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Contents

Editorial	5
Childhood Relational Adversity and ‘Maltreatment’ as the Primary Cause of Mental Disorder and Distress rather than ‘Endogenous’ Genetic or Neuro-biological Factors OLIVER JAMES	9
‘What Role am I Playing?’: Inpatient Staff Experiences of an Introductory Training in Cognitive Analytic Therapy (CAT) Informed Care NATALIE CLINKSCALES, RANIL TAN, LINDSAY JONES	37
Relational Patterns in Adolescents with and without Emotional Dysregulation and their Parents from a CAT Perspective JESSICA RUSSELL-CARROLL AND MICHAEL GORDON	50
Service User Experiences of CAT Diagrams: an Interpretative Phenomenological Analysis KIMBERLEY TAPLIN, BETH GREENHILL, CLAIRE SEDDON AND JAMES MCGUIRE	75
Service Evaluation of Cognitive Analytic Therapy for Patients with Complex Medically Unexplained Symptoms referred to a Liaison Psychiatry Department ALISON JENAWAY, CAROL GREGORY, DAMARIS KOCH AND KATE BRISTOW	97
Therapists’ Experiences of Facilitating Cognitive Analytic Therapy Groups LAURIE SIDDELL & ALISON WELLS	105
The Emerging Psychological Trauma Paradigm: an Overview of the Challenge to Current Models of Mental Disorder and their Treatment F.M. CORRIGAN & A.M. HULL	121
Reviews CATHERINE SHEA, STEVE POTTER, FRANK MARGISON. CAROLINE DOWER	147
Call for Papers	171

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What is ICATA?

It is a federation of national associations promoting training and supervision in the practice of cognitive analytic therapy from Australia, Finland, Greece, Ireland, Italy, New Zealand, Poland, Spain, India, and the United Kingdom. There is an executive made up of two delegates from each member country or organisation with established or newly developing training programmes in CAT. The executive meets regularly and organises a biennial international conference.

Further details are available on the website internationalcat.org

Aims of ICATA

To develop knowledge, use of and further development of cognitive analytic therapy.

To offer support, training and supervision internationally and oversee national accreditation programmes and procedures.

To publish the *International Journal of Cognitive Analytic Therapy and Relational Mental Health*.

Aims of the Journal

To promote the use and evaluation of CAT and its further integrative development across a range of settings, cultures and countries, and to publish novel and challenging material relating to this.

It also aims to promote cross-disciplinary dialogue within the broad field of relational mental health thereby contributing to further psychotherapy integration and the further development of CAT.

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For details contact: Carsten Schley
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1st Panhellenic Conference of Cognitive Analytic Therapy in Athens on 29th and 30th September 2018

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Editorial

IT IS AGAIN WITH GREAT PLEASURE that we offer this second issue of the *International Journal of Cognitive Analytic Therapy and Relational Mental Health*. This issue includes a wide range of contributions, covering both day-to-day clinical work using the CAT model, but also challenging, in-depth review articles by leading experts on the topic, broadly, of relational and psychological trauma and its consequences for mental health and treatment.

As we noted in the first issue ‘a common thread again in all these pieces is a relational conceptualisation of individual and systemic mental health problems’. This is firstly evident in the more purely CAT-based contributions, which range from drawing out the themes supporting a CAT-informed approach to group therapy (Siddell and Wells), working with challenging and ‘difficult’ clinical presentations (eg with ‘medically unexplained symptoms’, Jenaway et al.), through to staff and patient experiences of thinking and working in a more fundamentally relational manner (Clinkscapes et al., Russell-Carroll & Gordon, Taplin et al.). Taplin et al. look at the experience of diagrammatic reformulation as a key component of the relational process in therapy. For the most part these various

small-scale research projects would not be typical of the more individualistic ‘illness model’ approaches of Western mental health services currently and would stand in many ways as a challenge to them. These contributions well illustrate the trend within CAT of ‘using it’ as a means of thinking about and addressing the wider context of mental health problems, in addition to using it as an effective clinical means of offering psychotherapy day-to-day. We note that this trend was a source of great interest and pleasure to the late Tony Ryle, whose considerable achievement and illuminating presence we feel still permeates all these pieces.

