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Service User Experiences of CAT Diagrams: an Interpretative Phenomenological Analysis

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Abstract

Background: Formulation is an essential tool in psychological therapy. However, there is a paucity of research evidencing the efficacy, credibility and experience of formulation. Cognitive Analytic Therapy (CAT) uses a specific form of diagrammatic formulation.

Aims: This study aims to explore service-user experiences of the SDR.

Method: Seven participants who had an SDR and who completed therapy within three to twelve months were interviewed using a semi-structured interview/topic guide. Data were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes emerged from the data: *'Chaos to clarity (a process of meaning making)'*; *'The change process'*; *'Relational dynamics'*; and *'Focus on treatment options'*.

Conclusions: Results suggest the SDR facilitates understanding and reduces blame. Participants advocated for CAT as an early intervention. The visual and physical aspects of the SDR were important in developing ownership of the formulation. Collaboration was crucial to the development of the therapeutic relationship and promoted a sense of empowerment, hope and meaningful person-centred change. For participants in this study CAT was regarded as a preferable treatment compared to CBT and medical frameworks of understanding human distress. Study strengths and limitations, clinical implications and future research ideas are discussed.

Declaration of interest: None.

Keywords: Cognitive Analytical Therapy, Sequential Diagrammatic Reformulation (SDR), service-user, formulation.

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Introduction

FORMULATION offers an alternative or complementary framework to the prevailing medical model of human distress, and although the psychiatric classification system is often presented as scientific, a growing body of research challenges this viewpoint (Read & Dillon, 2004; Kinderman, Read, Moncrieff & Bentall, 2013). It is challenging to research formulation, due to its complex, idiosyncratic nature, which makes it a difficult subject for randomised control trials. For these reasons, despite formulation being valued within psychology, there is a lack of research exploring the development, use and effectiveness of formulation (Aston, 2009; Rainforth & Laurenson, 2014) particularly from a service-user perspective.

Defining formulation

Formulation is an idiosyncratic, theoretically based hypothesis about the cause and nature of presenting problems (Westmeyer, 2003; Kuyken, Fothergill, Musa, & Chadwick, 2005; Persons, 1989). Formulation is also described as a 'crucible' bringing together a range of psychological theories, research and idiosyncratic service-user factors (Dudley & Kuyken, 2013) to make sense of complex information and guide intervention (Butler, 1998). The Division of Clinical Psychology (DCP) defines formulation as a process constructing personal meaning out of psychological distress (DCP, 2011).

CAT theory and practice

CAT was developed in 1979 (Ryle & Kerr, 2002) as a time-limited, integrated approach to meet service-users' needs within NHS settings. The model incorporates ideas from Vygotsky and Bakhtin (Ryle, 1991; Leiman, 1992). CAT integrates psychoanalytic and developmental theories and is informed by attachment theory (Bowlby, 1969) personal construct theory (Kelly, 1955) and object relations theory (Winnicott, 1974).

CAT emphasises a collaborative approach and aims to identify and revise repetitive maladaptive patterns of thought and behaviour. These patterns are known as reciprocal role procedures (RRPs). A reciprocal role (RR) is a way of relating which is learned and developed through our early experiences of relationships. A RR can be helpful (appropriately caring-appropriately cared for) or unhelpful (neglecting-neglected).

Through exploration of service-users' early experiences of receiving care, a selection of RRs and RRP are identified. The client and therapist develop a list of therapeutic goals (target problems [TPs]). Unhelpful patterns (target problem procedures [TPPs]) are identified in terms of: 'snags' (barriers to change such as feeling guilty when happy), 'traps' (thoughts or behaviours exacerbating the problem) and 'dilemmas' (polarised 'either/or' and 'if/then' choices). CAT provides a prose (therapeutic letter) and visual (SDR) formulation focussing on TPs and TPPs, which is conventionally called the Sequential Diagrammatic Reformulation or SDR for short. The SDR is drafted collaboratively to support service-users to develop their awareness of maladaptive patterns and their ability to revise them. The SDR is reflected on and can be revised. It also can be used to explore any transference and counter-transference reactions within the therapeutic relationship.

