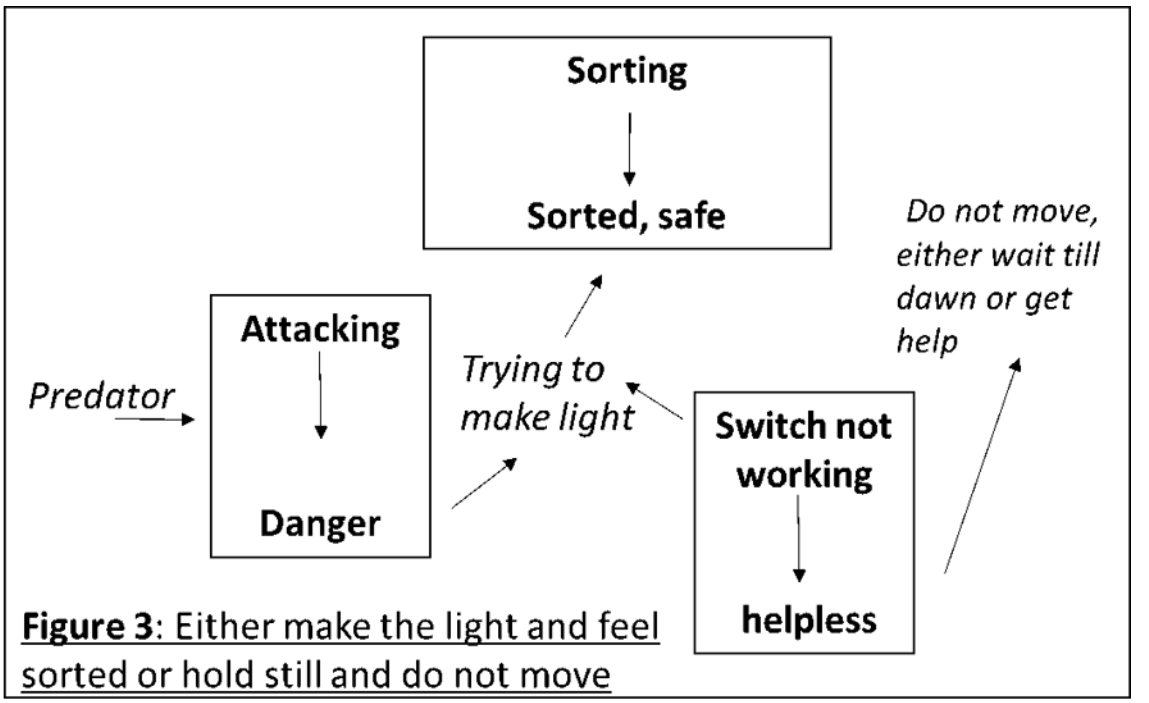

Figure 3: Either make the light and feel sorted or hold still and do not move

We also deal with nightmares. One she is having three or four times a week. In this nightmare Anabel reports. 'Being in the dark, lying down and having to switch on the light, searching for the button, finding it, but the button does not work.' This overwhelms her as she cannot 'make light'. She says. 'I do not move. I am petrified. I wait for daylight to come.' Another nightmare which she calls 'the attacking nightmare' goes as follows. 'I am supposed to put books into order on shelves… and there is a shelf where it says PREDATOR! As we map these nightmares (Figure 3) Anabel realizes that when she started feeling the onset of anxiety coming back, Maya was also showing symptoms on encopresis again. This diagram shows the importance of working relationally as there is constantly a mutual mother/child – child/mother influence. Could it be that Anabel was petrified by anxiety and fear of what could happen to her, so she would not move and Maya would pick up her anxiety and her bowels would stop moving? Could it be something of a co-embodied experience, with feelings deeply related between mother and child and a clenching of bodies defensively that is enmeshed in the transgenerational moments of aggression and opposition.

The additional sessions allowed Anabel to break out of the imprisoning family bubble. She started talking to her siblings about the

events that had been forbidden to be spoken of by her mother, elder brother and elder sister. She felt rubbished as they attacked her for 'disloyal' behaviour, made her feel as if she had made up the terrible events. But she was capable of distancing herself from these attacks and stepped out of the family circle, having learned to redirect her anger to those who she felt deserved it.

At follow-up three months later, Anabel said that she had put everyone in his rightful place, that she had taken her own place and was no longer in her words 'the helpless baby in the high chair watching events', but she was 'a grown-up taking responsibility and deciding for herself.' She felt relieved and so were her daughter Maya's symptoms.

Discussion

Whilst writing this article I became more and more conscious of the way I am working with parents in order to help the child. All of a sudden I had an impression of multiple voices simultaneously interacting – mothers with their children – mothers with their inner child – mothers with their own parents. It has started a theoretical enquiry for me between CAT's reciprocal role concept, the psychoanalytic idea of the 'compulsion to repeat' (1920) and Nasio (2012) and Bessel van der Kolk's (2014) more biological and body focused approach.

The parents of these two mothers seemed to have changing self-states, going from uncontrollable anger to hugging, caressing and abusing. As adults Anabel and Sophia were left with inexpressible and inaccessible anger. They behave in a controlling way with their daughters Maya and Lucy and show angry reactions when the daughters are showing oppositional behaviours. They are petrified with fear when the situation gets out of control. Both mothers had one parent abusing and the other parent not protecting, ignoring, behaving as if nothing was wrong, like a silent 'watcher'.

Their daughters carry symptoms of encopresis with an indication that this is an expression of opposition to their mothers. Both parents are controlling in the therapy sessions and need their own 'psychic time' to 'let go' as in both cases it was forbidden as too dangerous to 'talk of what was going on'.

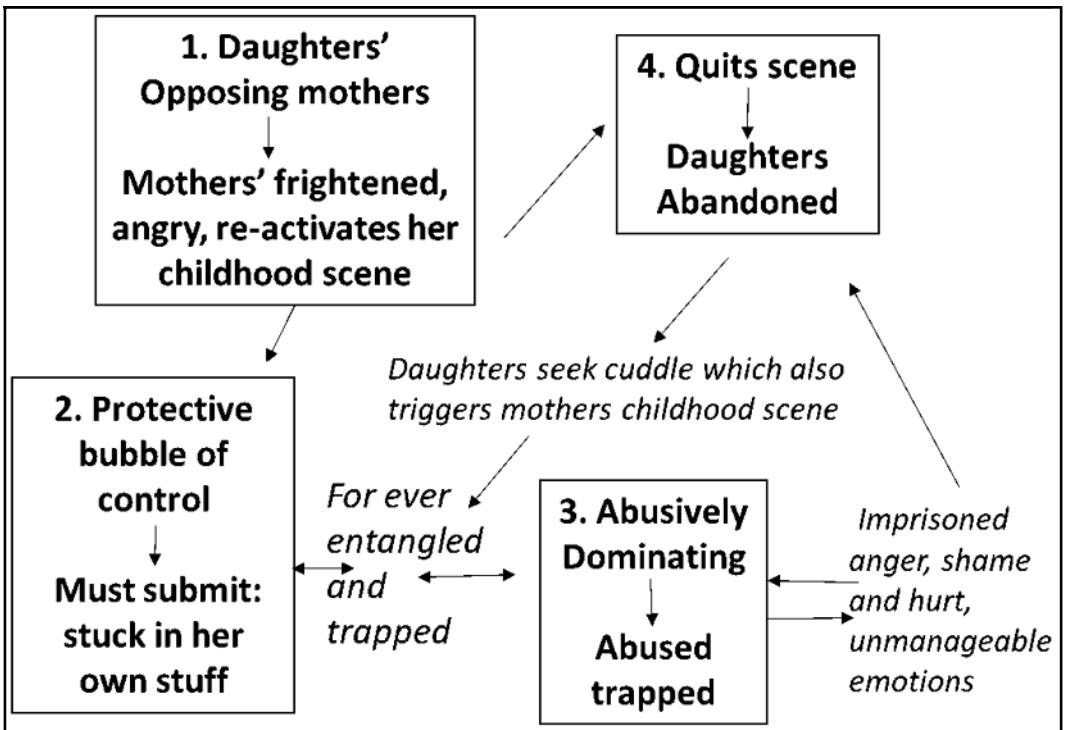

Figure 4: Mapping the compulsion to repeat using reciprocal roles

A conceptual map of the compulsion to repeat using reciprocal roles

I have tried to summarize in Figure 4 what could be at stake for the two mothers and how they need the help of being in dialogue with another (a third person) before they learn how to use the therapy.

The diagram attempts to summarize the concept of the compulsion to repeat in CAT terms. When the daughter is oppositional (1) in response to a protectively and controlling mother, the mothers' reciprocal roles are activated (2,3,4) of over protection entangled with abuse and control or domination followed by flight or quitting the scene. They are activated self to self and to the daughter and perhaps to the mother's body. Whether the daughters are oppositional or seeking a cuddle the mother's childhood pattern is equally triggered. Both mothers have grown up bottling

their angry inner child inside themselves. The expression of anger would have been too dangerous, maybe fatal. The mother is imprisoned '*dans son propre bazar*', 'in her own stuff' (Role 2 in the Figure 4) without a possible exit.

The compulsion to repeat their patterns by both mothers is painfully exposed when repeated with their own child who is free to react with opposing and rebelling behaviour rather than submit. This is an option which the mother never had and of which she cannot make sense or contain because in CAT terms the protective reciprocal role is entangled forever inside her with the abusive reciprocal role (2 and 3 in Figure 4). The repetition constantly brings back the mother's unmanageable anger as well as a feeling of helplessness of her inner child. This feeling seems to be mixed up with the daughter's oppositional feelings and when the child insists, the mother refuses. Because she feels stuck, she quits the scene (fawn, phantom) which then makes the child feel abandoned (4 in Figure 4).

Mapping together helped us hold a compassionate focus at points where the compulsion to repeat her reciprocal role procedure of running away was strongest. Two exits came alive in the session: one not to run away but stay with the mix of feelings and secondly to develop with me a shared reflective capacity. My way of mapping is to make scribble sketches beside her and then to offer her to take them away. Before the next session I have done a tidy version on my laptop which I share in print form. Once, when looking at the map and my tracing of the running away repetition when things get difficult, we noted she didn't run away at that point. In sharing and exploring their stories through CAT these two mothers were enabled to stay in therapy with me and not run away and hide. It was as if the mapping allowed the projection of terrible events out of the person's body onto a blank screen, enabling the freeing of imprisoned and cut off emotions. Through the words written on paper, it becomes possible to revisit the trauma, to understand what was happening and slowly step out of the compulsion to repeat by gradually letting go of the pain and the anger caused by the trauma and find exits to a healthier place.

These mothers try unconsciously to repair their own damage. But they are in conflict with what happened to them as children and their need to protectively control their daughters today. It is like a huge misunderstanding, where they 'say' to their daughters, 'Consciously I want to protect you, give you so much love but unconsciously I want to repair, through you, what happened to me'. Things get muddled up as

the parent has no awareness of wanting to repair her own trauma and the child does not understand why her parent is behaving in this way.

This interpersonal drama may also be enacted repeatedly through reciprocal 'body' memories between mother and daughter in ways which we cannot yet understand. I noticed that when both mothers were talking about their anger it showed up most in the region of the stomach. Both mothers were also talking about 'something that was stuck there and that they had not been able to get rid of'. Bessel van der Kolk's (2014) work on trauma makes me wonder about co-embodied transmission through the intestine. As the therapies went on, they could feel and express what was going on 'inside'. They seemed to be able to connect with the 'cut off feeling'. By the end of therapy, they were able to say that 'something had loosened', the knot of stuck anger was gone. Their two girls had started to go to the toilet. Although there must be a link between the mother's difficulties and the child's symptom, we are only at the stage of beginning to ask the right research questions before a possible wider and more focused study.

Conclusion

Encopresis as a symptom calls our attention towards a relational problem with the parent (1998, 1999). In these two examples, we might venture to argue that both children might have used encopresis as a symptom to show that 'something' in the relation with their mothers was not right. We might add that encopresis might have come into action as a way of controlling the mothers or of having some control of what was happening to them. As professionals we have to be careful not to get 'trapped' and only 'treat the symptom'. As D.W. Winnicott (1965) said 'there is no such thing as an infant'. We might expand that statement and say 'there is no such thing as a child's symptom'. In order to understand and help, we need to look into the family system and the relationships within it across the generations. The versatility of CAT's reciprocal role concept is very helpful in this respect. In work with children and their parents, there is always pressure to reduce the therapy journey to a problem solving one in relation to the child. I did not intend it to be a therapy for the mother but realized in the process that indeed it was. □

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The application of CAT within a school system; Reflections on a six-session intervention with a young person presenting with disruptive behaviour

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Abstract: 'Disruptive' behaviours are often used to describe a range of actions that challenge others, as well causing harm to the individual. Such behaviours present a significant problem in the school system with recognised wide-ranging impact on the young person and those around them (Lee, 2012; Victorian Government Department of Health, 2006). Current treatment approaches recommend that multiple systems are targeted yet these interventions tend to draw on behavioural approaches (Carr, 2002; Lee, 2012; McGee, et al. 2011) and emphasise the pathological processes of the individual (Varela, 2014). This paper reflects on the application of Cognitive Analytic Therapy (CAT) with a young person exhibiting disruptive behaviours at school, and includes the role CAT played in providing contextual reformulation and a relational understanding of the school system and the impact this

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had on the treatment. Reflections on the effectiveness of this intervention are made alongside a discussion about what CAT offers that is different to the more traditional treatment approaches used.

Keywords: disruptive behaviour; school system; young people; contextual reformulation; CAT; ODD

DISRUPTIVE behaviour is often labelled as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD). It is recognized as being a 'major mental health problem' in children and young people (Lee, 2012; Sawyer, et al. 2001; Zuddas, 2014). A Victorian Government Department of Health (2006) survey indicated that 17% of children and young people attending Child and Adolescent Mental Health Services (CAMHS) had Oppositional Defiant disorder (ODD) or Conduct Disorder (CD). The key feature of ODD or CD is 'a repetitive and persistent pattern of behaviour, which violates the basic rights of others and major age-appropriate societal norms' (American Psychiatric Association DSM-5, 2013). Indeed, such difficulties manifest as uncontrollable anger, verbal and physical aggression, destruction, defiance, extreme criticizing and blaming, and lying and stealing. A distinction has been made between ODD and CD with the former representing a less pervasive disturbance and a developmental precursor to the latter. In both cases anger and hostility are key mood states and problematic relationships with parents, teachers, peers and the wider community are a consequence. A high level of stress in any disruptive behaviour, caused to the young person or their family, peers and teachers, has been well documented (Eyberg, et al., 2008). They are also considered to be among the most costly of disorders of childhood and adolescence due to their unresponsiveness to treatment and poor prognosis, including reduced academic and employment prospects (Carr, 2002; Zuddas, 2014). Historically, emphasis has been placed on the pathological processes of the individual (Varela, 2014) and treatment approaches aimed to address this by focusing on social-cognitive skills training, emotional regulation (including anger control), medication and positive reinforcement from parenting (Lee, 2012; Steinert and Ramsing, 2007).

Multi-systemic theory recognises that multiple systems are involved in the genesis and maintenance of disruptive behaviours and that effective treatment must target as many of these systems as possible (Carr, 2002; Victorian Government Department of Health, 2006). Given the role of schools in socialising young people, and the bidirectional interactions

between disruptive youth and educational staff (Lee, 2012), school-based interventions have been recognised as a key component in the treatment of disruptive behaviours with inclusion of both class-wide and environmental interventions (Lee, 2012; Sanders, 2000). However, whilst it has been recognised that a poor working alliance between the young person and the school perpetuates conduct problems, school-based interventions tend to reflect an individual focus and be built around 'reward and sanction' programmes, as opposed to having a relational focus and looking at the unhelpful interactional patterns that play a role in the maintenance of such problems (Lee, 2012; Carr, 2002).

Thinking more contextually, consideration needs to be given to the reciprocity between organisations and the individual, or the link between the psychological world of the individual and the organisation (Caruso, 2013, Walsh, 1996), given the co-constructive relationship between schools (as organisations) and their students (as individuals). This article aims to think more about how disruptive behaviours are elicited and reciprocated by the school system and whether CAT can offer something new to this area.

As an integrative cognitive and analytic model, CAT involves looking at relationships that we have with ourselves (self-to-self) and others (others-to-self and self-to-others), with the formation of the self developing essentially in relation to others (Ryle and Kerr, 2002). Sign mediated experiences and the internalisation of the parent-child relationship (and the commensurate reciprocal role {RR} relationships that they come to represent) shape a child's understanding of the world and their sense of self (Ryle and Kerr, 2002). When working with young people with disruptive behaviours, it was hypothesised that there were some 'common', unhealthy reciprocal roles (see Figure 1).

CAT has a growing evidence base for use with a range of emotional and behavioural problems (Ryle and Kerr, 2002). Interestingly, early research conducted by Chanen, et al., (2008), looking at the application of CAT to young people with borderline personality features, found the strongest evidence of change to be a reduction in disruptive behaviours. There is also developing research looking at the effectiveness of CAT in the treatment of offenders who often present with externalising behaviour that challenges others (Pollock, 2007).

This article now describes a six-session CAT intervention with a young person presenting with disruptive behaviour. The intervention was conducted within the context of a school and reflections are made about

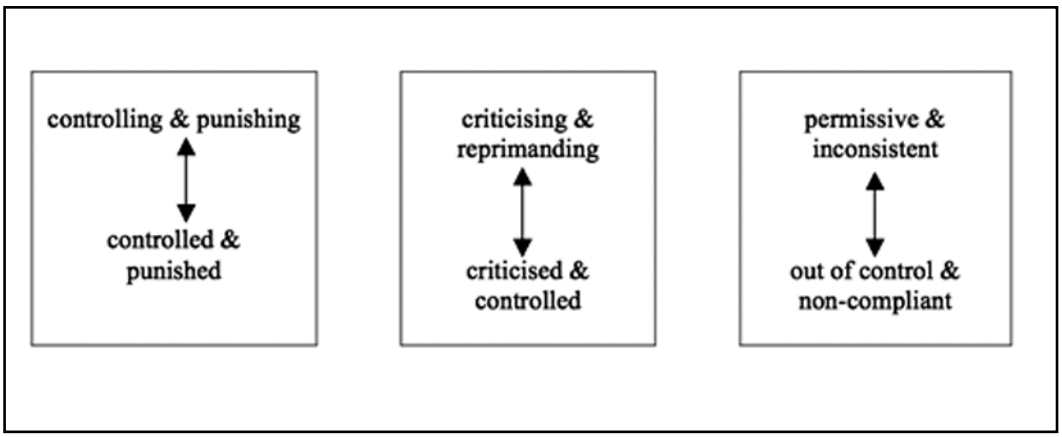

Figure 1: Translation of parenting styles to Reciprocal Roles (RRs)

the role CAT played in the case reformulation and treatment process and how it facilitated collaborative work with school staff. This is followed by a discussion about whether CAT can be applied, within the school system, to achieve better behavioural outcomes for young people with disruptive behaviour.