Notwithstanding these developments within CAT itself, Ryle also strongly felt and stressed the need for the model to continue to develop and integrate other important clinical and scientific findings and understandings. This issue includes also two very challenging contributions on the importance of psychological and relational trauma in mental health. ‘Trauma’ is arguably becoming a dominant paradigm through which to view the origins of mental health (and other) problems, and to frame the treatment needs of patients and clients. The concept of ‘complex trauma’, for example, will be included in the

forthcoming WHO ICD11 classification, as noted by Shea (see below).

Oliver James, an internationally-renowned figure in the broader field of mental health, provides a masterful overview of the broader developmental literature and its important implications, and makes a heartfelt, but evidence-based, call on this basis to critically re-evaluate much of what is currently offered as psychological treatment. We are also very pleased to include a contribution from Frank Corrigan and Alastair Hull, world experts in the field of trauma. This article, in our view, represents a considerable challenge to us with regard to keeping up, at least in broad principle if not in every neurobiological detail, with recent scientific and therapeutic developments, but also perhaps the current limitations of traditional talking therapies. Again however, this review is based broadly within a humanitarian and relational frame.

All of these contributions leave us, both as clinicians and as citizens, with some challenging thoughts for the future, including in relation to service provision as both James and Corrigan and Hull also stress. The final article in this issue (by Corrigan and Hull) is followed by a detailed and thoughtful review by Catherine Shea of the textbook at the core of the clinical approaches described by them. This will also stand, we hope, as a dialogic response to it from a colleague who is a practitioner both in CAT and other relational approaches, as well as being an experienced trauma therapist. However,

significantly, these reviews were written 'blind' to each other. This issue also includes detailed and thoughtful book reviews by Caroline Dower (on a partly CAT-based volume on music therapy by Compton-Dickinson and Hakvoort), by Frank Margison (on a book by Meares emanating from the 'conversational model'), and by Steve Potter (on a controversial book by Hari on the causes and nature of depression)

We hope and anticipate that these various contributions may raise some serious questions and concerns amongst our readership, and for the future we would very much welcome any correspondence that might ensue. This we feel would be an important and healthy aspect of the future development of the journal. We also urge our readership to consider whether the work they are doing or thoughts they may be having could, potentially, be material for novel contributions to the journal. We are aware that this second volume has a largely UK voice and call upon our colleagues internationally to nurture and seek out potential contributions from far and wide. For the future, we plan to include the 'dialogical turn' in mental health as one theme for the next issue. Finally, we hope these contributions will prove to be not only provocative and interesting to our readership but perhaps also a source of some nourishment and support in the difficult circumstances in which many colleagues work and often struggle to find support for humane and effective treatments.

The Editors
May 2018

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of Cognitive Analytic Therapy
and Relational Mental Health

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Childhood Relational Adversity and 'Maltreatment' as the Primary Cause of Mental Disorder and Distress rather than 'Endogenous' Genetic or Neuro-biological Factors

OLIVER JAMES

Abstract: There continues to be considerable debate within the field of mental health regarding the roles played by genetic, neuro-biological, and psychosocial factors in the genesis of major or minor mental disorder and distress – often termed 'mental illness' by psychiatry.

The dominant approach within Western psychiatry and clinical psychology is an individualistic 'illness' model, espoused by biomedical and cognitive-behavioural approaches. These have been highly resistant – antagonistic – to any other conceptualisation for over half a century, despite a wealth of contrary evidence which overwhelmingly points to such approaches no longer being defensible.

In the UK, in recent years, the political classes and media have added their support to the model of 'mental illness' as an individual, endogenous problem, removed from the socio-political context with its inconvenient challenges. The psychotherapeutic treatment programme emerging from this (IAPT) has been based around the CBT model, increasingly offering very brief computer-based packages, to the exclusion of other more relationally-based or trauma-focussed approaches. The CBT approach was mis-sold to politicians as a method for reducing bills to the UK Treasury for disability and unemployment benefit. In numerous studies, CBT has been demonstrated to lack the long-term (2 year plus) efficacy or 'real world' clinical effectiveness it claims, even though it is touted as 'the' evidence-based intervention. CBT and genetically-orientated models, with concomitant research funding, reflect

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vested intellectual, career and financial interests more than the true balance of scientific evidence.