There are different perspectives of SDR with it being conceptualised either as a process of collaborative mapping between the therapist and service-user, or as a tangible object produced in therapy. This parallels wider debates about formulation as a process and formulation as a 'product'. The focus of this research was on the SDR as a product which is then used collaboratively as an aid to facilitate therapeutic change.

Research aims

CAT prides itself on its focus on collaboration, however, even within collaborative therapies there is little evidence exploring how service-users experience CAT tools and approaches. This research aims to address a gap in the evidence base by exploring service-user experiences of the diagrammatic formulation in CAT (SDR).

Method

Design

IPA is a flexible, systematic and thorough qualitative research approach examining how people make sense of life experiences (Smith, Flowers & Larkin, 2009). IPA has three theoretical underpinnings: phenomenology, hermeneutics and idiography. Smith, Flowers & Larkin (2009) provide guidelines for IPA involving the process of moving from the descriptive to the interpretative (Smith, 2004; Finlay, 2008; Larkin, Watts & Clifton, 2006).

Phenomenology

Phenomenology is a philosophical and dynamic approach to the study of lived experience. Husserl (as cited in Smith et al. 2009) emphasised the importance of researchers developing an awareness of their own natural attitudes. He encouraged researchers to question and temporarily hold their pre-understandings (past, theoretical knowledge, culture and context) aside during research analysis. This involves 'bracketing' one's experiences to develop an understanding of the true essence of a phenomenon as it presents itself to consciousness. 'Bracketing' aims to reduce researcher bias and promote the identification of novel ideas and understandings. Heidegger (as cited in Smith et al, 2009) suggested this process of reduction is not possible, because we are fundamentally linked to our past experiences and contextual influences. Consequently, Heidegger explored the role and theory of interpretation (hermeneutics).

Hermeneutics

IPA acknowledges there is no direct route to understanding a person's experience. The methodology uses the researcher's interpretation of a participant's interpretation of an experience (double hermeneutic) to develop an understanding of the hidden meaning of the experience to the participant, and how the participant makes sense of the experience. The interpretation is valuable because the analytical lens allows us to discover and make sense of hidden meanings whilst remaining grounded in the empirical data. The researcher's immersion in the data facilitates the process of interpretation and sense-making, which is communicated through publication. Smith, Flowers & Larkin (2009) emphasise the process of engaging with the participant more than 'bracketing', which suggests the counter-transference reactions researchers experience during interviews facilitates awareness of their pre-understandings (for example if the researcher feels surprised or excited at the transcript).

Rationale for IPA methodology

IPA is concerned with understanding meaning at an individual level rather than attempting to establish universal or causal laws, or making claims at a group/population level. The value of IPA is that it provides a thorough, systematic analysis with a *depth* of understanding of people's lived experiences, as an alternative to numerical data that is removed from the individuals from whom the data was collected. Although one cannot generalise findings from IPA, implications can be drawn (alongside other literature that is available) to inform clinical work.

The research aim was to gain an in-depth understanding of how service-users experience and make meaning from SDRs. IPA provided a framework to develop an analytic interpretation of participant's accounts which is clearly grounded in each participant's sense-making (Larkin, Watts and Clifton, 2006; Smith, 2004). IPA allows the researcher to acknowledge the service-user's position as an expert in their experience, while providing in-depth analysis and interpretation.