Six Session CAT Intervention

Sam was a 16 years old boy referred by his GP for 'opinion and management of issues with behaviour' under the Better Access to Mental Health initiative (Department of Health) which allows for ten mental health sessions per year. His GP further reported that his 'parents were very worried about Sam's attention seeking issues and not dealing with rules set by the family and school'. This referral was supported by Sam's parents and the school's welfare team, with all sessions occurring at the school. The referral was made to the therapist who had worked in a private capacity at the high school for five years. During this time, good working relationships with the teaching staff and the school welfare team had been developed.

Sam was the eldest of three boys, born to parents in their late teens. His family unit was intact and traditional in that Mum was the main carer and Dad worked outside of the home. Mum reported that both parents were actively involved in raising Sam, but that she had always felt anxious

about parenting Sam because she was a teenage Mum when he was born and that Dad was 'fairly' strict in his parenting style. Mum reported that Sam's behaviour had become challenging when he started high school. She reported that his mood seemed to drop, as did his interest in completing school work and being social with his family. Further, he had also hit out at his parents and siblings, been smoking marijuana and cigarettes and been 'lying'. She was concerned about a lack of empathy and seeming indifference to being in trouble both at home and at school. He was not thought to have a developmental disorder.

On discussion with the teachers frequently involved with Sam, they reported that he was 'extremely challenging'. In the classroom, he was frequently non-compliant, disruptive and argumentative. Based on past attainments, he was considered to be underachieving. Outside of the classroom he was often in trouble for breaking school rules such as leaving the school grounds, using a mobile phone, smoking and swearing at teachers and peers. When confronted, he would be oppositional, refuse requests and could be aggressive ('pushing; shouting; intimidating'). Sam had had three suspensions within the preceding six months and any further significant incidents would result in expulsion. It was also felt that Sam's peers were starting to ostracise him.

In the first session Sam presented as disengaged and shutdown. Whilst he freely came to the appointment he provided limited responses to questions and made little eye contact. The therapist asked many questions to establish that he was often in trouble at school and at home and that he 'hated' school. Reference was also made to self-doubt, changeable moods and feeling 'confused' about who he was. In response to Sam's presentation the therapist noticed that she was asking a lot of questions and doing most of the talking, including hypothesising answers; that this was different to her normal interviewing style and that it felt 'authoritarian', 'bossy' and 'controlling'. This reflection was shared with Sam and he was asked if he had ever experienced others in this way. In response to this, Sam reported that he experienced teachers as 'forceful and controlling'. In this very early stage Sam was able to articulate that the reciprocal to others being 'forceful and controlling' was 'controlled and attacked'. Procedurally, Sam knew that this led him to 'zone out' which meant that he 'couldn't think'. Both these roles were mapped out and noted to cause frustration (see Figure 2).

Establishing diagrammatically, in the therapy very early on, the core reciprocal role by reflecting on the relational dynamic being experienced in the room helped the therapeutic alliance start to develop. Noticing

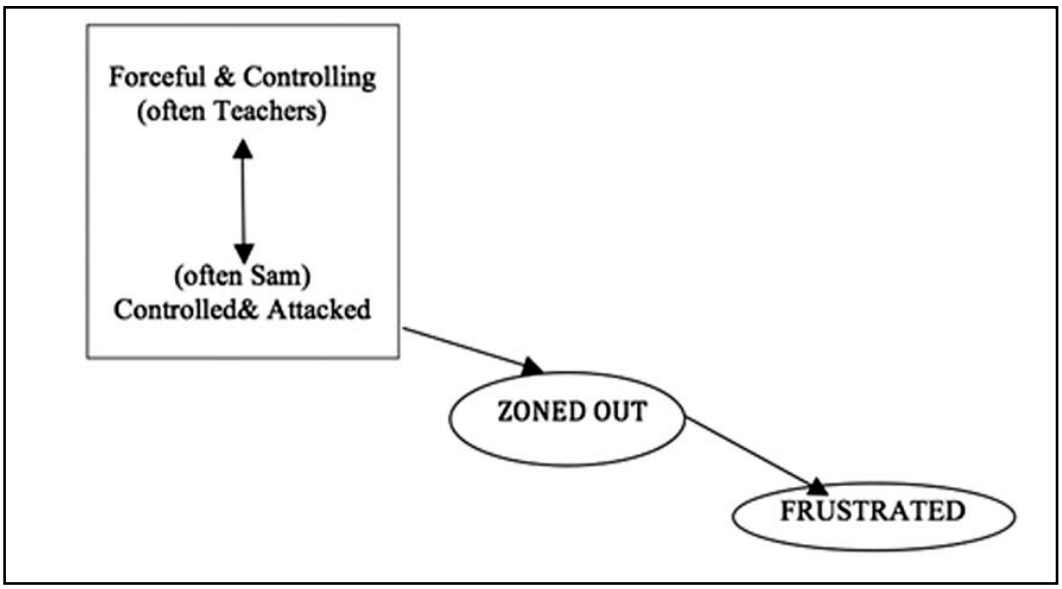

Figure 2. The core reciprocal role and mood state initially described by Sam

the invitation to take up a forceful and controlling role provided insight into the problems Sam was experiencing at school; namely how Sam experienced others and how others (or 'the school') experienced him. Noticing the 'invitation to dance' a controlling to controlled reciprocal role meant that the therapist was able to introduce a new reciprocal experience and use an alternative role of 'gently questioning and encouraging' to feeling 'open and encouraged'. This was in recognition of Sam being familiar with the position of feeling controlled and the need to give him a different experience. The aim was to assist Sam in expressing himself in a more flexible way, allowing for a collaborative therapeutic experience; a highly effective concept recognised as being central to the practice of CAT (Kerr, 1999). What was observed was that Sam shifted from his 'shut-down', 'zoned out' state and started to talk. He reported that he found it difficult to articulate what his problems were and that he felt frustrated with himself for not being able to 'figure them out'. Thinking 'too hard' or feeling pressured to provide an explanation further led him to 'zone out'. It was hypothesised that there was a self-to-self enactment of 'forceful and controlling' to feeling 'controlled and attacked'.

Following assessment Sam agreed to contract for six sessions of CAT-informed therapy following which there would be a review and further sessions offered if needed (as per Medicare guidelines). Six sessions were

agreed upon as Sam remained ambivalent about engaging in therapy and it was felt that this time-frame would provide Sam with some exposure to therapy (and a good enough experience), allow for a reformulation to be completed, as well as strategies to be explored that followed on from the reformulation.

In the second session, mapping was used straight away as it was hypothesised that something visual would assist Sam in communicating his experiences given his response to the diagrammatic representation of the core reciprocal role in the initial session (see Figure 2). The map gave a sense of sharing and collaboration within the room and provided scaffolding around developing a shared understanding of the target problem, leading to a verbal reformulation which initially Sam struggled with. Looking back, this was how the therapist stayed in Sam's zone of proximal development, a concept that Lev Vygotsky developed about learning (Wertsch, 1985).

Development of the Sequential Diagrammatic Reformulation (SDR) was made a priority in the second, and subsequent, sessions. Whilst more traditional CAT focuses on the development of the SDR after the reformulation letter in session four, it has been recognised to be of benefit earlier on in therapy (Ryle, 1997b). In this case, its value was highlighted by Sam's feedback that he could 'think more clearly' when his experiences were being mapped out which was paralleled by the experience of the therapist. Consequently, the reciprocal role procedures (RRPs) and main mood states were established (see Figure 3).

In exploring Sam's early experiences and through having phone contact with Mum, it was hypothesised that Mum compensated for her anxiety about being a good enough parent by being 'overly strict'. This parenting style was experienced by Sam as 'controlling'. Sam's perspective on Dad was that he was 'good at everything that he did', expected Sam to be the same and was 'harsh and critical' when these expectations were not met. In exploring Sam's early parenting experiences, we developed an understanding of how his sense of self developed (other-self internalisation), which is depicted in the core reciprocal role in Figure 1. We were able, to talk about how this core reciprocal role is played out in his relationship with himself (self-to-self), with the school and his parents (others-to-self and self-to-others). The sequential diagrammatic reformulation detailed the impact of these reciprocal roles and procedural enactments on Sam, in the form of a 'sunk low' mood state (see figure 3).

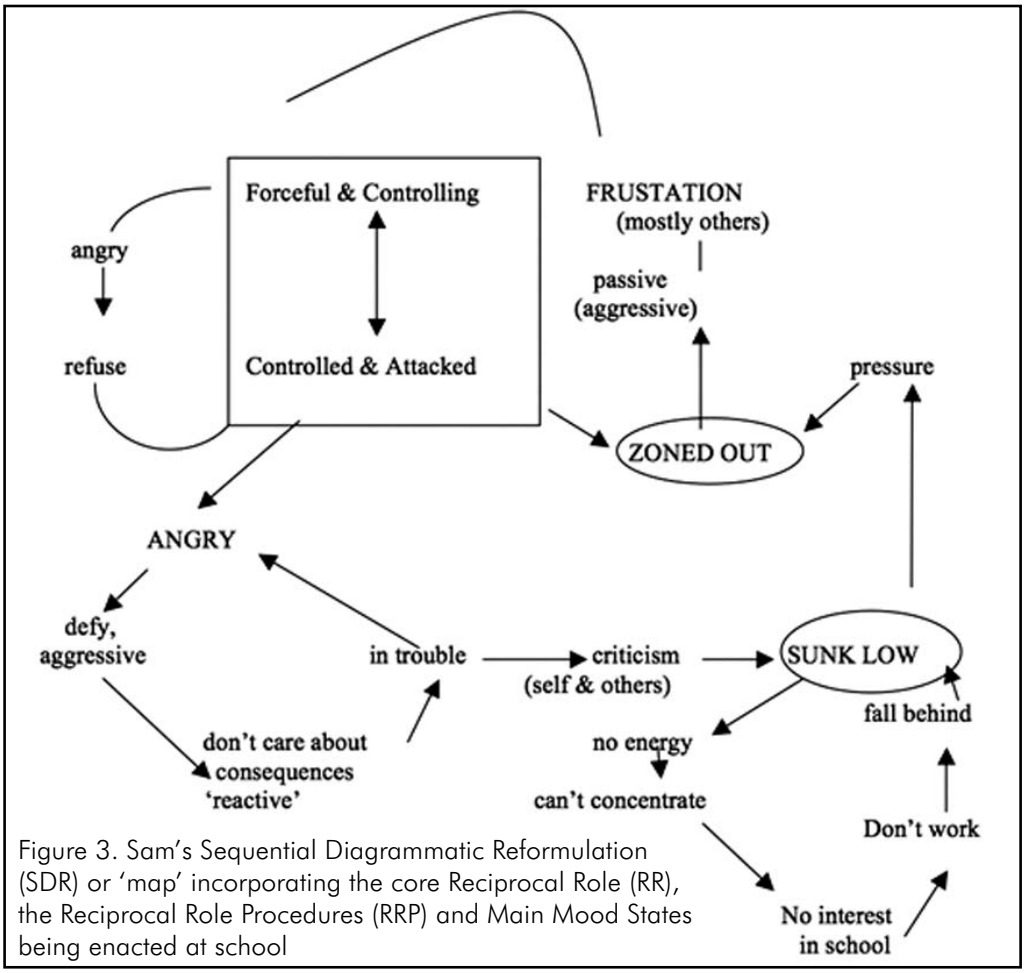

Figure 3. Sam's Sequential Diagrammatic Reformulation (SDR) or 'map' incorporating the core Reciprocal Role (RR), the Reciprocal Role Procedures (RRP) and Main Mood States being enacted at school

Given the reciprocity between organisations and the individual, and how unhelpful individual procedural enactments can amplify dysfunctional organisational processes (Walsh 1996), the authors started to think about what reciprocal roles existed within the broader school system. Schools must have clear rules and boundaries to function effectively (Victorian Government Department of Health, 2006) yet we wondered if appropriate rules and boundaries would translate into a reciprocal role of 'authoritative' to appropriately controlled and containing.

Given Sam's core reciprocal role he was sensitive to authoritarian environments and may have been likely to experience (or misinterpret) authoritative as authoritarian, himself feeling powerless, thus responding oppositionally to gain control and inviting others to become 'controlling and forceful'. However, Sam wanting (or needing) more control and in trying to move out of feeling 'trapped' pulls others to impose more rules and limits, and further contributes to him feeling 'trapped' and wanting

(or needing) more control. The aim of therapy with this model is to promote self-awareness through mapping these reciprocal role procedures (RRP); or the mechanics of what happens when we move from one relational stance to another. In mapping, it becomes clearer how specific behaviours, thoughts and feelings (or procedures) are intended to provide 'a way out' of an uncomfortable (or intolerable) self-state. However, when there are limited internalised reciprocal roles, there are limited reciprocal role procedures (RRP) leading to greater enactment and perpetuation of disruptive behaviours (and confirmation of the restricted stances).

Interestingly, Sam identified that he 'felt better' when with certain teachers, which led to discussion and reflection about what relational positions were being enacted at these times. It was detailed that the teachers with whom Sam felt that he got along, took a 'firm but clear and respecting' role, which allowed him to feel 'respected and accepted'. When this role was taken, Sam would feel irritated, but found this to be a manageable feeling and that he would usually comply (see Figure 4).

Linking back to Walsh, (1996), the SDR (or therapy map) in the case presented here provided a means of understanding the unhelpful relationship that had developed between the individual (Sam) and the organisation (the school). This understanding helped to make sense of how certain situations and interactions were perceived by Sam and the school, and resulted in an escalation of Sam's disruptive behaviour and the school feeling overwhelmed and imposing 'harsh' consequences. The 'therapy map' provided a visually accessible means of the problem interactions and allowed Sam, and the school, to take some ownership over the unhelpful procedural loops.

At this point in the therapy stage the map was used to increase reflection on what patterns were being enacted and the idea of 'exits' was introduced as alternative ways of relating and responding to unhelpful interactions. Ryle and Kerr (2002) state that recognition should be established before attention is directed to revision. However given that Sam was at risk of school expulsion and there was concern about maintaining his engagement in therapy, the notion of exits was introduced early on. It was hoped that identifying some feasible exits would provide Sam with some immediate alternatives, strategies and ways of coping, as well as highlighting the concept of 'exits' that could be further built on over time.

Sam's goal was to recognise when he was in the 'controlled and

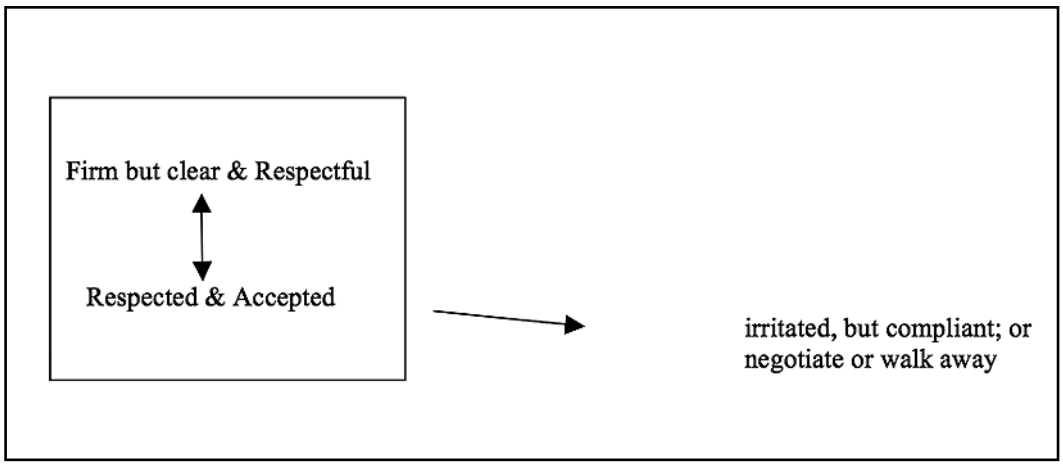

Figure 4. Alternative reciprocal role experienced by Sam with some teachers

attacked' position (the bottom pole) and when he 'came out fighting' was moving into the 'controlling and attacking' position (the top pole). Sam identified the following 'exits': complying; negotiating (if appropriate); or walking away (if it would prevent an escalation in anger). We also discussed more cognitive-based 'exits' such as identifying and challenging cognitions, with a theme around control, and identifying coping statements that he could say to himself.

The therapy map was shared with two key teachers who were regularly involved with Sam at school. These teachers were also known to be compassionate towards Sam, as identified by Sam and his Mum as being 'better able to manage him'. Working within the school system there is commonly a divide between teachers who hold a more traditional 'authoritarian' perspective on behavioural management and those who are willing to be more dynamic in their management of individual students. Given this, and that the intervention required teaching staff to take a specific relational stance, it was important to engage teachers that would support and become involved in the process. The aim of sharing the therapy map with the identified teachers was to provide an alternative non-blaming reformulation of Sam's disruptive behaviour. It was well received which was reflected by the acknowledgement of how different responses impacted on Sam's presentation. This led to further discussion around feasible management strategies (or 'exits') which included teachers taking a 'firm, but clear and respectful' role. It was further agreed that Sam could walk away (as opposed to being aggressive) with the incident being discussed at a later time, when Sam was less angry (and

that he would be accepting of any consequences). These teachers took the role of communicating the 'management plan' (via e-mail and verbally) to other teachers who were likely to come into contact with Sam.