This situation prevails despite the very considerable research literature implicating developmental, relational and social factors in mental health, and despite the striking absence of evidence to support the individualizing focus of geneticism or of biomedical and cognitive-behavioural models. There is good evidence that developmental maltreatment is responsible for most of the neurobiological abnormalities subsequently seen in mental disorders, but which are commonly adduced as evidence of ‘endogenous’ neurobiological causation.

In this review, some of the key evidence is presented that childhood relational adversity and ‘maltreatment’, including overt psychological trauma, as well as broader social dysfunction, are the major causes of most mental disorder, along with the implications for relationally-based treatment approaches founded upon such understandings. Recognising and understanding the role of relational factors and childhood maltreatment is of huge importance for the prevention, early intervention, and treatment of ‘major mental disorders’, as well as ‘sub-clinical’ emotional and relational suffering and distress. Quite apart from the huge suffering, these constitute a costly epidemic in the Developed World (especially the US and UK), with largely preventable psychosocial causes. Unlike CBT, psychotherapies which explore early years, formative experience as a key component of the treatment are shown to have long-term efficacy.

Keywords: Childhood maltreatment, relational adversity, social dysfunction, psychological trauma, psychotherapy, CBT, psychiatric genetics, psychiatric models.

Introduction

ONE of the key differences between Relational Psychotherapies (including Cognitive Analytic Therapy (CAT) – Ryle and Kerr (2002)) and their Behavioural cousin (CBT) is the importance placed on formative childhood experience and maltreatment as the initial focus, and the use of that adversity as the prism through which the treatment is viewed. What is the evidence that the early years play a major role in causing individual psychological harm and distress? Equally, what is the evidence for biological causes?

The findings of the Human Genome Project (HGP) have raised a significant likelihood that genes explain little of the variance in

psychopathology between siblings or offspring (James, 2014, 2016). Thus far, only 1-5% of differences between samples with ‘psychopathology’ and healthy samples has been explicable by genetic material identified by the HGP. There is a significant likelihood that no further evidence will emerge that changes this picture and that the null hypothesis of the HGP will have to be accepted: that differences in genes play little or no role in explaining why one individual is likely to suffer ‘psychopathology’ more than another (James, 2014, 2016). Given this eventuality, the question arises ‘If genes play little or no part in causing differences in ‘psychopathology’, what does?’

Ever since Sigmund Freud’s writings became widely known, and despite some of the unfortunate theoretical detours taken by the psychoanalytic tradition, we have been aware that childhood relational adversity and maltreatment, including psychological trauma, could be a major contributor. ‘Maltreatment’ is generally defined as ‘emotional abuse or neglect, sexual or physical violence, physical or emotional neglect, bullying and parental loss’. Studies arising from John Bowlby’s Attachment Theory provide the largest and most robust body of empirical evidence that childhood maltreatment is a major cause of subsequent emotional distress (Cassidy et al, 2010). However, social factors have also been shown to be highly influential, with large variations between nations, and between social classes, genders and ethnic groups within nations (James, 2008).

If genes are increasingly unlikely to explain distress and early experience and psychosocial stressors explain a lot, there is also good reason to suppose that non-genetic, but biological, factors may play a significant part. There is a possibility that epigenetic mechanisms have an influence, in which environmental slights cause the suppression or expression of genes (Carey, 2011; Roth, 2014). There is also emerging evidence that antenatal factors may play a significant role, for example, in the genesis of autism (Dawson, 2008; Hadjikhani, 2010) as well as in life-long vulnerability to most forms of mental disorder (see Glover, 2011). Toxins in the environment are another possible contributor (Lundeberg, 1998) and it must be assumed that there are likely to be other directly physical causes which have yet to be discovered. Hence, physical but non-genetic factors are likely to play a significant role in causing individual difference. But in this paper, I focus on the scientific evidence that childhood relational adversity and maltreatment, as well as its socio-cultural context, is the major cause.