Procedure

Recruitment

CAT therapists were emailed information packs containing a participant information sheet, consent form, and cover letter/opt-in sheet, to post to potential participants. Many of the therapists worked as Clinical Psychologists and therefore had training in a range of therapeutic models. Following discussion with experienced CAT practitioners during the developmental stages of the research, and consultation with CAT literature (Parkinson, 2008; Ryle & Kerr, 2002), a list of features was developed to ensure the SDR was a CAT formulation and not a formulation which could be attributed to another psychological model (Table 1). Collaboration could have been listed in these inclusion criteria; however, the aim of the criteria in Table 1 was to promote CAT integrity. Having a SDR at the end of therapy which looks sufficiently like a CAT map was not an attempt to make assumptions about how the SDR was developed or about process. Additionally, the researchers wanted to develop their understanding of how important (or not) the dynamic, co-constructive process of mapping is in addition to the use of the SDR as a product. Consequentially, the researchers were mindful to allow these findings to emerge from the data analysis without their pre-understandings moulding the findings. Service-users had different therapists; to ensure fidelity to the CAT model, therapists were asked to ensure participants had engaged with an SDR meeting these criteria. Authors were mindful of the aforementioned criticisms of the diagnostic classification system, consequentially, there were no diagnostic restrictions in relation to recruitment.

Table 1: Essential features of a CAT SDR

Essential features	
1	Includes a core state or core pain that encompasses undesirable/unmanageable distress.
2	Procedures must feed in and out of the core pain (TPPs take them back into it).
3	Must include a relational focus.
4	High predictive component.
5	Includes reciprocal roles or procedures that explain the client-therapist relationship.
6	Explores past, present and future.
7	Explains what goes on within the therapeutic space and outside of therapy.
8	Persistent, chronic and pervasive procedures that are played out in more than one domain.
9	Universal procedures – broad themes around managing emotions and interpersonal concerns (e.g. feeling ‘put down’).
10	Procedures should capture the transference during therapy.
11	Should go beyond the presenting difficulties (e.g. does not just look at what’s causing low mood).

Participants

A homogenous sample was obtained which met inclusion criteria of having a SDR meeting and ending therapy within three to twelve months of the research interview. Timescales were selected following previous research recommendations which suggested research focussing on sessions immediately after the reformulation was too soon to measure the impact (Evans & Parry, 1996; Hamill, Reid and Reynolds, 2008). Seven participants were included in this study. The sample size recommended by Smith, Flowers and Larkin (2009) is between four and ten, to ensure rich quality data.

Data collection

A semi-structured interview/topic guide with open ended questions was developed. Prompt questions were used if participants found it difficult to verbalise their thoughts, or if responses were too succinct. The main author attempted to collect less biased data by providing the opportunity for participants to voice their own opinions before being led by the

researcher’s questions. The topic guide used a funnelling technique (Smith, Flowers and Larkin, 2009) starting with a general question before asking more specific questions.

Data analysis and interpretation

Data was analysed according to the recommended steps outlined by Smith, Flowers and Larkin (2009).

Quality in IPA

The researcher applied the quality guidelines produced for qualitative approaches to the IPA process (Elliott, Fisher, & Rennie, 1999; Yardley, 2000).

Results

Analysis of seven interviews developed four superordinate themes and nine subordinate themes demonstrating how participants made sense of their experience of the SDR (Table 2). Themes are presented in order of prevalence across transcripts and supported with representative quotes from across the data. It was often difficult to tease individual themes

Table 2: Superordinate themes and constituent subordinate themes (Taplin, 2017)

Superordinate themes	Constituent subordinate themes
Chaos to clarity (a process of meaning making)	<ul style="list-style-type: none"> ● Understanding the selfl ● ‘Having it on paper’
The change process	<ul style="list-style-type: none"> ● ‘Stepping forward’ ● Emotional outcomes of mapping as a process ● Outside the therapy room
Relational dynamics	<ul style="list-style-type: none"> ● Dynamics within the therapeutic relationship ● Emotional responses to the endings in CAT
Focus on treatment options	<ul style="list-style-type: none"> ● ‘What if I’d had CAT years ago?’ ● Medical model

apart during the analytical process; this may reflect the challenges separating common therapeutic factors such as collaboration and the therapeutic alliance from model specific factors such as the SDR.