Over the course of three weeks, the intervention was monitored in session with Sam and through regular discussions with the two key teachers. Sam reported that he was 'amazed' that the teachers also had to 'try and behave differently' and that they were willing to do this. Acknowledgment of the contextual influence on Sam's disruptive behaviour and the possibility of more positive 'other-to-self' relational experiences enhanced his motivation to engage with the intervention. In these sessions, the focus was on increasing Sam's recognition skills in relation to the therapy map and to facilitate revision. At the end of session six, the outcome reported by both Sam and the two key teachers was encouraging. Sam had noticed a difference in the way some teachers had approached him and that combined with his growing recognition and ability to 'take different exits' meant that a number of situations had been defused. Sam said that he felt more 'listened to' and 'understood'. The number of incidents resulting in Sam getting into trouble had reduced and feedback provided was that Sam had generally presented as 'less defiant' when approached.

Unfortunately, before further sessions could take place, Sam suddenly left the school. In a follow-up, and final, session that occurred outside of school Sam reported that there had been an incident with a teacher whom he experienced as 'forceful and controlling' and that he had felt 'targeted' and as a result behaved angrily. Following this incident, he 'decided to leave'. It was reflected to Sam that this was an enactment of Sam being 'forceful and controlling' to himself, but Sam responded that he just did not think he was suitable for school. Sam did not want to engage in further therapy sessions at this time but was excited about new opportunities outside of school. It was left open for Sam to make contact should he want to re-engage in treatment in the future.

Reflection and Discussion:

The intervention described above, although brief, showed how the core relational component of CAT translated into practice. This was done primarily through the use of the therapy map by the individual and the system. Walsh, (1996), talked about how developing a sequential

diagrammatic reformulation in individual therapy can provide insight into organisational processes and enable a non-blaming approach to be taken. Being able to diagrammatically form a description of the context in which Sam's disruptive behaviour occurred and the reactions it elicited in others, had a clear impact on the therapeutic process. The CAT framework showed how Sam's disruptive behaviour was influenced by the school system and that both Sam and the teachers had a role to play through the enactment of an unhelpful reciprocal role and reciprocal role procedure. Sam was increasingly able to reflect on the unhelpful reciprocal role pattern being enacted and how different ways of relating could be explored. The teachers involved were also able to reflect on how different ways of relating could generate different responses and how the school (as a psychological organisation) could influence the psychology of the self (Walsh, 1996).

Feedback from the teachers involved was that they 'liked this approach'. They found the 'therapy map' enabled them to more clearly understand the unhelpful reciprocal role procedure being experienced. Further, they were more able to see how Sam's core reciprocal role procedure was being enacted at school and how the school system's authoritative role was contributing. It also opened discussions around how Sam had internalised such reciprocal roles, enabling them to hold a less blaming and more compassionate stance when confronted with his disruptive behaviour. On reflection, it might have been therapeutically beneficial to have mapped with the teachers first their experience of Sam, which could have then been integrated into Sam's map.

The therapist had been working at the school for several years and had built up good working relationships with the teaching staff and welfare team which enabled the contextual reformulation to be more readily received. A new professional to the school might further have exacerbated Sam's unhelpful reciprocal roles by placing expectations on the teachers to engage with the contextual reformulation and try out new ways of relating, triggering resentment and frustration. Instead, it seems as if the positive outcomes of this piece of work came from 'other to self'. When the therapy was terminated prematurely, Sam had decided that he did not want to continue psychological work (which was disappointing for the therapist) but he did reflect that he found the work helpful, useful and non-blaming. The authors reflected that the piece of work had given Sam permission to leave school and not to have to continue with something that 'he hated'. If Sam had stayed engaged in the therapy then the next step would have been to write a re-formulation

letter and to help Sam increasingly recognise when he (unintentionally) invited others into a controlling pattern (self-to-other).

Working within the school system an implicit (or explicit) aim of psychological work is often to improve behaviour at school. With the intervention described here, the CAT process identified the target problem as being that Sam became anxious when he felt controlled. Whilst the focus of this intervention remained around the school, Sam's Mum reported being more aware of how the 'authoritarian' role triggered his disruptive behaviour both at home and school, however there remained tension between what Sam wanted to do and what his parents were willing to agree to. Greater involvement of Sam's parents in the contextual reformulation and how it related to home may have further enhanced their understanding of his disruptive behaviour, and facilitated different relational experiences at home. Whilst it was outside of the scope of this piece of work, it is recognised that caregiver participation is considered critical for young people with 'disruptive behaviours' who are considered to be at high risk of negative outcomes (Lee, 2012).

In using a contextual reformulation, it is necessary to consider whether helpful reciprocal roles have been established within and between the organisation, as this will facilitate the therapeutic process. In the case presented here whilst there were teachers who were actively willing to make changes to their relational style to work better with Sam, there were also teachers who were less willing to do this instead believing that the school needed to maintain a core 'authoritarian' position which should not be modified for individual students. Given that schools have to manage a large number of young people with varying needs and behaviours, it is an important point to consider and further research in this area could help explore what reciprocal role schools tend to take and whether an appropriate authoritative position is the ideal.

In this intervention, it was felt that CAT provided a way of communicating that suited the different individuals and organisations involved and reinforced its effectiveness as a case reformulation and consultation model. Given the interface between organisations and individuals (Falchi, 2007; Parry, n.d) there are benefits to using contextual reformulations to better understand challenging relationships within systems. In fact, Falchi (2007) argues that it is necessary to look at the organisation first and the psychology of the individual second. In the case presented here, the reciprocal role concept helped explain why teachers felt and responded differently towards Sam. This clinical example described here suggests that the power position of the teacher-to-student mirrors the

parent-child role that is established in a child's early life; a theoretical concept that is central to CAT (Ryle and Kerr, 2002).

Providing contextual reformulation that focuses on role relationships within an organisation has been found to be containing, educational and enabling of communication (Walsh, 1996). It was felt that these things were experienced in the case described here.

Given the high rates of oppositional and conduct disorders seen in children and adolescents, the recognised levels of stress caused by such problems and their unresponsiveness to treatment, developing theoretical approaches that will assist in their treatment is of great interest (Sawyer, et al., 2001; Victorian Government Melbourne, 2006; Zuddas, 2014). Multisystemic theory talks about the need for treatment approaches to incorporate systemic level interventions and it is suggested that the relational nature of CAT, with its reformulation tools, can offer something unique to the treatment of disruptive behaviours. Indeed, the contextual reformulation can be used to assist the student and the school in their awareness of unhelpful relationship patterns (and the invitation to enact these) and thus explaining alternative ways of relating and responding to conflict that ensues. Such benefits have implications for enhancing school-based interventions that aim to reduce the impact of behavioural disorders within a school setting (Victorian Government Department of Health, 2006).

The application of CAT described here, although short, provides an indication of CAT's potential when working with young people with disruptive behaviour within the context of the school system. More thought needs to be given to the role of CAT when working with disruptive behaviours within the school system and how this relational model can develop an understanding of unhelpful relationships that are often seen between students and teachers and which are often found in schools with high prevalence rates of behavioural disorders and high rates of suspensions and expulsions (Erford, et al., 2014). Given that there does not seem to have been much written about the use of CAT as an individual therapy model and as a contextual reformulation tool within this context, further psychotherapy research in this area would help establish its effectiveness and be of great benefit. □

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A relational approach to young people's mental health

Nick Barnes

Abstract: In the UK reform of mental health services for children and young people is currently high on the agenda. Demand has never been greater but the risk of perpetuating services that stigmatise and disempower young people needs countering. I propose that a relational approach which offers collaborative, respectful and joined up ways of meeting young people's needs, might counter this risk. This would involve learning from and integrating individual, family, systemic, youth and community work. Conceptual tools and methods from CAT can help sustain this integrative and relational approach.

In this paper I focus on the need to reformulate the context to children and young people's mental health work. It puts trust and collaboration at the heart of a relational approach allowing a focus on needs for belonging, identity confusion and a more existential uncertainty about self in the world. Using examples, I explore how CAT can help find a more negotiable and integrative middle ground between different self-states. This is mirrored by the various services being more connected, more community based and offering real relationships with each other and with the children, young people and families.

THERE IS CURRENTLY a heightened awareness of the growing mental health needs amongst children and young people although there appears to be a paucity of both data and of the exploration of the causes. There is a greater appreciation of the symptoms or behaviour reflective of this need, but limited understanding of the drivers of distress. We are left with a real sense of mopping the floor, rather than turning off the tap.

This article argues that any integrative and sustainable strategy must be based on the fine detail of a relational approach which combines

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interpersonal, systemic, developmental and social dynamics and professional contributions in its understanding. In the UK, the profile of children and young people's mental health has risen exponentially over the last few years – there has never been a greater level of reporting of this issue within the media. A recent literature search by Fonagy et al charted this rise in the media (see figure 1). The focus tends to be on rates of diagnosis and the need for treatment, with far less attention being directed to the context which leads us to reach for the Diagnostic and Statistical Manual, DSM V, for 3 children in every classroom of 30.

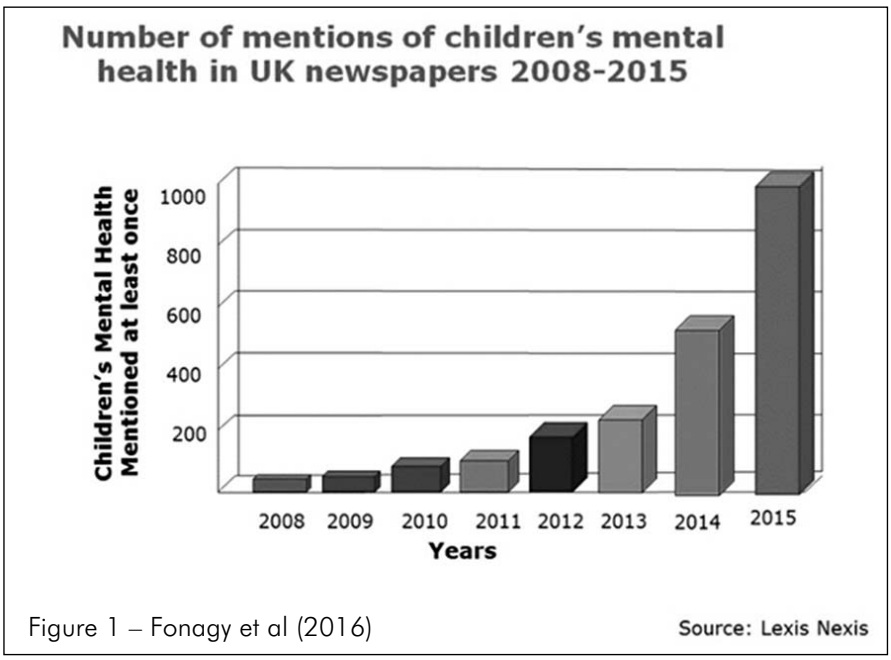
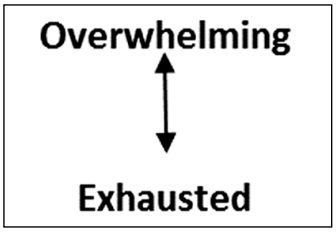


Figure 1 – Fonagy et al (2016)

Raising awareness will never be sufficient unless there is the capacity to meet demand – and many acknowledge, even with extra funding that 'specialised' services will never be able to fully meet the mental health needs of children and young people. I also doubt whether they should ever seek to do so. The shift for me, over recent years has been to explore earlier and more preventative approaches, offered much more within the community, and offering genuine opportunities for children and young people to stem this tidal wave of demand that is unlikely to subside. If we fail to initiate a more preventative approach at an earlier stage then I fear specialist services will find the demand overwhelming, and themselves become exhausted.

Figure 2



I have been particularly keen to develop ways of working preventatively, through CAT theory and with CAT tools in settings that are much more meaningful for young people.

As an example, for some this setting can be football, and partnering up with the foundation arm of a local premier league club Tottenham Hotspur, it was possible to develop a programme under the banner of 'A Game of 2 Halves'. Over a number of trial sessions, 'A Game of 2 Halves' evolved into a 12 weeks programme for young people aged 13-14yrs who were at risk of exclusion from school. By using football in both the dialogue and activity of the sessions, it was possible to help them develop an awareness of what might be going on within themselves and between each other, and to explore how their own actions could be impacting on how others felt about them, as well as reinforcing how they felt about themselves and others.

The sessions also involved support staff from the referring schools, so that a greater awareness could be shared not only within the group (team) on the pitch, but also be taken back into school and allow for a different perspective – a shift in gaze – to be offered to the wider staff team. With positive outcomes achieved from the viewpoint of the child, and an appreciation of further pro-social behaviour reported by the teaching staff, it was clear that a CAT-informed programme, offered within a group (team) setting, and delivered within a 'dialogue of football', created the space and opportunity for change for some young people. For the Bakhtinian influence on CAT theory, the dialogue of football represented a distinctly open time and place (chronotope) that gave different meanings to everything within it. It highlighted to me that a relational approach to mental health involves not only our relationships with ourselves and with others but also our relationship with the medium of delivery – on this occasion, football. I was left wondering whether Bakhtin supported a football team?

Barriers to support and loss of trust

In this spirit, much of my own work over the last ten years has focused on making services accessible and not marginalising young people's needs. We struggle to recognise our professional contribution to this reciprocal relationship of stigmatizing to stigmatized.

When I first started training, I was often faced with children or young people, and their parents, in clinic who simply did not wish to be there.

Figure 3

The 'systems' surrounding this young person and their family had eventually resulted in a referral to Children & Adolescant Mental Health Services (CAMHS) as a way of seeking to prevent an exclusion from school. The intention of the referral may well have been positive and supportive – but the young person had ended up feeling blamed, and the parents, often feeling angry, defensive, but most importantly, ashamed.

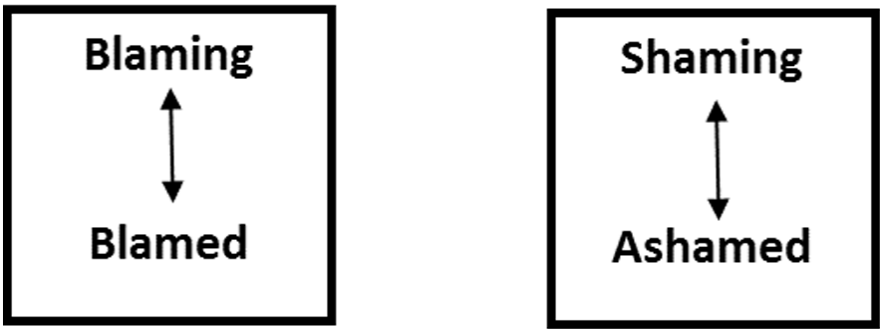


Figure 4

Time and again I met families in clinics for whom what was on offer meant very little to them, whilst the expectations of the networks surrounding this young person felt that CAMHS would and should offer something 'magical' to sort out the problem. The risk of disengagement was always considerable as there was never a collaborative agreement/ alliance about what someone was being asked to engage with. As a result the letter back to the referrer stated that the case had been closed because the young person DNA'd (Did Not Attend). From wanting to be able to offer something magical and helpful, CAMHS now became a place that was useless and unhelpful (see figure 5).

The original aim of the referral – prevent exclusion – was often unsuccessful, and the young person's trajectory towards social isolation or marginalisation was often reinforced by their experience of yet another

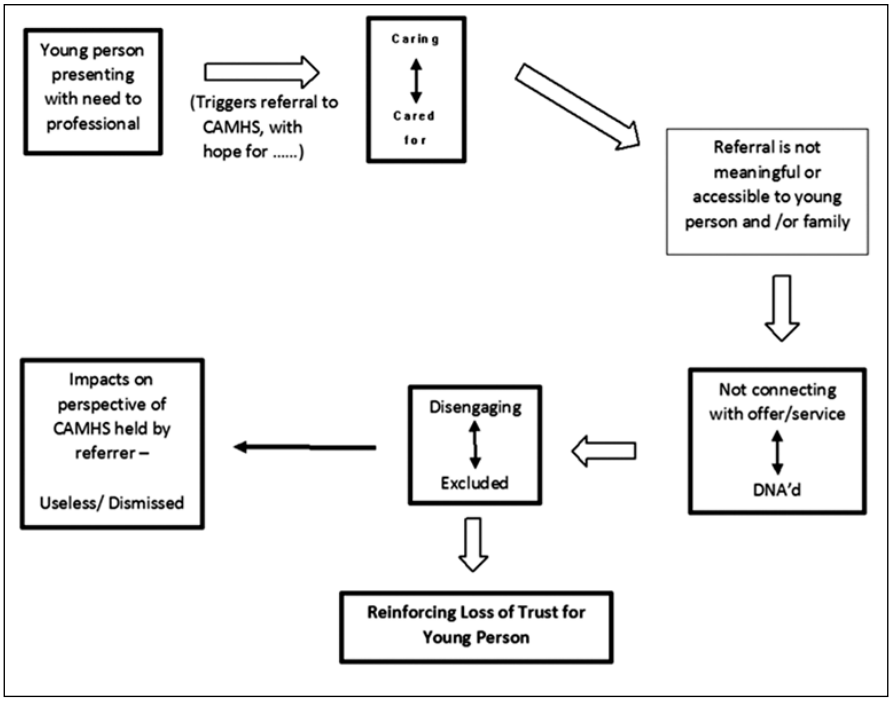


Figure 5 Reciprocal role relationships – expectations of the network alongside the experience of the young person and family when referred to Children & Adolescant Mental Health Services (CAMHS)

'useless' service. But the cost of exclusion is not just about missing out on education. The risks of becoming increasingly caught up in antisocial and offending behaviour, drug and alcohol misuse or suffering with more severe and enduring mental health needs are all greatly enhanced through exclusion. But it is often the experience of the loss of trust by the young person that will be the biggest price to pay. This loss of trust of services through stigmatisation and marginalisation will impact on any future willingness and capacity to access support further down the line – when it is often the law that is called upon to intervene.

Connecting – Connected; a relational approach

In light of this all too familiar pathway, I have spent much of my time seeking wider options for young people to be able to connect with support and feel that they have some sense of agency and ownership of their opportunity for change.

My medical training and psychiatry experience has contributed to

my work and the role that I offer within my team. However, I am more aware that it has been my training and involvement with Cognitive Analytic Therapy (CAT) over the last ten years, and my role as a Voluntary Youth Sector lead for over twenty years that has given me the confidence to feel able to propose and develop the projects that have evolved over the last few years.