Evidence of The Childhood Causes of 'Psychopathology' from Prospective Studies Following Children into Adulthood

In prospective studies, the child is observed with its parents at various ages when young and then tested in later life to see whether it has developed 'mental illnesses'. If early maltreatment is commoner in the children who develop 'mental illness' that strongly suggests it is a cause.

A review of the 23 best such studies found increased likelihood of later 'mental illness' if there had been early maltreatment (Weich et al, 2009). One of the most comprehensive (Sroufe et al, 2005) identified 180 infants who were at high risk for maltreatment and followed them to age 18. All the mothers had low incomes and over half were unmarried at the birth of the child. Half had their first child whilst still a teenager. Followed up, 90% of the maltreated children had at least one 'mental illness' at age 18 (p 189, Sroufe et al, 2005).

Prospective studies have also demonstrated that the earlier that maltreatment occurs, the greater the damage. This applies to all kinds (Lansford et al, 2002; fn p156 on p 335, James, 2005; English et al, 2005 (a); English et al, 2005 (b); Kaplow et al, 2005; Sternberg et al, 2006; Kaplow et al, 2007; Lansford et al, 2007; Kim et al, 2009). For instance, in a study of 800 children, severe maltreatment before the age of 3 was more disturbing than aged 3 to 5, which was, in turn, more damaging than aged 5 to 9 (Manly et al, 2001).

There are also numerous studies showing that the more severe the maltreatment, the worse the subsequent outcome (English et al, 2005 (b); Kaplow et al, 2005; Sternberg et al, 2006; Kaplow et al, 2007). Severity refers to how frequently a child was maltreated and how extreme it was. In the case of sexual abuse, the more repetitive, the more penetrative, and the closer the blood relation of the abuser to the abused, the more damage.

Studies of adoptees are particularly revealing of the long-term damage caused by early maltreatment of various kinds (pp 158-9, James, 2005; Esther et al, 2009; Rutter et al, 2010; Mccall et al, 2011). Several international studies have observed large samples of children who were institutionalized as a result of being orphaned or maltreated and then subsequently adopted, followed into the teenage years. Common problems identified are aggression, indiscriminate friendliness (seeking affection or approval from strangers), insecurity in relationships and in a minority of cases, signs of autism. There is also reduced intelligence

and scholastic performance, although to a lesser extent. The long-term outcome is affected by the kind and amount of damage occurring before the child is taken away from the maltreating parents. The longer the child spends in an institution, the worse, likewise the kind of institution affects the outcome – less individual attention is damaging. The later the child is adopted and the worse the quality of care in the new home, the more harmful. By implication, these studies provide overwhelming evidence that responsive, loving early care is crucial for later mental health.

Similarly, it has been shown that if a mother gets depressed, the younger a child is when that happens, the greater the long-term damage (pp160-1, James, 2005).

Multiple combinations of maltreatment are more harmful than a single kind (Dong et al, 2004; English et al , 2005 (b); Clemmon et al, 2007; Finkelhor et al, 2007; Sullman et al, 2009; Kim et al, 2009.). Where one kind of maltreatment is found, there is liable to be others. If there is physical abuse it is very often combined with emotional abuse or neglect and other maltreatments, likewise sexual abuse.

Some links have been suggested between specific kinds of maltreatment and broad categories of ‘mental illness’. A study of 34,000 Americans (Keyes et al, 2012) showed that, among men, physical abuse was related to ‘externalizing’ disorders, like aggression and violence. Emotional abuse related more to ‘internalizing’ disorders, like depression. Sexual abuse related to both internalizing and externalizing. For women, sexual and emotional abuse related to both internalizing and externalizing, physical abuse to only internalizing.