Superordinate theme one:

Chaos to clarity (a process of meaning making)

For all participants, the experience of mapping facilitated a process of self-reflection and sense making. Participants conveyed a need to understand past experiences and how these influence current functioning. Developing self-understanding was more important to participants than focusing on symptoms.

Understanding the self

This subordinate theme was present in all seven accounts. Participants often used visual language and analogies of reflection and light when describing mapping as a process of developing self-understanding. Laura describes mapping as ‘an eye opener’; ‘a light bulb moment’ which ‘brought clarity and credence to [her] thoughts’. Scott describes a process of self-reflection and subsequent changes in his self-perception: ‘looking at myself in a different light, erm (pause) I was getting to understand myself’. Lisa conveys the link between developing an understanding of the self through mapping and the consequential process of normalising human distress: ‘it (pause) demystified them, normalised them’.

‘Having it on paper’

This subordinate theme was present in all seven accounts. The process of converting the map into a visual object appeared to validate the emotions attached to it. Thus, externalising thoughts, emotions, memories and experiences so they could be acknowledged and reprocessed allowed participants to take ownership of them and internalise them in a helpful/meaningful way. The physicality of the map was central to this process: ‘Being a visual person for me was good so if I didn’t have that I probably wouldn’t have taken it is as well’ (Scott). Participants’ descriptions used the vocabulary of publishing. Tom emphasised the role of the map being a visual tool and how ‘sometimes we’re as well to see things in cold print you know erm (pause) yeah because it acknowledges that it actually happened or whatever or how you’re thinking’. Ben describes a process of internalisation of the map:

‘I have err a good picture of it inside my head; it imprints it you know’. Laura conveys her sense of ownership of the map: ‘I’ve still got my moments and I will do I can’t break 48 years of life, and life experiences overnight, but I now feel that I’ve got the tools because I’ve got the map’. Janine uses visual language and the metaphor of a tube station map to convey the internalisation of the SDR:

‘The map’s up here up here, it’s in my head. . . the map is like a map of a tube station and you know where all the tubes are, and you don’t need to erm go and have a look and see which line you need to go on or whatever because I know and that’s why I don’t need to look at the map anymore.’

Participants also discussed the importance of the map looking aesthetically pleasing: ‘it was kind of done like you know on scraps of bits of paper and it wasn’t very clear or easy on the eye’ (Sunita); and how adding colour to the map ‘made it much easier to refer to’ (Janine).

Superordinate theme two: The change process

Participants experienced the map as a symbol for hope and a vehicle for change. It was described as a tool evolving as a process both outside of therapy sessions, and beyond the therapeutic contract.

‘Stepping forward’

This subordinate theme was present within all seven accounts. Developing and engaging with the map enabled participants to contemplate change and put this into action: ‘It was stepping forward rather than being always in the past we were moving on to the future’ (Laura); ‘That label was an excuse to hide. This treatment was a reason not to’ (Ben). Scott discusses how mapping empowered him to make changes in his life:

‘What I can do is change the future. So that’s what the mapping has done for me. . . it’s one of the best therapies ever, it’s (pause) it’s changed my life, well it’s helped me to change my life.’

Emotional outcomes of mapping as a process

This subordinate theme was present within all seven accounts. Developing and engaging with the map generated a range of positive and negative emotional experiences for participants evidencing their emotional connection to the map and the mapping process.

Participants' experiences of mapping expressed mixed feelings containing a range of complex responses both within and between participants: 'well I found it all a bit difficult on one level you know. . . to a certain extent because it's very exposing' (Tom). Participants also conveyed inconsistent attachments to the map: 'Sometimes it was an elephant in the room. . . sometimes I wanted the map and sometimes I just didn't' (Laura). Some participants link the map to a place of safety: 'It's like a, what do you call it (pause) a safeguard kind of thing, it helps me' (Scott). Scott describes experiencing a range of emotions in response to the map: 'it was a range of emotions (pause) it was upsetting, it was (pause) as I said it was daunting, it was scary'.