Perhaps I should start with CAT as this offers a theory of the relational development of self and reflects on our development as a dialogue between other to self, self to other and self to self. This developmental model offers a framework for young people to think about their capacity to negotiate within themselves and with others whilst seeking a way of being and belonging that is meaningful and authentic. As noted by Steve Potter,

> 'A relational approach to mental health is ever more pressing: as the extent, mix and severity of distress, the awareness of and sense of entitlement to psychological help increases and the cost pressures on the tax payer pull us towards smarter more joined up ways of working. Regardless of the type of treatment, intervention or care, and, regardless of the profession of the provider, the quality of the helping relationship is going to determine outcome in the face of this complexity.'

CAT's strength lies in offering an approach that pulls all these themes together. It enables a more integrated and client-centred way of working. It has a focus on the interpersonal process, and a collaborative exploration promoting a sense of agency and integration through the use of tools such as maps, letters and other creative outlets. In this way CAT provides a model that can be both meaningful and accessible to the young person and their family, whilst holding in mind a framework of the relational development of self.

A sense of belonging and a relational view of identity

When working with young people, the core questions are frequently about 'belonging'. The adolescent desires to know where and how they fit in. This drives the need for peer recognition and endorsement. When the young person presents to services, these key concerns about belonging are often exacerbated by traumatic experiences in earlier life. They make the ground upon which they stand even more fragile and contribute to feeling uncontained.

This struggle with a sense of belonging, and even existence, reminds

me of working with a young person who was seeking the 'perfect suicide'. Meeting with Amy wasn't easy – she was reluctant to engage and doubtful that a therapist could offer her anything useful. However, exploring her symptoms and actions led to questions about a diagnosis of Bipolar which was enough to tweak her curiosity. By the time she started attending for regular appointments at the clinic, she was fully involved – to the outer world she presented a sense of capability and being in control, with the receptionist referring to her as the 'head girl'. But getting to clinic had been hard and had required consistency and patience from me and colleagues through an outreach approach.

Since losing her father as a child, Amy had taken on the role of looking after her mother at the expense of not feeling parented herself. By the time she reached her teenage years, it was clear that she was becoming increasingly overwhelmed by her sense of 'duty' and started to find herself bouncing between poles – from a place where she felt in control and seeking to be the perfect high achiever in all that she did (the Head Girl), through to a place where she felt unsafe, insecure and everything was 'fuzzy'. It was in this later place that she found herself attacking herself and thinking about life not being worth living. And it was this thought that she would carry with her to contemplate the perfect suicide – finding a way to leave, without having an impact on those around her. For Amy, the perfect suicide was a 'non-relational' suicide, one where she is no longer entangled in or by the lives of those around her. It was a perfectly controlling way of ending the yoyo between being on top or fuzzy? Working with this longing to escape from relationships and the painful meanings they provoke needs a versatile framework that can help find a way to separate her relationship with her-self from her relationships with others without the result of her taking her own life.

Working through CAT with Amy allowed the flexibility: to think about the symptomatology and possibilities of diagnosis, and not ignore the potential risks. It also enabled an exploration of some of her more fundamental queries and questions. As the therapeutic relationship developed, the chance to think about being and belonging, of loss and longing, became easier and more relevant to the work. The need for 'a perfect suicide' dissipated as the therapeutic relationship became increasingly secure, and the space felt safe enough to test out her thoughts, ideas and experiences without fear of being judged, criticized or simply 'not fulfilling one's duty'. As the therapeutic space became a place for learning to negotiate, Amy started to allow herself to learn how to look after herself, parent herself and become her own therapist. By

being in dialogue in therapy, she could begin to be in a relationship with herself. Amy started to think about herself more in the context of relationships – thinking about 'self to self', 'self to other' and also beginning to allow 'other to self' in ways which felt negotiable, compassionate and not frightening.

Living with uncertainty, managing ambiguity

Today young people face so many dilemmas in shaping a relationship with themselves and the world. Do they explore the past or shut off from it? Do they conform and fit in but lose part of their spontaneity or do they take risks but feel exposed to scrutiny? Some young people appear to have a greater acceptance of uncertainty, and ambiguity that might not have been experienced or tolerated by previous generations in relation to work and identity.

The rise in mental health need amongst young people may link in part to the underlying sense of uncertainty that exists in the world around them. Previous generations might have had collective fears of world war three and the impact of the cold war but individually young people often expressed fears and anxieties about spiders or friends. Now fears are reported to be far more about failure and debt, bullying and safety, as well as wider environmental concerns such as climate change. We appear to have generated a dynamic for young people where they have greater level of responsibility but with the least amount of accountability than at any other time. It feels as though this gap (between how young people are expected to manage without the guidance and tools to manage), underpins many of the concerns that young people express when seeking help.

For change to be possible and meaningful, there needs to be not only a relationship that allows the building of trust, but also promotes agency and is empowering. Young people need to believe that they have some sense of control over mental health work and that it is not about doing to, but rather about being with and alongside. It involves being empowering and enabling, rather than fostering hope whilst maintaining dependence

The uncertainty described, especially regarding identity, feels open to a far wider exploration than I would suggest has previously been considered. Sexual identity, gender and sexual orientation seem far more open for discussion and consideration within some peer groups with a greater tolerance and acceptance of uncertainty.

I am very aware that many young people from LGBTQ communities will present to CYP mental health services with severe levels of distress, with marked risk of harm to self and suicide needing to be acknowledged and addressed. But I am also struck by how many young people I meet with currently who are far more willing to explore these areas of identity and belonging within a much more fluid and flexible framework – with the anxieties of any uncertainty perhaps being held more by their parents than themselves and their peers. To reflect on 'gender fluidity' or 'pansexuality' would have been relatively unknown at the start of my practice in mental health, and yet I find this is becoming increasingly the norm in today's consultations. As CAT offers such an openly accessible way of thinking about self, and how one's sexual and identity development is so relationally dependent, then I feel that this dialogue sits comfortably within the therapeutic space – being picked up and worked with if required, but not necessarily needing to be the sole focus of the work.

The case of Polly perhaps best exemplifies this aspect of the journey through therapy. Having presented at the age of 15 through emergency services and an admission to a pediatric ward following a very serious suicide attempt, Polly was determined to engage in therapeutic work that aimed to address her uncertainty about her sense of self – especially in relation to her gender identity.

The work with Polly seemed to go through three distinct phases. The first was a balance between managing risk and clarifying the scope of the work. Given the severity of her attempt to end her life, my hope had been to recruit the parents (separated and estranged) to this work, but it became increasingly clear that this would not happen. This helped me understand how difficult it was for Polly to feel able to belong, and to feel connected. This initial phase focused a lot on the extreme responses and reactions of the world around Polly, as well as trying to gain some understanding of her world within. Many of these initial discussions were about needing to address concerns about gender identity through hormones and re-assignment. Polly would present at these initial sessions filled with thoughts, ideas and questions about how to embark upon this transformative journey, and yet the early mapping allowed for her to see that this quest regarding identity might also underpin wider questions about herself, and her relationships with the world around her.

As the therapeutic relationship developed, and became more focused on trust and allowing for negotiation, the dialogue shifted into a more relational and interpersonal understanding of being and belonging. We

moved away from needing to focus solely on whether her own identity needed to be challenged or questioned, and more into an area of being able to negotiate with her peers, and with herself, about connecting and feeling connected. Her episodes of crisis and times of feeling overwhelmed became increasingly seen through a shift in gaze, as she started to consider the impact of relationships on her overall sense of wellbeing. Maps reflected patterns and procedures that started to integrate different parts of herself as she began to test out and prove to herself that her sense of self could also be defined by others as much as by herself. A crushing rejection by a partner a few months into the work outlined the relational impact with and of others, whilst reminding myself to be alert to the potential risks.

And then finally, in the later stages of this work it felt possible to pull together a more 'over-arching' perspective – a view that allowed for negotiation with others and self that enabled Polly to just 'be' – and that some of her 'unknowns' or 'uncertainties' were OK, and didn't need to result in her feeling distressed and overwhelmed. Dialogue about sexuality and identity returned, but in more reflective and exploratory sense – in a space where it was possible to be inquisitive and questioning, without needing a concrete answer. The capacity to live with ambiguity and uncertainty was available and allowed, and the sessions reflected this capacity for negotiation.

Enabling a Negotiating Voice

Hence, I am often asking myself what it is that CAT offers young people – what is it that they are getting from this type of approach. The process of facilitating an opportunity for change through understanding the past as well as present procedures is clearly the framework that we all work within – whether we stick to the 3 'Rs' of Reformulation, Recognition and Revision or not. Likewise, I feel sure that we would all refer to the sense of collaboration and the need for working alongside as being very much at the core of our CAT practice – whether we do this through letters, maps or other tools. But I feel that this type of work often connects far more with some people as it enables the young person to develop the necessary negotiating skills – a 'Negotiating Voice' – that provides a dialogue with self and other and allows for a legitimation of the emerging self in this ever uncertain world.

I have found the use of the template map an invaluable tool in developing a therapeutic alliance and relationship with young people as

it allows for a relatively clear understanding of what might feel very complex and overwhelming material. But it is also a map that enables young people to see the circularity of some of their patterns and procedures, as well as giving easy wins for thinking about from where their exits could emerge.

Finding the middle ground

In other articles I have referred to the phrase I often use in therapy of finding ways of helping young people negotiate for themselves to be more 'in the middle' – a place that represents the more integrated sense of self, the compassionate heart of their Map, a place where positive self-to-self and self-to-other reciprocal roles and procedures can placed just as exits on an SDR (therapy map). This concept of being 'in the middle' seems helpful as an accessible means of describing and depicting therapeutic change for many young people who, at times, feel overwhelmed by some of the more formal therapeutic procedures.

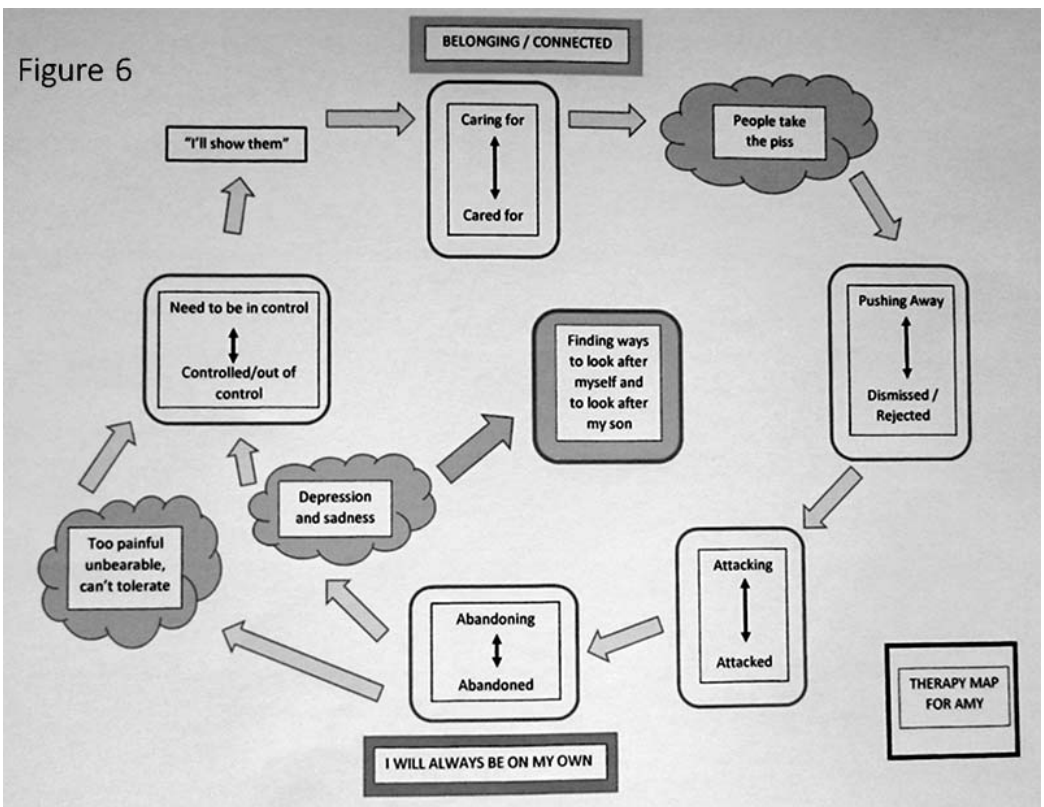


Figure 6 Example of using a template map for a young person – with focus of how to be more 'in the middle' at the centre of the diagram

Being 'in the middle' may sound as though this is a fudge – that it is some form of compromise, and a way of accommodating to adverse events or significant past difficulties. But what I hope the template illustrates is that this idea of being 'in the middle' is really about offering a space for a young person to test out their newly acquired negotiating skills, and seeing where they fit in with established patterns, procedures and the more established reciprocal roles. The space at the centre – in the middle of the template map – demonstrates the circulatory nature of some procedures and patterns, but also shows that the skills being developed and proposed for the middle can have a relationship with many of the surrounding reciprocal roles – being possible exits that need to be negotiated and trialed both within the therapeutic relationship and outside. Being in the middle legitimises the opportunity for developing the negotiating skills that will enable change.

For some young people, there can be a need to 'find a balance' of their needs and the demands and expectations placed upon them (by self or other) and for others, there is often a greater focus on learning how to care and look after yourself, how to parent yourself, and eventually, how to think about becoming your own therapist. Whichever approach is needed within the work, CAT offers a flexibility to test out a number of tasks, rather than needing to focus on one goal in isolation.

CAT has the capacity to facilitate a space for the young person to really discover and test out these negotiating skills (as shown by Amy's case above) and become familiar with their own 'negotiating voice'. Opportunities for change need the young person to have some understanding of their past, and how this becomes re-enacted in current relationships, but they also need to be able to develop a sense of trust in another – and often it is the therapeutic relationship that allows this to happen. But as noted previously, there also needs to be a sense of agency for the young person, and I am of the view that it is by enabling a young person to develop these skills and start to engage with their 'negotiating voice' which gives them the sense of empowerment to make things different.

Preventing the Flock of Seagulls effect

As CAT therapists we are privileged in being in dialogue with the legacy of radical educationalists and psychologists such as Lev Vygotsky whose work has helped inform CAT theory and understanding of self-development. His construct of the Zone of Proximal Development (ZPD)

has been enormously helpful in thinking about learning, translating itself easily from the 'teaching relationship' to a therapeutic relationship that is enabling and empowering. But Vygotsky's work also needs to help us think about the wider determinants of development and of where and how we practise as therapists/practitioners who seek to engage young people.

The ZPD allows us to think about working with young people where they 'are at' rather than where services would like them to 'be at'. The number of young people who are willing or able to attend a clinic and engage with 8, 16 or 24 sessions of a formal therapy is always going to be small – and perhaps should always remain so. The transformation of services is, therefore, not simply about providing bigger budgets in order to offer more therapy and therapists.

If we are really seeking to explore how young people access support, and what type of support they would be willing to engage with, then we need young people to help and assist in the design and development of these services.

Perhaps driven by my involvement in the voluntary youth work sector I have increasingly considered the need for services for young people to be offered in more grounded and neutral settings – such as youth centres and community centres, rather than through clinics that are separated off and invite the risk of stigmatising and marginalisation. There will always need to be places where young people feel they can be helped and supported in a more private and confidential setting – but we need to allow young people to feel they can meet and build trust with professionals and staff in settings that lessen the barriers to those professional relationships being able to develop.

Having taken groups of young people away on residentials, camps and trips across Europe, and also been involved in running regular group sessions on a weekly basis, I am very aware of how important and powerful this work can be. It is in these settings that young people can test out and give informal voice to their 'negotiating skills' and build their resilience by being allowed to fail, and yet feel supported to get back on their feet. I am increasingly of the opinion that through youth work I feel I have probably done as much, if not more, for the emotional and relational wellbeing and mental health of some of the young people as I have through my role as CAMHS psychiatrist. I certainly have been able to work with some young people, far more intensively, helping them feel more connected and accepted by their peers, than is ever possible through a clinic.

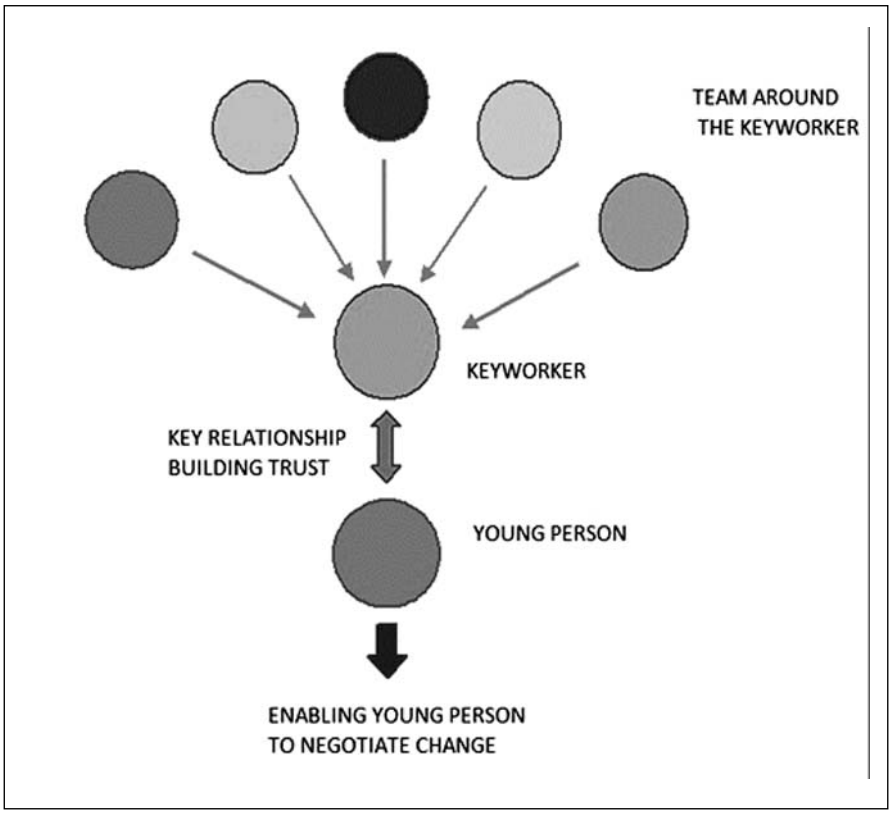
A community based approach

A more relational approach to mental health for young people needs to be developed within a youth centre/community centre setting, with the role of the specialist being as much about offering guidance and support to the youth workers, as offering one-to-one support for the young person. The tools of making maps, exploring reciprocal roles, and generating a contextual reformulation can often be just as powerful when directed through others, enabling a relational understanding of emotional development and distress that can be more easily supported within the community. It has been possible to do this work with youth workers, gangs workers and football coaches in a variety of settings. All have helped to generate a better understanding of the difficulties facing the young person, or group of young people by maintaining the focus on the relationships rather than solely on the distress.