A significant body of evidence also links childhood maltreatment with adult patterns of attachment, insecure patterns being a predictor of ‘mental illness’. Patterns of attachment take four forms: Avoidant (in which others are rejected); Ambivalent (where approach or avoidance to others happen in quick succession or simultaneously); Disorganized (where there is a confusing, often bizarre mixture of reactions to others); and Secure (where others are innocent until proved guilty) (Weinfield et al, 2010). Our childhood and adult patterns of attachment are influenced by the responsiveness and accessibility of carers, aged 6 months to 3 years of age (Van Ijzendoorn et al, 1999; Dozier et al, 2010; Grossman et al, 2010). People who have insecure patterns of attachment as adults are nearly twice as likely to be ‘mentally ill’ than people who are secure: three quarters of those being treated for a ‘mental illness’ are insecure

compared with 42% of the general population (Bakermans-Kranenburg et al, 2009; see also Van IJzendoorn et al, 2008). Adult attachment patterns play a big role in linking childhood maltreatment and adult mental illness (Bifulco et al, 2006; Booth-LaForce et al, 2014). Broadly speaking, adults with internalizing disorders (like depression) are more likely to be Clinging-Resistant in their pattern (or, 'preoccupied' as the adult version is called). Avoidant (or, 'dismissing') people are more prone to externalizing disorders (like aggression). The Disorganized (or, 'unresolved') are prone to both kinds of disorder.

Being institutionalized as a child – for example being taken into State care – also greatly increases the risk of insecure attachment. Disorganized attachment is particularly likely, with two-thirds to three-quarters of institutionalized children displaying it before adoption, compared with one quarter who grow up with their parents (Bakermans-Kranenburg et al, 2011). The earlier the child was adopted – and therefore removed from the maltreating neglect of most institutional care – the more likely they were to develop secure attachments to adoptive parents.

Childhood pattern of attachment has been shown to predict the specific kind of 'mental illness' which adults are prone to. In one study (Sroufe et al, 2009), children measured as Ambivalent were much more at risk of suffering anxiety at age 18. Their risk of externalizing was not increased at all. By contrast, Avoidant children were at greater risk of externalizing in later life and had no higher risk of anxiety. Both kinds of insecurity increased the risk of depression. Disorganized children were at greater risk of dissociation.

Each of these patterns of attachment is connected to specific kinds of parental care (see Ch. 4, James, 2005). The importance of the early years for later attachment pattern is sharply highlighted by a study which measured the degree of negativity mothers felt towards their babies during the first month (Broussard et al, 2010). Followed up forty years later, the babies whose mothers had felt negative were fully 18 times more likely to be insecurely attached adults (and therefore nearly twice as likely to be 'mentally ill') than babies whose mothers felt positive to them all those years ago.

Evidence from Retrospective Studies of The Impact of Childhood Maltreatment

Whilst prospective studies are the most reliable evidence, retrospective ones, in which adults are asked about their childhood, seem to have validity and support the results described so far. The most comprehensive is the Adverse Childhood Events (ACE) study of 17,000 middle-class Americans (Felitti et al, 2010). Adults are asked to score themselves on eight categories of childhood maltreatment (like sexual, physical and emotional abuse). An ACE score is the number of categories of maltreatment a person believes applied to them in their childhood.

One third of the sample scored 0 – recalled no events and therefore had no categories of maltreatment – one in six had more than 4 ACE. Nearly everyone who had one ACE had at least one more: more than one kind of maltreatment tended to occur if there was any, just as the prospective studies find.

The greater the number of ACE the greater the likelihood of all kinds of ‘mental illness’, just like the dose-dependent findings of prospective studies. For example, regarding depression, 15% of those with it had no ACE, rising to half of those with 4 or more. Over half of depression and suicide attempts in women are attributable to ACE. Hallucinations and dissociation are similarly shown to be related to number of ACE. Similar findings exist for damaging lifestyle behaviours, like smoking, drinking, obesity, drug use and sexual promiscuity.

The impact of ACE is not limited to ‘mental illnesses’, it also applies to physical ones. For example, increasing ACE scores raise the risk of suffering heart disease, liver disease and auto-immune deficiencies. Whilst this effect of ACE is partly through the greater likelihood of damaging lifestyle behaviours (like smoking or obesity) which increase the risk of physical illness, it has also been shown that there is a direct effect of the distress from the maltreatment: when lifestyle is taken out of the equation, the risk of the physical illnesses is still heightened by increased number of ACE alone. Not surprisingly, this means people with high numbers of ACE die earlier. At the extreme, those with 6 or more ACE die nearly twenty years younger than those with none.