Participants represent the role of the map as a concrete, tangible attachment object providing psychological and physical support/security. Tom describes the map as 'something tangible. . . that you can sort of hold onto (pause) in between visits you know erm which I think is very important'. Conversely, Sunita describes a lack of ownership or attachment to the map suggesting it is the therapist's tool (not the service-user): 'A useful tool for him. . . an important part of his work'.

It was important for the participants in this study to not be blamed for their difficulties: 'So it was quite a revelation really and quite cathartic because as we started mapping I kind of realised that all these things weren't my fault' (Laura). This is also a moment of shared discovery. The process of mapping created a therapeutic moment contributing to the development of the therapeutic alliance. In contrast, Ben describes his experience of mapping as a difficult process to engage with: 'You know it's hard to accept that that was the person I am you know that is me written down on that paper'.

Outside the therapy room

This subordinate theme was present within all seven accounts. Participants described the map as a tool which developed over time. Participants described engaging with the map after therapy had ended: 'I keep the map in my bedroom behind a wardrobe door because it's my wardrobe, it's my map' (Laura). The map evolved within and across the sessions and became a metaphorical map for the journey of life: 'the map evolves and it evolved, it's like a journey, you need a map for every journey don't you (laughs)' (Laura). The map acted as a tool which supported participants to achieve cognitive, behavioural and emotional change outside of therapy: 'The whole, the whole diagram itself I've still

got it at home you know its helpful' (Ben). Sunita discusses the importance of looking at the SDR and adding to it between sessions: 'So continually to add things on'.

Superordinate theme three: Relational dynamics

Participants talked about dynamics of the therapeutic relationship and how the map encompassed a relational focus in a varied way. Within this theme, some comments were positive and others were negative.

Dynamics within the therapeutic relationship

This subordinate theme was present within all seven accounts. Participants experienced the SDR as an embodiment of common therapeutic factors (for example: validation; empowerment; control; and acknowledgement). A range of common factors were activated through the development and use of the map. Key themes within this subordinate theme include trust and collaboration. The therapeutic relationship was often described as a process of empowerment and collaboration. Lisa described the importance of collaborative goal setting through the SDR and 'doing with' the therapist: 'to have a shared goal right from the start is brilliant'. Janine discussed the value of a collaborative approach: 'It was individual it was me erm so I was leading it so that is very useful' and the role of the therapeutic relationship in supporting people to feel heard: 'made me feel at least this time I'm being listened to and it's going to help so erm yeah it was definitely different from anything I've had before and erm well I just feel like a normal person now'. The impact of validation through therapeutic reflection and writing linked to the SDR was also acknowledged: 'It allows the therapist to acknowledge that they understand your problem and that they're honouring what you're saying erm and your feelings and erm experiences' (Tom). Conversely, some participants reported an ambivalent therapeutic relationship, a lack of bonding with the CAT therapist and an unhelpful power dynamic:

'Other treatment I've had in the past I've kind of built up a trust relationship you know. . . where I can, I feel as if I can tell you these things what are going on in my mind. . . and I didn't feel that with with my therapist, I didn't feel it at all. . . I felt as if he was the enemy and I was fighting that enemy.' (Ben)

Emotional responses to the endings in CAT

This subordinate theme was present within three of the seven accounts. Participants wanted to continue with CAT post discharge: 'So yeah I just think it's a shame because I think with [therapist's name] I would of liked to have you know continued and I was willing to pay private' (Sunita). In contrast Lisa suggested the collaborative goals developed at the start of CAT provide a planned ending that was more containing than her experience of counselling: 'I think it's a really good structure to undergo counselling with, yes it kind of scaffolds and gives both of you an exit.'