Other therapeutic models have also developed this type of approach with mentalisation-based therapy perhaps being the closest ally in this field. The AMBIT model has emerged to seek to work with young people where there are real difficulties with engagement – and the integrative application developed by MAC-UK are some of the best examples of how to put this work into practice. Likewise, the HYPE model developed by Chanen et al in Melbourne offers an assertive approach to community engagement and this being entirely focused around CAT as the tool for change. Both of these approaches offer valuable opportunities for thinking about how we might transform our services, as they fundamentally seek to place the relationship at the centre of all that is offered – and instinctively allow for a relational approach to mental health.

But we need also to ensure that we are not overwhelming the young person who may be presenting with need. After all, it is seldom that a young person presents to a service with just one difficulty – they can find themselves being passed from service to service, from professional to professional, as each of their individual difficulties are identified. How many young people have a list of 4 or 5 professionals in their lives – all of whom need to complete their assessments, write their reports, clarify their risk assessments, even before they consider an intervention that might enable some change. Many young people will have social workers, mental health workers, drug and alcohol advisors, youth offending officers, teachers etc. – the list goes on and on – but how effective everyone feels in what is provided is often brought into question. One young person I worked with summed this experience up completely, being asked to meet with me, after a whole raft of professionals. Put

simply he stated: yous lot is like a flock of f***in seagulls – you're each coming in for your own little bit then p*** off' (Figure 7)



A relational approach to the support for this young person – including their mental health needs – would allow for the specialists to focus on the keyworker – the individual with whom the young person is most engaged, or wants to work with – and it is the keyworker who will sustain the relationship with the young person. The focus is on the team around the keyworker – who all inform and help sustain the key relationship between keyworker and young person. It is through this approach that relationships are formed and sustained, trust is allowed to develop and the young person, in collaboration with their keyworker is enabled to start making steps towards change. This is a relational approach to development. It is what Vygotsky talked about when referring to the Zone of Proximal Development, and it is the core of a relational approach to mental health.

Maintaining a focus on the 3 Rs

For a relational approach to mental health for young people, we need to focus on supportive and meaningful relationships around the young person. CAT enables a way of exploring a more integrated perspective of support (and of self) across agencies and services so that a young person will feel more empowered and take ownership of change in their life. But perhaps most importantly, CAT offers a theory and understanding of development that facilitates the testing out of the Negotiating Voice that is so crucial for transition into adulthood. It is a voice which the recovering young person finds in themselves often for the first time because they hear it from the teachers, mentors, peers and mental health professionals around them. CAT has evolved over time so that we can all comfortably reflect on the roles of Reformulation, Recognition and Revision – the 3 Rs of time limited therapy. What I am considering in this paper is a reappraisal of the 3Rs for CAT. A proposal that we should keep the 3 Rs – but this time the focus is on Relationships, Relationships and Relationships. □

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'Map and Talk' – A Cognitive Analytic Therapy Informed Approach to Reflective Practice in a Forensic Setting

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Abstract: This paper describes the context, ethos and establishment of a Cognitive Analytic Therapy (CAT) informed approach to Reflective Practice in an Inpatient NHS Forensic setting in East London. It is a preliminary description of the project, setting the scene for further quantitative research in the future, and captures our experiences and initial thoughts at this early stage.

The 'Map and Talk' approach (Potter, 2010, 2016) is described, followed by a discussion about the achievements, challenges and reflections on the process of introducing the model to the service. The paper emphasises the importance of a robust supervision structure, and multidisciplinary input at all levels of the project in order to maintain the ethos of 'doing with not doing to'. The experience has highlighted the importance of reciprocal roles and multiple positions as 'active' ingredients of the approach. The development of the Reflective Practice Groups as they have formed from discussing patient staff interactions to reflecting on wider themes such as gender, hierarchy, race and culture, which are often unspoken, is described, as well as the resonating of relational patterns across the various levels of the service and the supervision structure. Reflections on the impact of the project on the project lead group are included and the project is described in relation to the wider social and political context. Finally future directions and research opportunities and directions are outlined.

Keywords: Reflective Practice, Forensic, Multidisciplinary, Staff Groups, Map and Talk, Cognitive Analytic Therapy

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IN 2013, Sir Robert Francis QC published his report of the public inquiry into Mid Staffordshire NHS Foundation Trust in England (Francis, 2013). The report is a summary of an investigation into the causes of serious failings in the provision of care in that Trust between 2005 and 2008. In his conclusions, Francis indicates that an organisational culture at Mid Staffordshire, which allowed poor and unsafe practice to be overlooked and which prioritised the meeting of targets above patient safety, played a critical role in those failings. The publication of the report gave rise to a period of reflection across the NHS in England about organisational culture and how the recommendations from Francis might be applied locally.

One year previously Adlam et al. (2012) published 'The therapeutic milieu under fire', a volume of chapters by experts in aspects of forensic mental health provision describing some of the challenges both psychodynamic and socio-political of working in secure care from a number of different perspectives. The 'fire' of the volume title is conceptualised as something both internal to the ward, as an 'emotional heat that is generated by an interaction of group dynamics and toxic attachments in both patient and professional groups' (Adshead, 2012) and also as coming from outside of the hospital setting from the socio-political context for example as cuts to funding and the deletion of services (Wrench, 2012) and attacks on professionals who work with people who present a risk of harm or who perpetrate actual harm to others (Cooper, 2012).

Both Francis (2013) and Adlam et al. (2012) came at a time of uncertainty and insecurity within the NHS in England as a result of financial austerity and restructuring. They helped to inform our thinking at a time when as a Forensic Service there was a renewed focus on how to maintain the health of our organisation in the face of these challenges. The creation of effective 'shared thinking time' was a consistent theme of discussions and seemed essential to critically evaluating culture and maintaining the psychological health of staff in order to continue to support them in delivering compassionate, patient-centred care.

Use of CAT in Reflective Practice

The use of Cognitive Analytic Therapy (CAT) in helping teams understand their experiences systemically and not as purely located inside the individual is not new. In the 1990s, there were several examples of the pioneering use of CAT in helping teams understand the complex interactions between the patient, staff and organisations, referred to in CAT as contextual reformulation (Ryle & Kerr, 2002). Walsh's (1996) qualitative research showed how CAT and the diagrammatic reformulation can help understand the relational patterns within a team with dysfunctional dynamics. Dunn & Parry (1997) discussed the value of incorporating CAT formulations into care-planning for patients with borderline personality disorder in a community mental health team. Kerr (1999) reflected on his experience of working with an individual with borderline personality disorder and how sharing the diagrammatic formulation with the team started the process of compassionately understanding the patient's presentation and how staff can play a role in maintaining difficulties.

Since then, there have been several innovative projects focusing on helping teams understand how the roles of the patient, professional and system interact to maintain or improve problematic patterns of relating. This includes the development of CAT skills training courses aimed at educating and equipping whole teams with a relational understanding, especially when working with the 'difficult' patient with complex and severe presentations (Kerr et al., 2007).

Thompson et al. (2008) evaluated a team training course that incorporated an intensive training week, a brief personal reformulation followed by six months of CAT case supervision in a small group setting. A qualitative thematic analysis showed that the course increased professional's therapeutic confidence and skill as well as fostering the development of a shared model within the team and bringing a sense of cohesion. Challenges were also discussed including increased work load, 'non-compliance' with aspects of the model and role confusion.

More recently, Caruso et al. (2013) evaluated a parallel initiative in Italy. They delivered a basic CAT training intervention to twelve team members from different professional backgrounds. The training consisted of five two-hour theoretical and practical sessions introducing the use of CAT and contextual reformulation. They administered several measures before and after training and at one-month follow-up. Results showed that the training facilitated team cohesion and patient engagement whilst reducing burnout levels.

The value of contextual reformulation has also been emphasised in forensic settings. Marshall et al. (2013) provide one example of how an overarching CAT framework based on the 'Map and Talk' approach (Potter, 2010) has been developed within a forensic unit. They describe a tiered approach including a two-day introductory training for all staff and a more intensive CAT skills training for several people referred to as 'champions' to help embed the model into the ward environment.

In summary, the literature reviewed highlights the value of using CAT with teams with the aim of promoting team cohesion, staff wellbeing and patient care. Key ingredients include developing understanding and a common language in a non-blaming way, using tools such as diagrammatic reformulation.

The Map and Talk Approach

'Map and Talk' (Potter, 2010) has continued to develop the application of CAT to reflective practice. This approach focuses on the collaborative construction of a map with teams to aid the process of reflection. This involves sketching out (on large paper) the relational dynamics of a particular moment, theme or interaction, such as when there has been a serious incident or when a strong feeling has been elicited, positive or negative. The facilitators are there to help develop the map *side-by-side*. The aim is to do reflective practice *with* and not *to* teams. The mapping enables a dialogic process, extending beyond talking as the name would suggest to becoming a 'listening' map as well.

The emphasis is on 'using' and not 'doing' CAT, as the approach does not try to teach/deliver CAT as a therapy but incorporates some key CAT concepts and techniques in reflective practice sessions to help teams understand the relational dynamics at play.

The Helper's Dance and One-Third Rule

The ethos of 'Map and Talk' is encapsulated by 'The Helper's Dance' and 'One-Third Rule' (Potter, 2014), emphasising how helping others is a joint activity. Professionals working in complex care settings are inevitably invited, or invite others, to join many different relational 'dances' with patients, colleagues and the wider organisational contexts. Some dances may be positive, such as joining in a caring and compassionate interaction.

Others may be problematic, perhaps even harmful, at times. It is not a case of if, but when, we will join the dance. Each one of the thirds (the professional, the patient and the organisation) are dancing together to create and maintain any given situation.

Potter emphasises the importance of not avoiding or hiding from the possibility that certain dances will happen but to become more confident in *noticing* and *naming* what is happening relationally to *negotiate* a better outcome for all involved. This involves the professional not only negotiating the dance with others but also negotiating its operation within themselves. Facilitating the 'three Ns' of Noticing, Naming and Negotiating is the aim of reflective practice meetings. To avoid any individual feeling blamed, it is important to name the dance and *not* the dancer when reflecting on the relationship dynamics in teams. The more or less 'One-Third Rule' encourages teams to notice and name the contribution of the different thirds, shifting the dance from blame to one of shared responsibility.

Reciprocal Roles and Multiple Positions

'Map and Talk' uses the core CAT concepts of reciprocal roles, multiple positions and the procedures that link them as the basis of the map. The reciprocal roles procedures (RRPs) that are drawn out may represent the dynamics between and within any of the thirds. The patients, professionals and organisation as a whole will each bring their own repertoire of RRPs stemming from earlier experiences, both personally and professionally. The interaction of these RRPs can result in a variety of dances being enacted at any one time, leading to team members sometimes having very different experiences in the same situation. Helping teams understand that such multiple positions exist and to notice and name them is a key focus of this approach.

Map and Talk Template

Potter (2010) proposes a mapping template to capture the multiple positions often experienced by teams (Figure 1). This template comprises a 'stuck' or 'battling' place, a 'hiding' place, a 'hoped for' place and a 'feared' place. Within each position, a particular reciprocal role or set of roles is enacted and there are often procedures both within and between positions.

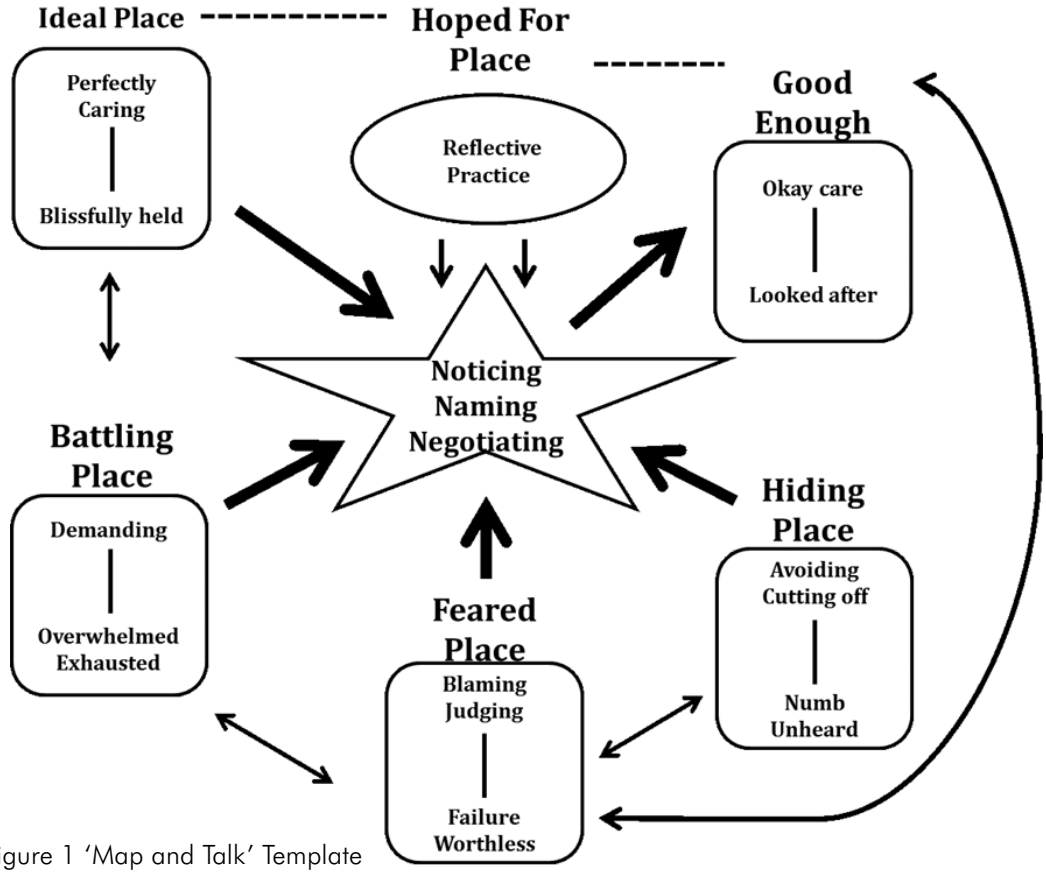

Figure 1 'Map and Talk' Template

In a forensic setting, the 'battling' place often relates to the violence and aggression that is perpetrated. This may be experienced as an *abusive/threatening/dominating to scared/vulnerable* reciprocal role for example. However, the 'battling' place is not limited to violence and aggression but can be understood in broader terms when someone feels like they are stuck 'battling' against something or someone. For example, the professional who responds to a patient's relentless demands by always trying harder.

The professional may sometimes feel like they have achieved the 'hoped for' place of being caring. However, the 'hoped for' place is on a continuum from the 'good enough' to the 'ideal' place. The professional who relentlessly tries to meet *all* the patient's needs at *all* times may temporarily find themselves in the 'ideal' place of 'perfectly caring' but this is impossible to sustain and the professional may be left feeling overwhelmed, burdened and exhausted.

In contrast, a professional may go to the 'hiding' place by avoiding interactions with the patient, especially if they think that other colleagues

are always meeting the patient's needs. This may result in the staff member, as well as other with whom they interact, feeling cut-off or detached.

Being in the 'battling' or 'hiding' places often stems from attempts to avoid a 'feared place', characterised by unbearably painful feelings, which have often been experienced before. For example, being scared of failing or judged as not good enough. However, going to the 'battling', 'hiding' and 'ideal' places can be a defeating procedure that leads back to the 'feared' place.

Helping teams notice and name the multiple roles and positions experienced by the different thirds can lead to negotiations that help all involved reach the 'good enough' place. This may include reciprocal roles such as reflecting/understanding/communicating to understood/heard/safe. In the process of such map and talk interactions a key reciprocal role of compassionately and curiously negotiating to more fully understood is being encouraged as the basis of building reflective capacity for individuals and teams.

Putting it into Practice: The 'Who' and the 'How'

In setting up the 'Map and Talk' project, it became clear quite early on that decisions about 'who' would facilitate and attend reflective practice would be significant. Different opinions were (and are still) expressed about whether nursing teams need a space just for themselves which provides more of a staff support function, in that it gives them a place to air difficulties which it would be challenging to think about with other members of the team present. Another perspective is that it is more beneficial to aim to create sufficient safety so that we can have these discussions together and that not to do this creates a sense of reflective practice being something that is 'done to' rather than 'done with' nursing teams.

As a service we chose to have as our aim, the creation of reflective practice spaces that are attended by all members of the multi-disciplinary team for a ward, even though this would mean doing something different for most ward teams. We also chose to emphasise the multi-disciplinary aspect of the approach by inviting people from across disciplines to train as 'Map and Talk' facilitators. Our aim was to train a pair of facilitators from different disciplines for each ward in order to help to set up and facilitate conversations that cut across boundaries of professional identity

(and sometimes culture and gender by association). Careful thought was given to the inclusion criteria for recruitment, such as level of seniority required to run the groups effectively. An attempt was made to train facilitators from a range of ethnic backgrounds, as issues of diversity are very relevant in our service, where there is a multicultural staff and service user group.

Between April and October 2014, 34 facilitators from across nursing, psychology, social work, medicine, occupational therapy and arts therapies received five days of training in 'Map and Talk' provided by Steve Potter. We allocated Reflective Practice Facilitator (RPF) pairs to each of our 14 wards. We decided to allocate pairs of facilitators rather than individuals because the ward-based multidisciplinary teams can be quite large (up to around 30 people) but most importantly to aid the process of dialogic reflection. We asked the pairs to engage in a 'scoping phase' with their ward, working with the team on that ward to think about how 'Map and Talk' might best be introduced to their context.

