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

KATIE BYRON

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

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

Dr Katie Byron is a Clinical Psychologist, Cambridgeshire and Peterborough NHS Foundation Trust.

Introduction

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

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

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

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

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

Clinical Context

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

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

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

My experience is that problems with endings are often attributed to

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

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

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

Why are endings difficult?

Client Factors

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

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

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

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

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

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

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

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

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

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

Practitioner Factors

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

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

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

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

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

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

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

Cultural Factors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Final Thoughts

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

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

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

REFERENCES

Anderson, R., 1992. *Clinical Lectures on Klein and Bion.* Hove: Routledge.

Bowlby, J., 1980. *Attachment and Loss. Volume 3: Loss, Sadness and Depression.* New York: Basic Books. Available at: http://parentalalienationresearch.com/PDF/1980bowlby.pdf.

Chused, J., 2012. The Analyst's Narcissism. *Journal of the American Psychoanalytic Association,* 899–915.

Coleby, J. & Freshwater, K., 2019. The Idealised Care Smokescreen: How the Tools we Share can be Used to Attack. *Reformulation, Summer,* 13-16.

Collins, B., 2019. *Outcomes for mental health services: what really matters?,* London: The Kings Fund.

Craven-Staines, S., 2019. Reflecting on the role of Cognitive Analytic Therapy in the provision of care for mental health staff in an Employee Psychology Service. *International Journal of CAT & RMH, 3,* 94-105. Available at: https://research.tees.ac.uk/en/publications/reflecting-on-the-role-of-cognitive-analytic-therapy-in-the-provi.

Department of Health, 2008. *End of Life Care Strategy,* London: Department of Health.

Hamilton, L. 2010. 'The Boundary Seesaw Model: Good Fences Make for Good Neighbours'. In *Using Time, Not Doing Time: Practitioner Perspectives on Personality Disorder and Risk*. Chichester: Wiley-Blackwell, 181 – 194.

Kerr, I., 1999. Cognitive Analytic Therapy for Borderline Personality Disorder in the Context of a Community Mental Health Team: Individual and Organizational Psychodynamic Implications. *British Journal of Psychotherapy, 15 (4),* 425 -438.

Kübler-Ross, E., 2009. *On death and dying: What the dying have to teach doctors, nurses, clergy and heir own families.* Oxon: Routledge. Available at: https://epdf.pub/on-death-and-dying-40th-anniversary-edition.html.

Mann, J., 1973. *Time-Limited Psychotherapy.* Cambridge: Harvard University Press.

Menzies, R. & Menzies, R. G., 2008. Death anxiety – The worm at the core of mental health. *InPsych, 40 (6).* Available at: https://www.psychology.org.au/for-members/publications/inpsych/2018/December-Issue-6/Death-anxiety-The-worm-at-the-core-of-mental-heal.

Moran, C., 2019. 'The Sense of an Ending''– Death and Endings in CAT. *Reformulation,* 23-25.

Nehmad, A., 2017. Are narcissists a special case? Narcissism and supervision. In: *Cognitive Analytic Supervision: A relational approach.* Oxon: Routledge, 95-108.

Parry, G., Roth, A. D. & Kerr, I. B., 2005. 'Brief and Time-Limited Psychotherapy'. In: *Oxford Textbook of Psychotherapy.* Oxford: Oxford University Press, 507 – 522.

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

Ryle, A., 1998. Transferences and Countertransferences: The Cognitive Analytic Therapy Perspective. *British Journal of Psychotherapy,* 303-309.

Ryle, A. & Kerr, I. B., 2020. *Introducing Cognitive Anyaltic Therapy: Principles and Practice of a Relational Approach to Mental Health.* Chichester: John Wiley & Sons Ltd.

Staunton, G., Lloyd, J. & Potter, S., 2015. Relational patterns amongst staff in an NHS Community Team. *Reformulation, Summer,* 38-44.

Welch, L., 2012. Reciprocal roles within the NHS. *Reformulation,* 14-18. Available at: https://www.acat.me.uk/reformulation.php?issue_id=24&article_id=312.

Yalom, I., 2008. *Staring at the Sun: Overcoming the Terror of Death.* San Francisco: Jossey-Bass.