Superordinate theme four: Focus on treatment options

Participants discussed the treatment context in which CAT is available and different frameworks for conceptualising mental health difficulties, while considering potential strengths and weaknesses of different models. Participants recounted their emotional reactions to the lack of access to psychological interventions in the NHS and conveyed a sense of feeling lucky and grateful to have been offered CAT. Participants shared the experiences they had to go through before CAT was provided as a treatment option.

'What if I'd had CAT years ago?'

This subordinate theme was present within four of the seven accounts. Several participants had experienced difficulties in accessing CAT in the NHS, particularly as an early intervention. Laura describes the personal consequences this had for her:

'It's a pity I didn't have it a long, long time ago. I didn't have children because I was scared, of, being my father and treating them the way that he treated me (pause) with control, so it stopped me having children, whereas if I'd had CAT years ago erm like I said before it is a crutch is the map.'

Participants described being offered CAT after experiencing difficulties for some time and often following a crisis:

'I got locked up for 5 months and it was, so it was anything prior to the episode that caused the distress that enabled me to access those kind of services' (Lisa). Participants also reported a lack of choice regarding the model of therapy they engaged with. They describe uncertainly and inconsistency regarding psychological provision across geographical areas

and wonder if provision of a psychological intervention would have negated any 'need' for medical interventions:

'To think that I might not have needed to have those at all if I'd have been offered this therapy all that way back and the only reason I've been offered this therapy is because that's what they happen to do here.' (Janine)

Some participants compared their experiences of CAT to other psychological treatments they had been 'forced' to engage in before being offered CAT:

'Because I was at a bit of crisis point they said right we'll give you these six sessions [of CBT] and then we'll put you on the waiting list [for CAT] erm, but I couldn't be put on the waiting list till I've been for the six sessions, it was particularly ridiculous.' (Janine)

Medical model

This subordinate theme was present within five of the seven accounts. Several quotes within this theme focus on psychiatric diagnosis. However, other medical model treatments such as electroconvulsive therapy (ECT) and medication were also discussed. Participants discussed the dilemma regarding the potential value and/or damage of receiving a diagnosis. Participants described experiencing ambivalence regarding diagnostic labels:

'Sometimes I think would it of been nice to have a diagnosis' (Sunita);

'I do feel that if I'd got something that was more of a diagnosis I would be less inclined to blame myself in a way' (Tom).

Some participants voiced their experiences of diagnosis as unhelpful:

'I was a heroin addict for 16 years (sighs) I was a right mess and err, just having that label just enabled me to be in a mess' (Ben).

'One time. . . I was very thank goodness I've got a diagnosis. . . that means well I can look it up, I can research. . . also diagnosis allows you to get benefits a map doesn't. . . but as soon as you realise a diagnosis is for one moment in time and completely irrelevant and out of date as soon as it's given, the map is useful. . . the diagnosis is not.' (Lisa)

Participants also discussed their experience of psychiatric medication, particularly its side effects:

'I have been on lots of different antidepressants and erm, side effect wise they go from making you feel sick to er erm making you

feel like you're on another planet to or not just not working.'
(Janine)

Biological treatments (such as ECT) were experienced as frightening, disempowering and unnecessary in the context of developing self-understanding:

'That was something being done to me in it felt to me like somebody was trying to wipe my memories. . . perhaps I could have done without all those nasty things that I've had by just having sat there and understood my life.' (Janine)

Discussion

This study explored seven participants' experiences of the SDR. Four closely interwoven superordinate themes emerged from the data: (1) chaos to clarity (a process of meaning making); (2) the change process; (3) relational dynamics; (4) focus on treatment options. Participants emphasised the value of the SDR in developing self-understanding and how the visual tool supported them to understand, take ownership, and internalise their formulation. Participants discussed how common factors of therapy, such as the therapeutic relationship, collaboration, empowerment, trust and validation (Asay and Lambert, 1999) are activated through the SDR and the complex relational interplay between participant, therapist and SDR. Participants' emotional responses to endings in CAT emerged from the narratives. At times, the SDR was considered a concrete, tangible attachment object. Participants reflected on the SDR's role in promoting hope for, and achievement of, therapeutic change both within and beyond therapy. Challenges in accessing CAT and a range of negative experiences some participants endured before being offered CAT were also explored.