This phase of the project was characterised by emerging anxiety about getting started and uncertainty about how to introduce 'Map and Talk' to the wards in a way which would give it the best chance of being helpful. There were tensions between those of us who preferred to 'jump in' and those of us who preferred to 'go slow' and hold off starting until an official launch date. There were differences of opinion about how much direction should come from senior management about attendance and frequency of sessions and how much the project should evolve around the varied team dynamics and spaces available for reflection on different wards. In reality, sessions started at different times in different ways on wards and there was some 'top down' support in determining that sessions would happen in team away days which occurred every 4-6 weeks. Our official launch date was in December 2014 and by March 2015 every ward team had had a teaching session on 'Map and Talk' and an identified reflective practice space.

An important aspect of the project was to develop a Supervision Structure (see Figure 2). As the Project Lead Group we (the authors) have led on the organisational and strategic leadership of the project. Alongside three other multidisciplinary colleagues we formed three multi-disciplinary supervisory pairs (the Supervisors' Team) who each facilitate a closed monthly Supervision Group comprising of the Reflective Practice Facilitator pairs. We have maintained input from Steve Potter in the form of monthly supervision of the Supervisors' Team and the Project Lead team.

Figure 2 Supervision Structure

Achievements, Challenges and Reflections

The 'Map and Talk' project has now been running across the medium and low secure sites of the Forensic Directorate for almost two years. All 14 wards of the Forensic Directorate now receive monthly or six weekly multidisciplinary Reflective Practice groups. Development has been an organic process, and while we were guided by the 'Map and Talk' approach, as outlined in the preceding pages, there were many aspects of the shape, process and experience of the project that we had to 'discover'. The following pages describe some of the achievements and challenges of the project, as well as reflections over the course of the project by the Project Lead and Supervisors' Team.

Achievements

As described in the preceding pages, a central principle of the 'Map and Talk' approach is that of 'doing with, not doing to', and the development of a 'common language' (Ryle & Kerr, 2002) to discuss the relational dynamics of patient, staff and institution (the three parts of the 'One Third Rule'). Multidisciplinary recruitment at all tiers of the project (Reflective Practice groups, Reflective Practice Facilitator pairs, and Supervisors) was central to this aim. To date we have trained 50 multi-disciplinary Reflective Practice Facilitators. We have retained almost all

those trained in the project and the main drain on retention has been related to staff turnover, in that nine members of staff have left the service. Although the three Project Leads (the current authors) are clinical psychologists, the main criteria for these positions are that two are CAT practitioners and one is the Head of the Medium Secure Psychology Service thereby occupying an important 'political' role with links to the Directorate Management Team. The Supervisors' Team consists of three psychologists, two nurses (modern matrons) and a social worker. As such the multidisciplinary establishment of the project has been sustained.

Anecdotally, alongside the creation of more multidisciplinary relationships, there are more multidisciplinary 'conversations' across the various levels of the project. These are observably (and as evidenced in accompanying maps) different kinds of conversations – 'relational' rather than 'task focused'. For example, discussions about service users are focussed on the felt experience of the service user, and the impact of this on staff, rather than solely descriptions of events. The use of two hands held up in conversations to represent the poles of the reciprocal role, known affectionately as 'Potter hands' can been observed in conversations across the service, as well as gestures accompanying conversations which make explicit the 'mental map'. The use of mapping at all levels of the project (and the accompanying focus on reciprocal roles and multiple positions, as described in the preceding pages) helps to sustain a reflective process.

Challenges

Group Processes, the 'feared place' and the Zone of Proximal Development (ZPD): 'The fear that it won't work, the fear that it will'

At the 'launch' of the 'Map and Talk' project one of the members of our Supervisors' Team expressed the above 'fear that it (the project) won't work, and a fear that it will!' This was reflective of both the time, thought and emotion dedicated to the project, and the pressure this put on us to 'succeed', but also the impact of 'succeeding' – the daunting prospect of the experience of 'reflection' in a Forensic Service in which trauma, violence and danger are commonplace, and where often a depended upon 'dance' is to retreat to the 'hiding place' of avoiding/cut-off, or the battling place of powerful/powerless, controlling/controlled. The 'successful' implementation of Reflective Practice groups involved opening the door to difficult conversations the service, staff and patients

often protected themselves from for their very survival. Reflective Practice and Supervision Groups alike could at times feel extremely daunting, like 'opening a can of worms', mirroring the processes encountered in relation to patients in that risky or potentially traumatic aspects are either avoided or 'over controlled'. How to begin these conversations in a safe way for staff, facilitators and supervisors, negotiating the balance between 'exposing' and 'hiding' positions, was a crucial first challenge to the groups and the project.

In such situations facilitators often described feeling they were balancing between challenging and avoiding, this 'knife edge' itself describing the feeling of being 'in' the process of *noticing*, *naming* (by mapping) and *negotiating* these procedures. The facilitators' skill in engaging the group in this process through mapping provides a form of 'scaffolding' (as developed by Wood, Bruner and Ross, 1976) to allow the group to reflect on rather than simply re-enact the dance.

Maintaining integrity to CAT

Grasping the concept of reciprocal roles in a short training event is not straightforward for many facilitators. This led to some debate early in the project about whether it is necessary to have reciprocal roles if other components of the map were present. However, we soon found that without understanding of RRPs and multiple positions, the problems experienced by the whole team may be placed on one third only, recreating the blame dance. Take the example of a professional disclosing, in reflective practice, a difficult moment they have experienced. If only their feelings are named and the upper part of the reciprocal role is not acknowledged, then there is no realisation that something has happened to make the person feel that way. This may leave them feeling like it is their issue alone. Without multiple positions, there would be no acknowledgement that everyone is experiencing something in a shared moment, even if very different. It is not necessary to map every single position and reciprocal role procedure within a single session, but the overall template is helpful for the facilitators to hold in mind.

Reflections

Our experiences through the delivery of the Reflective Practice and Supervision Groups have therefore been of an emergent process for

groups, with mapping providing 'scaffolding' in relation to a Zone of Proximal Development (Vygotsky 1978), which leads to the development of reflection over the longer time frame of the group. In this respect over the longitudinal course of the project we noticed that groups increasingly moved from focusing on a discrete patient moment, to engaging in more difficult and potentially exposing discussions about relational group processes involving issues of discipline, hierarchy, gender, race, difference. Similarly our experience of the Supervision Groups has been that we have moved from 'how to' didactic supervision sessions, getting to grips with the practice of mapping as a skill, to becoming increasingly proficient at this to be able to concentrate on using the mapping tools and supervision spaces to reflect on the relational processes between pairs and groups, and how this might relate to the service-wide picture. We also discovered that at times varying the spaces occupied in the specific Reflective Practice and Supervision Groups was important, for example offering the group, when presented, the opportunity to reflect on positive moments sometimes seems to allow groups to feel safe enough to explore more difficult moments, involving emotions it seems more difficult to access in the Forensic setting such as sadness.

Iterative Processes ('Shimmering')

Described in preceding pages in relation to the 'One Third Rule', there was an observed 'shimmering', that is a resonating or iterative effect of the relational dynamics played out at all levels of the project. We often had the experience of dances 'cascading' through the system and as supervisors being just 'one step ahead' of the emerging dances subsequently described in groups. The use of mapping as a debriefing and supervision tool was essential in capturing the 'dances' we were each pulled into in relation to each other throughout these processes, and supervision provided the space to create and reflect on these processes. The importance of 'iterative' supervision at all levels of the project, although expensive in human resources proved to be particularly important to capture and reflect on this phenomenon.

A further reason that supervision has been such a cornerstone of the project is the disentangling of the 'thirds' and the need for a means to process the dances involved at every level. As described, we all have our own 'dances' impacted by both personal experiences but also sometimes the roles we find ourselves in relate to wider categories such as our

gender, race, culture, discipline. Being thoughtful about 'mixed' facilitator pairs along such dimensions, and the provision of a space to discuss processes between pairs involving these issues and groups in supervision was important to manage this. Noticing our own dances, through use of the 'Helpers Dance Checklist' (Potter, 2014) and feeling secure enough to risk exposure of discussing the processes between facilitator pairs and the groups in supervision was crucial in this respect to reflect on our own positions in the bigger 'dance' of the project. For this reason external supervision for the Supervisors and Project Leads groups has also been important.

Reflections as a Project Lead Group

The 'shimmering' effect was often acutely felt in the Project Lead team, and we (the authors) have reflected on the process of this as a group. As a group of three we noticed how we would often 'catch' the reciprocal roles described and enacted at other levels of the project and therefore perhaps it was very important to the project that we were a group of three, rather than one 'leader'. Through mapping our own experiences as a team we noticed how the impact of a position taken by one of us impacted on the availability of other positions taken by the other members of the three, at times leaving one of us at a time feeling alone and isolated, another feeling successful and empowered, another feeling pragmatic but cut off, and who occupied each position varied amongst us. By mapping the processes between us we were able to again bring the discussion back to the 'dance not the dancer', and recognise the impact of the 'One Third Rule'. For this reason the ongoing provision of external supervision for the Project Lead and Supervisors' Team was essential.

We have also reflected on the positions we have held in relation to the project as a whole. Whilst recognizing the importance of being 'side by side' there has also been a need for us to be 'leaders' at times, a position which has not always sat easily. We have reflected how, as considered with reference to the one third rule, the dilemma of 'doing to'/ vs 'doing nothing'/ as opposed to 'doing with' is a struggle encountered across the Forensic Directorate, and is also mirrored in our daily struggles to work with service users in a Forensic context. However we have also reflected that sometimes 'doing nothing' or 'doing to' is important.

Clinical Governance and Responsibility

We have been fortunate in being supported to develop this project by our Directorate Management Team. To an extent our success in this project reflects the great willingness and enthusiasm of our staff group to think relationally and a desire to be compassionate, which it is important to protect and harness as described earlier in relation to the current climate of encouraging reflective practice in the NHS to maintain compassion. The 'collaborative' leadership, ethos and 'inclusiveness' of participants in the project has been an important part of our success. However we remain aware of the need to continue to nurture and support the project and all those involved in it. This is important to avoid the 'engine' for the venture being staff willingness to go 'above and beyond', risking burn out. It is important to recognise at all levels of the service and perhaps beyond in the wider context of the NHS that compassion needs to be supported from both above and below.

The Bigger Picture

We have noticed the resonance between micro and macro levels of analysis when 'zooming in and out' and mapping a micro moment can just as well represent the service as a patient. However we have also noticed resonances with issues 'beyond the walls' of the Forensic institution but which impact on our service users staff and service. For example, the stigma experienced by our patients in relation to society seems to be felt at many levels across the service – wards, disciplines, individuals feeling stigmatised or blamed or punished. The striving for control of fear has resonances with the experiences of patients in forensic settings, with staff in relation to the 'management' of patients, but also with a world in the grips of a 'war on terror'. We have noticed at times of threat in the groups, the tendency to resort to a 'them and us–ness', dance: groups and individuals finding security in the 'us' and projecting threat onto 'them', leading to a relentless 'battling' place, which is full of anger and fear. The impact of an NHS increasingly focused on performance and the need to be 'doing something', at the expense of 'thinking space' has also been played out in group processes. As such we are beginning to notice dances related to wider political, social and economic issues being played out in the Reflective Practice groups.

Limitations and Future Directions

'Map and Talk' is now embedded within the service and there are opportunities for further development. We have received requests beyond the ward-based teams within the service and there is curiosity about the project from other services within the Trust. While very exciting, this also feels somewhat daunting and makes us realise the importance of ensuring adequate support, resources and supervision before we venture into the next stage.

Although the project has now been running for two years, we feel that we are still in an early stage, perhaps reflecting the longer-term nature of working in an inpatient forensic setting. It is important to acknowledge the limitations of what we are able to offer. We have noticed in the service that the project can often be viewed as a somewhat 'magical' solution by all involved, which places additional pressure on the project to respond to new challenges as they are identified, and can be an impediment to acknowledging the limitations of the approach as well as the successes. The process has been labour intensive, raising some questions about sustainability and replicability. Kerr et al. (2007) reflected on how there needs to be clarity and realism in advance about the aims and limitations of such initiatives to avoid unrealistic expectations of what can be delivered, especially in settings that are confined by resource issues. This has been a work in progress and we have had to notice, name and negotiate aims and limitations as the project has evolved and will continue to do so.

We are now looking forward to the future. Whilst this paper focuses on our preliminary experiences and reflections it is clear in order to secure ongoing resources more quantitative and qualitative data are important. We are concurrently completing a more formal evaluation process, gathering data on ward atmosphere at six monthly points of the project. We are learning more about the key qualities required to be a Reflective Practice Facilitator/Supervisor and think it will be important to conceptualise what these core competencies are to contribute to professional development and adherence to the integrity of the approach. This may include incorporating strategies used by similar initiatives, such as more intensive CAT training for 'champions', both facilitators and participants of the reflective practice sessions. It will also be important to support some individuals to access CAT practitioner training to promote sustainability of the model. We are aware that this paper is mainly a reflection of the voices of the Reflective Practice facilitators and supervisors, not yet the voices of those in the groups themselves, and

how to discuss the themes of the groups whilst maintaining the confidentiality and safety of the Reflective Practice spaces is something we have wrestled with in this paper. This is something we intend to address in future evaluation and publication. □

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Exploring the Efficacy of Cognitive Analytic Therapy in Reducing Anxiety and Depression in Older Adults

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Abstract: The present study aimed to explore the efficacy of Cognitive Analytic Therapy in supporting people aged 65 years or over, and who experienced depression, anxiety, or a combination of the two. There are presently no studies which explore the effects of CAT in supporting older adults who experience mental ill-health.

The study used a quantitative, within-subjects, cross-sectional design.

The outcome measures data of 28 clients, aged 65 or over, and open to an NHS mental health trust in the North East of England were included in this study. Outcome measure data were collected across two time points: just prior to the commencement of CAT; and once more following therapy completion.

The following outcome measures were used: Inventory of Interpersonal Problems 32; Personality Structure Questionnaire, Clinical Outcome in Routine Evaluation Outcome Measure; Clinical Outcomes in Routine Evaluation 10; and the Hospital Anxiety and Depression Scale.

T-tests showed a significant reduction in scores across all of the measures used post-therapy ($p<0.05$). Effect sizes across all outcome measures used were high ($d\geq 0.59$). Chi-squared analyses were used by way of exploring the efficacy of CAT in affecting a clinically significant change; both anxiety and depression scores significantly fell to below the clinical cut-off using the HADS outcome data ($p<0.001$).

In this sole study focusing on CAT in older adults, the findings demonstrate that CAT is significantly effective in reducing anxiety and depression in this population.

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INITIALLY developed in the 1980s by Anthony Ryle, Cognitive Analytic Therapy (CAT) integrated psychoanalytic and cognitive models into a time limited relational therapy. Therapy aims to facilitate a collaborative approach, within which early experiences are drawn upon to help inform descriptive reformulations of current concerns (Ryle and Kerr, 2002). The client and therapist may try to better understand procedural patterns via the use of a psychotherapy file. In using the file, the client is encouraged to identify possible traps, dilemmas or snags that they feel may apply to their current experience. Further to this, the therapist and client will consider possible Reciprocal Role Procedures (RRPs). These are patterns of behaviour – often experienced in relation to caregivers early in life – which the client continues to both experience and enact presently. By engaging in this work at the beginning of therapy, a better understanding of possible patterns of behaviours and thinking can be understood. From this, the client and therapist may attempt to outline this understanding in written and diagrammatic form, via the use of a reformulation letter and a Sequential Diagrammatic Reformulation (Ryle and Kerr, 2002).

The use of CAT for supporting clients experiencing a range of difficulties has grown over the previous thirty years. However, the evidence base supporting the use of CAT remains limited. Calvert and Kellett (2014) undertook a systematic review by way of exploring the efficacy of CAT. Inclusion criteria were set and required that each study meet two research validity checklists. Calvert and Kellett (2014) were left with 25 studies, of which, five were randomised controlled trials (RCT). The majority of these studies were small-scale studies and included participants who were experiencing complex and severe difficulties. The majority of participants (44%) had acquired a diagnosis of personality disorder; this indicates that, for the most part, studies exploring the efficacy of CAT appear to explore CAT and its ability to support people with personality disorder. Calvert and Kellett (2014) argue that although generally, the quality of studies exploring the efficacy of CAT was good, the current evidence base for CAT is limited in terms in terms of 'breadth and depth', meaning that more research is required using larger sample sizes, and in participants who experience a range of mental health difficulties (not just personality disorders). In evaluating the evidence base for anxiety and depression, Calvert and Kellett (2014) cited two

studies that met their inclusion criteria (see Bennett, 1994 and Hamill and Mahoney, 2011). Bennett (1994) concluded that CAT had a positive effect in reducing depression and interpersonal difficulties; Hamill and Mahoney (2011) utilised a case design by way of concluding that CAT was effective in reducing anxiety and depression in carers of people supporting those living with dementia. While the studies' findings are encouraging, and demonstrate the potential benefits of CAT in treating anxiety and depression, the current evidence base would also benefit from studies that include larger sample sizes.

The current CAT evidence base operates from a practice-based evidence approach. According to Salkovskis' (1995, in Feltham and Horton, 2012) 'hourglass model' the evidence base for new therapies progresses via three stages, these being: theoretically developed and tested against case reports and single case designs; the widening of evaluation to RCTs to explore efficacy; and finally efficacy is explored via service evaluations and field experiments. According to Feltham and Horton (2012) so far CAT has progressed through the initial phase of the hourglass model, yet further research is needed to move the model forward through the subsequent phases.

Birtnchell, Denman, and Okhai (2004) examined the efficacy of the Clinical Outcomes in Routine Evaluation (CORE 34) and the Person's Relating to Others Questionnaire (PROQ) in 32 clients who had completed a course of CAT. A significant decline in mean CORE 34 scores was determined post therapy. Furthermore, CAT was found to be helpful in reducing interpersonal difficulties. Marriott and Kellett (2009) explored the efficacy of therapy across three different psychological services {Cognitive Behavioural Therapy (CBT) service, a Person Centred Therapy (PCT) service and a Cognitive Analytic Therapy (CAT) service} in 193 clients. A statistically significant improvement in psychological symptoms was established across all therapy services post therapy. Both short term and medium term therapy were analysed. It was found that of the three services, short term CBT demonstrated the largest improvement. However, it was also found that medium term CAT (17 to 30 sessions) affected significantly higher psychological improvement than short term (7 to 16 session) CAT. The findings suggest that short term CBT may be more effective in reducing distress than other short term forms of psychological therapy, however, medium term CAT was found to be more effective than its short term (7 to 16 session) equivalent. The findings of Mariott and Kellett (2009) reflect the outcome of psychological therapy with younger people, it would be interesting, therefore, to explore further the efficacy of CAT in supporting older people.