Findings in relation to the literature

Chaos to clarity (a process of meaning making)

The SDR supported participants to self-reflect and gain self-understanding, while developing insight into how previous life experiences may be associated with current functioning. Normalising distress in the context of challenging experiences was important for participants. These findings are consistent with aims of CAT (Ryle & Kerr, 2002) and empirical research (Pain, Chadwick & Abba, 2008; Shine & Westacott, 2010). Results from the current study also provide novel

information regarding the process of visualisation during the mapping process. The presence of a visual and tangible formulation facilitated ownership and internalisation.

The change process

The SDR and mapping process were experienced by participants as inseparable. Participants described the SDR as a self-management tool, and a symbol of hope and empowerment. The mapping process was described as an enabler of client-centered meaningful change (cognitive, emotional, behavioural, and interpersonal). Participants discussed the value of client-centred outcomes such as returning to work, having children, or being in a relationship, in contrast to standardised outcome measures focusing on a restricted definition of recovery reliant upon symptom lists (Hemmings, 2012).

Participants acknowledged their emotional responses to the SDR and the mapping process including: a cathartic release of guilt and distress; feeling heard and validated; a sense of exposure; and engagement with raw/challenging emotions. This is consistent with research exploring service users' mixed responses to CBT formulation (Pain et al, 2008; Kahlon, Neale & Patterson, 2014).

Participants highlighted the use of the SDR as a tangible object which could provide psychological comfort across contexts, both between therapy sessions and after therapy has ended (Winnicott, 1974). These findings echo other empirical research (Shine & Westacott, 2010). Participants' responses suggested ambivalent attachments (Ainsworth, 1964) to the SDR characterised by periods of relying on the SDR for safety and security alongside periods of not wanting (or finding it difficult) to engage with the SDR. Participants who developed the SDR collaboratively developed a stronger attachment to the SDR and a greater sense of ownership. This is consistent with research exploring service user's responses to CBT formulation (Pain et al, 2008). The shared experience of making the SDR may be the key mechanism of change. However, it remains very difficult to separate mapping from other CAT tools such as the reformulation letter and from the common factors of trust and good interpersonal alliance.

Participants described the process of change as an evolving journey within sessions, between sessions and after therapy had ended. This is consistent with findings from Rombach (2003) exploring the role of 'homework' in enhancing outcomes.

Relational dynamics

Common factors highlighted in service-user narratives in this study include: collaboration; trust; validation; empowerment; control and acknowledgement. Results suggest a range of common factors are activated through the mapping process. There is a plethora of research debating relative contributions of common and model specific factors (Duncan, 2010; Hampson, Killaspy, Mynors-Wallis & Meier, 2011; Hatcher & Barends, 2006; Wampold, 2001). The evidence-base corroborates findings from this study suggesting a range of common factors are associated with clinical outcomes, with a particular focus on the role of the therapeutic alliance (Grencavage & Norcross, 1990; Martin, Garske & Davis, 2000). Participants' narratives suggest the SDR plays a role in developing therapeutic relationships by promoting collaboration and providing a tool to validate the participants' experiences through therapeutic reflection.

The findings are consistent with Rayner, Thompson and Walsh (2011) highlighting the value of 'doing with' the therapist and a collaborative conceptual framework. Findings from the current study considered a range of dynamics within the therapeutic relationship including some participants describing it as a 'safe base' to practise exit strategies from the SDR. This is consistent with findings by Hamill, et al, (2008) who reported CAT letters enhanced the therapeutic relationship. In contrast, quantitative research exploring the effect of the reformulation process in CAT on working alliance (Shine & Westacott, 2010) and the impact of CAT with difficult-to-help clients (Evans & Parry, 1996) suggests the SDR has a little impact on the therapeutic relationship. However, qualitative data collected alongside one of these studies (Shine & Westacott, 2010) suggests the SDR enhances the therapeutic alliance.