Older Adults and CAT

When discussing their clinical experience of the advantages of using CAT in supporting older adult patients, Hepple and Sutton (2004) draw upon its helpfulness in examining life events to inform complex, relational causes of distress in later life. Specifically, Loates (2004, in Hepple and Sutton, 2004) discussed the systemic and organisational effects of long term psychiatric care provision, noting that very often clients who may have had support for many years prior to accessing psychological therapy, will have acquired the unhelpful label of 'treatment resistant' following several courses of medication change and, in some cases, ECT. The unfortunate paradox being that,'for many clients accessing older adult services for support, it is highly unlikely that they will have been offered psychological therapy until that point of last resort (Loates, 2004). Consequently, both services and the client may find themselves in a dual position of being 'stuck' in terms of progressing further with regards to distress reduction. Such stuck-ness in combination with the tendency of services to view older patients within a purely biological and ageing context devoid of relational, social, and life history can serve to reinforce the 'stuck' state for both services and the patient (Loates, 2004). Loates goes further, citing specific examples of ways in which the particular processes of CAT have helped clients to begin to notice and process powerful emotions, thus leading to a position of becoming 'un-stuck'. For instance, Loates (2004) describes the case of Mrs A – a woman in her seventies, who experienced significant distress as a consequence of rumination. In unpacking difficult parental relationships, noting down reciprocal roles, the use of the reformulation and working towards an ending, she supported her patient towards a point of understanding and the processing of powerful and painful emotions. Mrs A had not been afforded this opportunity by services previously.

An additional advantage in using CAT with older adults is that of its potential benefits of supporting patients experiencing distant trauma. Robbins and Sutton (2004, in Hepple and Sutton, 2004) argue there is a lack of therapeutic models designed to address complex or very distant trauma, suggesting that current approaches serve to treat sudden or unexpected trauma experienced relatively recently. Robbins and Sutton (2004) argue that CAT, as an integrative approach, offers a clear model which provides scope in which to address distant trauma, thus offering very specific opportunities in supporting older adult patients. Hamill and Gaskell (2014) support such an argument, citing the use of the therapeutic relationship for the purposes of promoting well-being and

the bringing about of change within CAT being particularly pertinent as factors supporting emotional regulation in later life. Hamill and Gaskell (2014) go further, arguing that the ability of CAT to explore early life experiences in the context of trauma and its subsequent effects upon the lived experience of an older adult patient offers a unique understanding of their distress and serves to reduce feeling of self-blame and shame. Hamill and Gaskell (2014) argue that this process consequently can open the door for older adult patients to experience changes in their self-to-self and self-to-other relationships.

The literature presented here highlights the very specific and specialist needs experienced by patients aged over 65. It is argued that CAT offers a unique model which can complement and explicitly support such needs (Hepple and Sutton, 2004). Sutton (personal communication, in Ryle and Kerr, 2002) writes that while she found CBT to be a useful model in working with aspects of anxiety in older adults, she felt it fell short of fully appreciating the effects that life experiences can have upon the clients she supported. CAT, Sutton felt, was a useful model by which to draw upon early and later life experience, and to value the impact that a life lived with many relationships can have upon her client's current situation. Sutton argues that CAT, more so than other therapeutic types, is able to value and take into consideration a rich life story, and it is for this reason that CAT ought to be especially applicable to older people.

While theoretical literature provides context and depth for the possibilities and usefulness of CAT in specifically supporting people aged over 65, the evidence base for the use CAT in supporting older people remains limited. Indeed, in Calvert and Kellett's (2014) systematic review, of the 25 studies that did meet the inclusion criteria, none focused solely on the efficacy of CAT in supporting older adults. Hamill and Mahoney (2011) argue that within their NHS service, CAT has shown to be, anecdotally, effective in supporting the psychological needs (which include depression and anxiety) in people aged over 65 years who care for a person with dementia. Hamill and Mahoney (2011) use case examples to demonstrate that CAT lends itself well to the specific needs of older adults, which may include a complex combination of bio-psychosocial and cognitive difficulties. While arguing a case for CAT in older adults, the current evidence base may benefit from studies which include larger sample sizes by way of broadening the empirical rigour of CAT in older adults.

Research Question

Can Cognitive Analytic Therapy significantly reduce signs of anxiety and depression in older adults?

Method

Participants

The outcome measures of 28 service users were included and all had received support from a mental health NHS foundation trust based in the north east of England. All service users had completed a contract of CAT with an accredited CAT practitioner clinical psychologist. Early experiences and current relationships are explored by way of drawing on life story and reciprocal roles. Service users were also provided with additional support via their care coordinator. All service users were white, British. Gender was evenly distributed (females, n = 14; males, n = 14). The age of participants ranged from 65 to 87 years (mean age = 73.2, standard deviation = 6.0). The majority of participants had a diagnosis of depression (n=17), four participants had a diagnosis of anxiety and the remaining six had a combined diagnosis of anxiety and depression. Most participants completed 16 session CAT, three completed 8 session CAT, three participants completed 12 session CAT and the remaining six participants completed 24 session CAT.

Measures

A total of five outcome measures (collected as standard by the service who offer CAT to clients) were used by way of assessing psychological well-being prior to and post CAT. The measures included: Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM) and Clinical Outcomes in Routine Evaluation 10 (CORE-10); Hospital Anxiety and Depression Scale (HADS); Personality Structure Questionnaire (PSQ); Inventory of Interpersonal Problems (IIP-32).

Outcome measures

Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM) and Clinical Outcomes in Routine Evaluation 10 (CORE-10)

The CORE-OM includes 34 questions designed to assess mood and

risk. The CORE-10 is a shortened version of the CORE-OM and derives 10 questions from the original measure by way of providing an outcome measure that is quicker – and thereby more convenient— for patient use. Both have demonstrated good reliability and are widely used, validated tools (Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark, & Audin, 2002; Evans, Mellor-Clark, Marginson, Barkham, Audin, Connell & McGrath, 2009).

Hospital Anxiety and Depression Scale (HADS)

The HADS includes 14 questions designed to offer a total score for depression, and a total score for anxiety. The scale is a standardised outcome measure with an acceptable level of reliability, and a clinical cut off score of 11 for both anxiety and depression scores (Crawford, Henry, Crombie & Taylor, 2001).

Personality Structure Questionnaire (PSQ)

The PSQ is an eight item questionnaire designed to assess for identity difficulties within CAT's multiple self-states model. It has been shown to be a reliable and valid self-report measure (Pollock, Broardbent, Clarke, Dorrian, & Ryle, 2001).

Inventory of Interpersonal Problems (IIP-32)

The IIP, is a shortened, 32-item version of a lager, 172-item version, and was designed to assess interpersonal difficulties experienced by people within their relationships. It has been assessed as a reliable measure for objectively measuring difficulties with interpersonal relationships (Barkham, Hardy & Startup, 1996).

Procedure

Outcome data was collected from the completed paper notes of 28 service users who had previously completed a course of CAT. Data were transferred to an SPSS data file.

Ethical Considerations

Ethical approval had been sought and granted by the appropriate NHS trust's clinical assurance and registration department and the University's ethics board prior to commencement of this study. Service user details were anonymised and confidentiality was maintained throughout.

Analysis

T-tests or non-parametric equivalents were used to identify significant differences in aggregate scores of the outcome measures pre and post therapy. By way of exploring for meaningful, clinical, change, Chi-squared analyses were also used for the most complete data – these being the CORE 10 and HADS outcome measure scores – to identify differences between pre identified clinical cut off scores pre and post therapy.

Results

Difference between CORE-OM scores pre and post CAT

The pre and post therapy CORE-OM outcome data of 16 clients was analysed. Tests of normality indicated that data were normally distributed ($P>0.05$). A significant difference between pre and post CAT therapy scores ($t,(15)=6.1, p<0.001$) was found, whereby CORE scores prior to therapy ($M=52.19$, $SD=23.66$) are significantly higher than CORE post therapy scores ($M=27.13$, $SD=20.6$). This indicates a decline in mean CORE scores following CAT. A summary of these findings is shown in table 1.

Difference between CORE-10 scores pre and post CAT

The pre and post therapy CORE-10 outcome data of 28 clients was analysed. A test of normality indicated that data were normally distributed ($p>0.05$). Therefore, a paired samples t-test was used. A significant difference between pre and post CAT therapy scores ($t,(27)=5.08$, $p<0.001$) was found whereby scores prior to therapy ($M=16.82$, $SD=9.39$) were significantly higher than post therapy scores ($M=10.43$, $SD=7.4$).

The CORE-10 user manual identifies a score of 13 and above as a cut off measure for depression. A dichotomous variable was created with scores of 12 or below categorised within the 'normal' range and scores

Measure	Pre-CAT		Post-CAT			
	M	SD	M	SD	*p*	d
CORE-OM	52.19	23.66	27.13	20.6	.001	1.13
CORE-10	16.82	9.39	10.43	7.4	.001	.76
HADS Anxiety	10.56	4.43	7.72	5.12	.001	.59
HADS Depression	10.69	4.6	6.23	4.0	.001	1.04
PSQ	22.77	8.33	18.0	5.5	.05	.69
IIP-32	43.86	23.31	32.21	17.48	.05	.57

of 13 and above categorised within the 'depressed' range. A chi-squared analysis was used. The analysis did not show a significant effect ($x^2(1, N = 28) = 3.5, p>0.05$).

Difference between HADS anxiety scores pre and post CAT

The pre and post therapy HADS outcome data of 25 clients was analysed. A test of normality indicated that data were normally distributed ($P>0.05$). Therefore, a paired samples T test was used. A significant difference between pre and post CAT therapy scores ($t,(24)=4.21, p<0.001$) was found, whereby scores prior to therapy ($M=10.56$, $SD=4.43$) are significantly higher than post therapy scores ($M=7.72$, $SD=5.12$). This indicated a decline in mean anxiety scores following CAT.

Crawford, Henry, Crombie and Taylor (2001) advise a HADS cut-off score of 10 to 11; this, they say would incorporate the 'moderate' and 'severe' clinical scores previously identified by Snaith & Zigmond (1994). Crawford et al. (2001) argue for this threshold as their analysis of normative data found that 33% of participants' scores exceeded Snaith & Zigmond's (1994) 'normal' range on the anxiety. Therefore, a dichotomous variable was produced; scores of 10 or below were identified as falling within the 'normal' range for anxiety. Scores of 11 or above were identified as falling in the 'clinical range'. A Chi-square test was used to determine for differences between predefined clinical cut offs. The analysis found a significant effect ($x^2(1, N = 25) = 13.0,$

$p<0.001$). Cross-tabulation demonstrates that, by the end of CAT, 16 clients had anxiety scores within the 'normal' range, in comparison to 9 within the 'clinical' range.

Difference between HADS depression scores pre and post CAT

The pre and post therapy HADS outcome data of 25 clients was analysed. A test of normality indicated that data were not normally distributed ($P<0.05$). A Wilcoxon signed ranked test indicated a significant difference between pre and post HADS depression scores ($p<0.001$). Mean depression scores ($M=10.69$, $SD=4.6$) pre-therapy were significantly higher than mean depression scores post-therapy ($M=6.23$, SD, 4.00). The analysis indicates that HADS depression scores pre therapy were significantly higher than HADS depression scores post therapy.

As described previously, a dichotomous variable was produced; scores of 10 or below were identified as falling within the 'normal' range for depression. Scores of 11 or above were identified as falling in the 'clinical range'. A Chi-square test was used to determine for differences between predefined clinical cut-offs. The analysis did show a significant effect ($x^2(1, N = 25) = 9.37, p < 0.01$). Cross-tabulation demonstrates that, by the end of CAT, 20 clients had depression scores within the 'normal' range, in comparison to 5 within the 'clinical' range.

Difference between PSQ scores pre and post CAT

The pre and post therapy PSQ outcome data of 13 clients was analysed. Tests of normality indicated that data were normally distributed ($p>0.05$). A significant difference between pre and post CAT therapy scores ($t,(12)=2.63, p<0.05$) was found, whereby PSQ scores prior to therapy ($M=22.77$, $SD=8.33$) are significantly higher than PSQ post therapy scores ($M=18.0$, $SD=5.5$). This indicates a decline in mean PSQ scores following CAT.

Difference between IIP scores pre and post CAT

The pre and post therapy IIP outcome data of 14 clients was analysed. Test of normality indicated that data were normally distributed ($P>0.05$) Therefore, a paired samples T test was used. A significant difference between pre and post CAT therapy scores ($t,(13)=2.68, p<0.05$), was

found whereby IIP scores prior to therapy (M=43.86, SD=23.31) were significantly higher than IIP post therapy scores (M=32.21, SD=17.48). This indicates a decline in mean IIP scores following CAT.

Discussion

This is an initial attempt to evaluate the efficacy of CAT in reducing symptoms of depression and anxiety in adults aged 65 years or over. The results indicate that CAT is effective to this end. Given that no study currently exists evaluating the efficacy of CAT in older people the present study makes a valuable contribution to this area of research. The aggregate analysis of significance between pre and post therapy outcome scores indicated that significantly lower scores were obtained across all measures following CAT. This illustrated that CAT is significantly effective in reducing signs of depression, anxiety and interpersonal problems in people over the age of 65 years. Furthermore, the lower PSQ scores in the study suggest a greater sense of integration in the self and the lower IIP scores are indicative of an improvement in relationships with others following CAT. These findings corroborate with similar studies exploring the efficacy of CAT in younger adult populations (e.g. Bennett, 1994).

Such a shift was not observed in the CORE 10, and this does undermine the efficacy of CAT in reducing distress. It is plausible that a single item (Q6) within the CORE 10 may have affected the results in the present study. A factor analysis revealed that question 6 'I have made plans to end my life' affected alpha across both pre and post outcome measures. On examining responses to this question it would appear that the majority of respondents would score '0' for this question both pre and post therapy, thus indicating a possible floor effect. However, when the data was reanalysed following the removal of question 6 no significant effect was found between CORE 10 clinical cut-off scores ($p>0.05$). While the results of the CORE 10 were not necessarily affected by respondents' answers to item 6, it is worth noting that the service in question is currently considering the validity of the CORE 10 in terms of its ability to appropriately assess risk.

Unfortunately, due to missing data, it was not possible to assess for clinical cut-offs using the IIP, PSQ or CORE-OM measures. It is worth noting that the time needed to complete a total of five outcome measures at two separate time points is likely to account for the missing data here.

The sample size of 28 remains a limitation of the study. In their

evaluation of the current CAT evidence base Ryle, Kellett, Hepple, and Calvert (2014) conclude that the average sample size of CAT studies included within Calvert and Kellett's (2014) systematic review was 27. While they conclude that, generally, this meant that studies exploring the efficacy of CAT using such sample sizes were underpowered in terms of heterogeneity, the effect sizes when considering the studies as a whole were positive ($d+ \geq 0.5$). This indicates that, while the present service evaluation remains underpowered, the findings do hold merit in terms of generalisability and, therefore, go some way to contributing towards the evidence base in this field.

D was calculated across all measures in the present study. Medium effects ($d \geq 0.5$) were found for the HADS anxiety, IIP and PSQ measures. Large effects ($d \geq 0.7$) were found among the HADS depression, CORE-OM and CORE 10 measures. The strong effect sizes of the present study further serve to support the ecological validity of the present findings.

While the majority of participants completed 16 session CAT (n=15) there was a degree of variability among length of therapy. Despite this, medium to large effects were seen across all outcome measures and a significant reduction in scores indicative of anxiety and low mood was observed. The findings not only indicate the positive effects of CAT for a range of session durations, but also serve to highlight the extent to which CAT practitioners may be relied upon to make effective clinical judgements with regards to deciding upon the length of CAT to offer.

Implications

The present study would have benefited from the exploration of the potential effects of CAT at a three-month follow up. While the service in question did provide three-month follow up support for CAT patients, the collection of outcome measure data was insufficient for the purposes of analysis. Future research would benefit from the exploration of CAT at three-month follow up in addition to pre and post therapy by way of exploring the potential longer term gains of CAT. Future research would also benefit from larger sample sizes, across all outcome measures used, by way of determining for the potential effects of CAT upon reducing symptoms to pre-defined clinical cut-off scores. It would also be interesting to compare outcome CAT measures in older adults with the outcome measures of other psychological therapies.

The lack of current research in CAT highlights the difficulties faced

by busy clinicians. Time pressures, lack of facilities, resources, and access to staff support are all factors which may contribute to the ability of clinical staff to conduct research trials. This means that, while the efficacy of CAT in reducing distress is anecdotally evidenced, the current pressures faced by clinical teams mean that preparing research for publication can be very difficult. The authors recognise these difficulties and argue that more protected time and resources are needed in order to promote a wider evidence base for CAT. Further, clinical teams may benefit from delegating research tasks to junior team members with skills in research, such as Assistant Psychologists, Trainee Psychologists and Student Nurses.

The findings demonstrate the potential benefits of CAT for improving the mental well-being of people aged over 65 years experiencing mental ill health. As a time limited therapy, the present service evaluation serves to highlight the value of CAT as an effective therapy for reducing distress within the ever-increasing constraints of limited NHS resources. □

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Reviews

Cognitive Analytic Supervision – a Relational Approach

edited by Deborah Pickvance

Published: (2017) Routledge

Deborah Pickvance has assembled chapters from an impressive range of experts in the field of Cognitive Analytic Therapy (CAT), and invited them to turn their attention to the process of supervision. This book therefore offers a rich variety of chapters on different aspects of supervision, through which the key features of cognitive analytic therapy gradually emerge. In particular, the collaborative nature of the supervisory relationship, which echoes the therapeutic relationship in CAT, the supervisor being constantly open to what the supervisee wants from the supervision, asking for feedback and adjusting the approach accordingly. The book also refers frequently to what is probably the unique selling point of CAT, the ability to draw out visual representations of relational patterns in CAT diagrams or maps. The book starts with some general chapters on the helpfulness of supervision and the CAT approach.