Focus on treatment options

Participants' accounts detailed a range of negative experiences prior to being offered CAT. Participants associated these experiences with a range of emotional and physical side effects and a lack of change. Participants reported being offered CAT if CBT did not resolve their difficulties. These experiences resulted in delayed access to CAT. The accounts highlight the lack of access to a range of psychological therapies within the NHS, and the need for therapies to be informed by idiosyncratic formulations and patient choice. From a health economics viewpoint, CAT could be offered as an early intervention instead of being reserved for crisis resolution or service-users deemed 'difficult to help'.

Participants discussed their experiences of psychiatric diagnosis. Narratives suggest participants wondered if a diagnosis would be helpful in reducing self-blame. However, concerns were raised that diagnosis reduces one's sense of hope and agency over difficulties and decreases motivation and potential for change and personal recovery. This is consistent with literature exploring how service-users manage the potential for shame that can arise from receiving a diagnosis (Leeming, Boyle & Macdonald, 2009).

Read and Harre (2001) replicated previous findings that people reject biological explanations of mental health problems in favour of psychosocial explanations focused on negative life events. Their study reported biological causal beliefs are related to negative attitudes, including perceptions that 'mental patients' are dangerous, antisocial and unpredictable. This research extends to service-users' beliefs about their own difficulties and the likelihood a diagnosis would reduce hope and motivation. Other research exploring service-user experiences of psychiatric diagnosis suggests it often leads to a range of negative consequences such as: feeling labelled and unfavourably judged by others (Nehls, 1999); a reduced sense of self with the diagnosis becoming their whole personhood (Rose and Thornicroft, 2010); and questioning one's sense of self and a lack of control. Others experienced diagnosis as destructive, exposing (Hayne, 2003) and promoting a sense of uncertainty and rejection (Horn, Johnstone & Brooke, 2007).

Clinical implications

Results from this study suggest a SDR enhances self-understanding, internalisation and ownership, reduces blame, and despite focusing less specifically on controlling and eradicating symptoms, provides client-centred meaningful outcomes. The SDR is described as a tangible self-management tool, facilitating psychological and physical support, empowerment and hope. Service-users report positive and negative emotional responses to the SDR. It is important practitioners reflect on the level of *collaboration* involved in developing the SDR and scaffold this learning process for service-users with the aim of strengthening the therapeutic alliance and the patient's relationship with the SDR. Participants found aspects of the formulation letter focusing on strengths, empowering and validating; the SDR may benefit from a section acknowledging resilience, strengths, goals, healthy attachments and

behaviours. Service-users advocated for early access to CAT as an alternative to costly inpatient stays or long-term use of psychiatric medication. □

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Service Evaluation of Cognitive Analytic Therapy for Patients with Complex Medically Unexplained Symptoms Referred to a Liaison Psychiatry Department

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Abstract: This paper describes the introduction of cognitive analytic therapy within a liaison psychiatry service in a general hospital. This therapy modality was offered as an alternative to cognitive behaviour therapy for patients referred with complex medically unexplained symptoms (MUS). A brief introduction to using cognitive analytic therapy in this group of patients is included.

The paper gives information about a sample of patients with complex MUS (n=28) who were treated by trained cognitive analytic therapists. Rates of drop-out, experience of previous therapy and the duration of MUS are detailed.

The outcome measure of the CORE34 was collected before and after completion of therapy. This measure showed a clinically meaningful reduction towards the normal range, from an average of 1.87 per item to an average of 1.09 per item.

The findings suggest that cognitive analytic therapy is an acceptable and effective therapy for treating psychological symptoms in patients with complex MUS.

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