Written to be accessible to therapists who have little or no knowledge of CAT, several of the first few chapters start with a basic description of the key elements of 'what CAT is'. As an experienced CAT therapist and supervisor, this was a little irritating for me. The third chapter, by Eva Burns-Lundgren, is a lovely basic introduction to CAT as a therapy, and to CAT supervision, and I think it would have been better to put that as the first chapter, and then encourage other contributors to refer to it, rather than repeat that information. I very much liked Annie Nehmad's chapter on the 'healthy supervisor' and her ability to translate into CAT terms, other expert writers on supervision. It was also useful to read Carolyn Lawson's summary of research in her chapter 'What makes Supervision helpful'.

I enjoyed less some of the chapters in

section 2 and section 4 where the focus was on the type of patient being supervised, and so the suggestions about supervision really felt like just a summary of how to work with a particular client group. I can see that this would be useful if I was about to change fields, or to start supervising someone working in an area that I had no experience of, but I think I would be looking for more in-depth articles than that provided here. Also, the choice of patient type seemed a bit arbitrary – for example, where were the chapters on supervising those using CAT with patients in older age services, or physical health departments?

Having said that, for me the best chapter in the whole book was by Jessie Emilion and Hilary Brown on 'Intercultural supervision'. I loved this chapter, both the content and their writing – I wanted them to carry on and write the rest of the book too, perhaps they will write their own book at some point? Also useful were the chapters on supervising non-CAT therapists by Mark Westacott and supervising CAT consultancy by Angela Carradice. Both of these raised issues that I have not thought enough about when doing these kinds of supervision – particularly the focus at the start on clinical roles of the supervisee and what they want to get out of the supervision sessions. Both of these writers also described interesting clinical scenarios which made the issues come alive.

The chapters which I personally found most interesting, were those in section 3, the more general focus of the methods and tools of supervision, regardless of the client characteristics. These chapters helped me to stop and think about what I actually pay attention to when supervising. Is it aspects of the group dynamics, described by Jane Blunden and Hilary Beard, the map making illustrated by Steve Potter, the competence of the supervisees, or slowing down and being mindful of the microcosm? I was disappointed that Steve Potter did not describe the use of CAT diagram 'templates' – either his own, or the one developed by Michael Knight, as I think these are really useful as a supervision tool in teaching trainees who are new to CAT and have no idea where to put things as they start to map in with patients. However, he does include in his chapter some lovely examples of mapping the supervision relationship provided by Cheryl Delisser.

I suspect everyone will have a different favourite chapter or section, and it will depend a bit on where they are in their journey as CAT therapist or supervisor. This book should definitely be required reading for anyone doing their CAT supervisor training, and will also be useful to dip in to for those changing field or starting to supervise CAT consultancy or non-therapists. I was left, most of all, reassured by the wealth of incredible talent and experience in the CAT community and with the sense that the future of CAT is indeed in very capable hands.

Alison Jenaway

As an adjunct to the review Debby Pickvance reflects on the relational process of editing her book.

CAT Supervision – a relational approach, published in September 2016, is a multi-voiced creation, containing nineteen chapters written by twenty-four authors; within it there are several frameworks for understanding supervision, all recognisably CAT. As its editor, I saw my job as one of forging a channel through which experienced supervisors could communicate their experience and knowledge to others. In addition, I wanted the voices of supervisees to be heard, as these are rare in supervision literature, so there are quotes from supervisees about their experience of supervision. Above all I was keen to avoid bland generalities and hoped that readers would gain a strong sense of the clinical base from which everyone wrote, the pulls and pushes of the real human relationships at the core of supervision and the subtleties of choice, judgement and style used when supervising. I wanted the book to give a CAT perspective on issues which challenge supervisors and create tension in supervision and on approaches which make supervision a containing, productive, enjoyable and stimulating experience for supervisees. I was keen too that the gender ratio of the authors would mirror that of CAT therapists and so most contributors are women.

Producing the book has been a truly collaborative effort and without the help of many people it would never have come in to being. Having no prior experience of editing or publishing I turned to old hands, both within and outside the CAT world. Along with invaluable advice some gave me ominous warnings to expect that one or two chapters would not arrive, and I would have to write them myself. Fortunately, all the chapters did arrive. The contributors have been enthusiastic, cooperative and responsive. All were seasoned supervisors, many were already authors of books and papers, but several were new to writing for publication. In asking people to write for the book I found I was drawing on a strong and willing community of therapists and supervisors. In some way collaborating on the book has made that community stronger.

The idea for the book first occurred to me when a CAT therapist asked me about training as a CAT supervisor. When I tried to think what she could read about CAT supervision I drew a blank. Apart from a handful of sentences in some of the CAT books nothing had been published at that time; this was before Robert Marx's (2011) article appeared. Most therapy models have at least one book on supervision written from within the model, but CAT did not. And so the idea was born – a book that would plug that gap.

Of course, it begged the question: what is a CAT view of supervision? Could we simply describe supervision by applying CAT concepts to it or is there more to say? It seemed right to articulate a view of CAT supervision as part of the relational tradition of therapy.

'Relational' is a word that runs the risk of being used as a loose catch-all, so I wanted to define its meaning when applied to CAT supervision clearly. The more I read the more I realized that supervision of CAT fitted comfortably alongside other developments in relational theory and practice through the 1970s and 80s. Every chapter of the book reflects a relational perspective, whether summarising research on supervision, describing the process of supervision or the qualities and skills of a supervisor or issues in supervising specific areas of CAT practice.

The book came out a few days before Tony Ryle's death. Tony refused to be treated as a guru and was always keen that other people developed the model. The book is a testament to his success in doing just that and a tangible example of his huge legacy. It is a tribute not only to the power of his ideas, but to his ability to inspire others and to his willingness to share and develop his ideas with others. Tony had been encouraging and supportive of the book, and wrote an endorsement for it despite being frail. He never saw the complete book – the publisher, Routledge, was about to send him a copy when the news of his death arrived – but he had read several chapters and was very pleased to find within them some new developments in the model. The contributors all wanted to dedicate the book to him and wrote the dedication jointly.

For Marx, R. (2011) paper, see *Psychology and Psychotherapy: Theory, Research and Practice,* 84: 406-424.

The World Within The Group: Developing Theory For Group Analysis

Martin Weegman

Published, Karnac Books, London

Martin Weegman, in this innovative and thought provoking book, wishes to expand the social and clinical horizons of group analytic thinking. In doing so he emphasizes the importance of the cultural context and setting of how we live our lives and he highlights the essential interconnectedness and relational dynamics in human interaction as paramount in any comprehensive understanding of individual and social developments. Outlined in a series of disparate essays, drawing on different but related themes, he presents the reader with an eclectic blend of philosophy, historical analysis, social theory and clinical experience. His aim is to connect group analytic theory and practice to the wider domain, showing how it can influence and expand our understanding of how we function together individually and socially outside, as well as within, the boundaries of the clinical setting.

The group analytic principle that all individual processes cannot be conceptualized independently of the social/group matrix in which they occur is persuasively outlined in chapters on working with intersubjectivity, group analytic theory and practice, philosophy, the English Reformation and one on the narrative dimensions of human life. There are also chapters on the

exclusionary matrix, and Stevenson's novel *Dr Jekyll and Mr Hyde*, which illustrate the need for negative constructions of the 'other' to reinforce the solidarity of the in-group and points up the conflictual struggles we have with the negative aspects of human duality.

The significance of relational thinking, reciprocal dialogue and reflective inquiry are also highlighted throughout the book, countering the prevailing notion that things can somehow be known, fixed or discoverable by evidence-based scientific activity. The intrinsic value of viewing life as an emergent (open-ended) activity, located in dynamic, interactive processes, is emphasized by explorations of historical, religious and cultural ideas, practices and developments and the chapter on the social unconscious is a rich and stimulating essay on how we continually create discursive worlds and imagined spaces to establish order to our understanding and perception of social and individual meaning. These organizing principles help create social cohesion, giving us a sense of living within ''safe enough' containing contextual structures. However, the consequences of this can be good or bad, ordered or disordered, depending upon the particular individual and social perspectives in any given cultural or historical situation. In terms of individual psychotherapy models, like CAT, these discursive world views highlight how self-destructive reciprocal relational structures can lead to limiting internal horizons which distort how we see ourselves in relation to others and constrict and constrain our ability to adapt and make positive therapeutic change.

These constantly changing spaces are adaptive to setting, cultural conditions and to external and internal events. They are not false or illusory but are essential as good working hypotheses, enabling us to function individually and socially. The author affirms that group analytic thinking, focusing, as it does, upon contextual containment, intersubjectivity and relational dynamics, is well placed to contribute to our understanding of the complexity of these processes.

The book finishes with a chapter on group analysis in contemporary society, which reflects upon the importance of the democratic, ethical, political and social implications of group analytic theory and practice and how these can be utilized to help us understand the world we live in and negotiate the way ahead. There is also a useful glossary of the main concepts and their historical and academic relevance attached.

This is a stimulating and at times, complex and challenging book, which will reward readers outside of the group analytic field who are interested in human relational dynamics, the tensions between the individual and the group and the private and public aspects of ourselves.

Ian Simpson. London

Thinking in Cases

John Forrester

Published: Polity

John Forrester has changed the way I think about case studies. His argument reaches across psychoanalysis, Foucault, Winnicott and Kuhn and finishes with a review of the idea of case histories in terms of gender based on the work of Robert Stoller, the man Forrester passionately calls the last psychoanalyst. This collection of essays offers a rich diet of reflection for the practitioner of relational approaches to therapy such as CAT. The essays, published posthumously after the author's untimely death invite a 'circulation' of ideas around what makes the discipline of 'thinking in cases' representative of and participative in something more general. He explores whether a case study can count as a form of scientific practice. He wonders at Freud's eloquence in writing up cases (judge them by their truth not their eloquence). He makes a case himself of the overlapping intellectual Jewish lives of Freud and Einstein and takes a close look at Kuhn's key work on the structure of scientific revolutions.

Forrester, who was a postgraduate student with Kuhn, says the second edition of *The structure of scientific revolutions* (1977) revised the popular but confusing idea of paradigm with two component ideas: the relational matrix of social practices that make up a scientific community in a particular discipline or period and the idea of an exemplar which Forrester redefines as 'shared reasoning with cases'. The use of exemplars is at the heart of scientific practice for Kuhn and Forrester and this chimes well with CAT which has built its understanding from careful and accurate description of cases in their relational context.

As a reader of Forrester's book I am intrigued. Psychoanalytic imagination is alive and kicking. As a CAT therapist and as one who as an examiner has closely read and marked many case studies, I know that the case story is at the centre of our practice. But how do we test the truth of the account before us. Or indeed the one which we shape in our minds as a 'CAT case' from the client's unfolding story in the consulting room? How do we distinguish the case as exemplar – one story within a conversation of stories about our work – and the case as casuistry – the moralistic plea to live in a certain way such as the Good Samaritan?

One truth test for Forrester would be evidence of those moments of self-doubt, transference, confusion and acknowledged failure. A good case story is not necessarily a 'good' case. How do we judge the CAT therapist in his or her ability to weave a self-conscious, self-curious account of the client's story with the story of the therapy or treatment? Would the client present a different case if they were the author? In teaching the client to be their own CAT therapist are we also teaching the client to be their own case historian? We get a glimpse of this in the client's good-bye letter which

is appended to all 'marked' CAT cases for examination.

In sum this collection of psychoanalytic essays offers some pointers to a relational approach to thinking together about the myriad of cases that make up the story of mental health, illness and its treatment. For the CAT practitioner who cares about the analytic A in CAT it is a good read.

Steve Potter

The Future of Psychological Therapy: From Managed Care to Transformational Practice

(Ed) John Lees (2016)

Published: Routledge

This polemical collection of essays edited by John Lees, with a thoughtful and thought-provoking foreword by Andrew Samuels, constitutes an important resource and articulation of concerns about 'psychotherapy' as 'delivered' through the IAPT ('Increasing Access to Psychological Therapies') initiative in England, and about its broader managerial and political context. Samuels, in his otherwise sympathetic foreword, does note some issues arising with the collection. These include how best to convince opponents at whom the book is partly directed, and the question of why relational therapists should necessarily be opposed to 'neo-liberal' politics. These the book only partially addresses.

The collection offers a trenchant critique of IAPT and its conceptualisation as a kind of mechanical, 'quick fix' means of mending citizens efficiently, and of getting them back to work (part of Lord Layard's original rationale, doubtless well-intentioned). Mental health problems are seen here simply (and, given the evidence, wrongly) as technical problems, and in terms of symptoms and behaviours, arising somehow 'within' the heads of individuals, and regardless of their relational and social formation or context, or possible broader existential or spiritual concerns. Few would dispute the aim of offering more help to more people, but rather how it is conceived, and how it is done. (In IAPT largely through some form of 'dilute' CBT, or 'state therapy' as Samuels notoriously described it!) Curiously, CAT is described as part of IAPT, and as essentially 'cognitive' (Morgan Ayrs).

Variously the essays describe an unholy alliance existing between IAPT, CBT, a commodified and commercialised health care system run by a 'new public management' (NPM), and its neo-liberal broader context. These are at times virtually co-identified and conflated, in part understandably. The book is mostly preoccupied with the prevalent situation in the UK, and especially England, apart from one chapter (Bento) noting parallels and problems within the 'HMO' system in the US. This does limit its generalisablity. This political context in England is seen as increasingly neo-liberal and free-market, with its NPM approach to delivering health care in the

NHS. This is characterised by a top-down 'managerialism' that views health care (and health professionals) as essentially commodities in an increasingly commercialised setting. They note it is consequently preoccupied with and 'espouses' the Ms of managers, markets, measurements, (and money), to the neglect and detriment of quality and of real cost-effectiveness, and also the well-being, concerns, views or expertise of front-line staff, critical in the delivery of good care. Such a system wilfully neglects and fails to address or 'contain' (Simpson) the inevitable anxiety and 'risk' (Totton) inevitably engendered by such work in such settings. Things simply can't (and shouldn't) always be controlled. Indeed some authors argue persuasively that one task of therapy is opening up and challenging 'things', including the socio-political establishment. In this context too patient-centred care or real choice suffers. An important implicit question arises as to whether in such circumstances it eventually becomes impossible to maintain a secure place in which to do meaningful, effective therapy. Many relational therapists may feel this has already happened in the NHS in the UK.

Throughout this collection there is an impressive, manifestly humanitarian and impassioned, commitment to care and concern, and respect for individual clients/patients in their whole-life complexity. In many ways this appears to constitute the core of the collective critique in the book. However, the very assumption that this humanitarian and 'relational' counter position in itself (opponents might argue this is worryingly based essentially on intuition and personal, 'anecdotal' experience), with its critique of current dominant 'scientific' evidence-based approaches (as enshrined in e.g. NICE guidelines or current classification systems of 'mental illnesses') represents a convincing radical alternative (e.g. to managers, commissioners or politicians) appears problematic. Most relational therapists would doubtless agree about the very serious limitations of these approaches ('a scientific and political mess' as one leading psychiatric authority recently noted, off the record). They would also argue that 'process' type, qualitative and socially-embedded research is hugely important. Lees describes the wealth of such experience within the relational therapy tradition as constituting 'transformational research'.

But there remains a '*tua res agitur*' – i.e. an important need to demonstrate that our various approaches are more effective than simply e.g. social support or befriending (a non-finding in many RCTs e.g. of psychosis, or PTSD), are reasonably cost-effective (especially with taxpayers' money), user-friendly, or, at the least, do no harm. And there is still an urgent 'meta-challenge' to integrate these various dimensions of research. As Parry and Richardson properly noted in a landmark Department of Health report almost two decades ago, unevaluated practice is simply no longer acceptable. The history of health care (including mental health and psychotherapy) is littered with examples of well-

intentioned treatments which possibly delayed improvements (however 'measured'), or actually caused harm. The question is how, meaningfully, given the complexity of mental health and the inadequacies of current approaches to 'diagnosis' and evidence, we undertake these evaluations. It is not clear that from its impassioned position, and perhaps partly due to it, this book overall rises to this meta-challenge.

Thus, as Samuels notes, these arguments might not do too well in the imaginary scenario of persuading politicians, commissioners of managers responsible for health care why the various protagonists of these relational approaches should also be funded to work as they like, for as long as they like, in a taxpayer-funded system, as the argument might be seen. The approach apparently advocated (by Loewenthal – a major relational therapy campaigner), of adopting a 'theory-free' approach to clinical practice seems paradoxical and not obviously helpful.

Incidentally, the authors are really quite various ranging, arguably at times mutually contradictorily, from e.g. psychoanalytic (including Jungian, Lacanian, group analytic) to humanistic, anthroposophical, and integrative. How far these represent genuine differences or not is an issue, along with the spuriousness of 'brand name' debates, from a 'common factors' perspective, but is not really named or addressed. This is unfortunate as there is an argument to be made that we don't need large RCTs of every new variant 'therapy' to justify them, and about what constitutes evidence for (likely) effectiveness of any psychotherapy. The questions are rather more about nuances of effect including e.g. strength of therapeutic alliance, cost-effectiveness, user-friendliness, or drop-out rates. And the evidence is that these are features of a more fundamentally relational approach to mental health and therapy – including, paradoxically, CBT when effective!

(Ironically, adherence to formal NICE-type evidence approaches will – ultimately – discredit the exaggerated claims for effectiveness of CBT as the 'real-world' effectiveness results of, especially, 'dilute', brief CBT emerges).

If these comments sound critical it is more out of frustration given some challenges that might have been productively addressed and weren't. Otherwise this collection represents an important resource and rallying point, and contributes powerfully to the argument that a more compassionate, caring and 'effective' alternative exists to the current *status quo* of the NHS and its socio-political context.

Ian B. Kerr, Stirling, Scotland

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International Journal of Cognitive Analytic Therapy and Relational Mental Health

Contributions and enquiries for the second issue of the journal need to be received by August 1st 2017 and sent to journalicata@gmail.com Guidelines for authors are below and can also be accessed at http://www.internationalcat.org/journal/

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

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