There have been hundreds of other retrospective studies demonstrating much greater likelihoods of ‘mental illness’ as a result of childhood maltreatment (Kessler et al, 2010; Varese et al, 2012; Matheson et al, 2012; Read et al, 2014). Many objections have been made to retrospection, such as that the ‘mentally ill’ could be a group of people

whose memories are impaired or who are looking for reasons to blame their parents. However, most research does not support these criticisms (Fisher et al, 2011). In the case of sexual abuse, for example, the pressure on the abused to remain silent and the distress that recall of the incidents entails, should lead to under-reporting rather than over-reporting, because such people have a strong incentive to do their best to forget unpleasant experiences. When the claims of the sexually abused have been investigated, looking for corroboration (such as records of events by social workers or other professionals), in two studies, respectively, in 74% (Herman et al, 1987) and 82% (Read et al, 2003) of cases, such corroboration did occur. The phantom of 'False Memory Syndrome' (people making up abuse or having the idea planted in their heads by therapists) has been shown to be exaggerated, although it is a real phenomenon (Dahlenberg et al, 2010). In the case of the ACE study, the investigators conducted a study testing out the method and found it to be valid (Edward, et al, 2001).

Taken overall, prospective and retrospective studies provide a formidable body of evidence that childhood maltreatment is a major cause of mental illness. Whilst the World Health Organization (Kessler, 2010) estimates that it explains 29% of all 'mental illness' and in the case of schizophrenia, the estimate is one third (Varese et al, 2012), these are almost certainly considerable underestimates. If the same amount of money as has been spent on the Human Genome Project was devoted to prospective studies which follow large samples, studying all the offspring from families for comparison of the care they receive from before birth into adulthood, measuring all the key variables, the figure would surely be far higher. This is suggested by the fact that 90% of the maltreated were found to have a psychiatric 'illness' at age 18 in what many regard as the only study to have observed the pattern of nurture in a sample of families in sufficient depth and frequency (Sroufe et al, 2009).

What is more, future studies will surely prove that maltreatment has its effect through changing the brain and body. There is already considerable evidence that this is so.

Impact of Maltreatment on the Body's Neuro-Endocrine 'Thermostat'

The best illustration of the impact of maltreatment on brain chemistry are studies of the fight-flight hormone, cortisol, which is secreted when a response is needed to threat. The Sympathetic Nervous System (SNS) stimulates 'fight or flight' when faced with perceived threats, preparing us for action, responses like diverting blood from the gut to the muscles, faster breathing and raised heartbeat. Conversely, the Parasympathetic Nervous System (PNS) prepares the body to 'rest and digest', with more blood for the guts, slower breathing.

In a review of the 30 best studies (Hunter et al, 2011), 27 reported a significant effect of childhood maltreatment on the cortisol response to stress (this can be a reduction in secretion, as well as an increase – some children become so used to threat they stop secreting because they feel at risk all the time). Thirteen studies found that maltreatment increased cortisol reactivity, two found a blunted reaction. Six of the studies demonstrated an effect of prenatal substance exposure (smoking or alcohol) on what the child was subsequently like. Three studies reported that cortisol reactivity could be rectified by intervention programmes which changed the way children were cared for.

The review does not cover several studies which suggest that maternal stress in the last three months of pregnancy seems to increase cortisol reactivity in infants: the cortisol of the mother is passed to the foetus through the placenta (Sarkar et al, 2008). This has been shown to have long-term effects into childhood, such as increased risk of aggression, conduct disorder and Attention Deficit Hyperactivity Disorder (ADHD) (Van Den Bergh, BRH et al, 2004; Glover et al, 2011; Korhonen et al, 2012; O'Connor et al, 2014). When siblings are compared, if the mother was stressed prenatally whilst bearing one foetus but not the other, stress increases the likelihood of ADHD in the ones whose mothers were prenatally stressed (Grizenko et al, 2012). This suggests both that prenatal stress is a cause and that genes are not. The impact of the cortisol reactivity resulting from prenatal stress is reduced if the baby has a secure attachment to the mother (as a result of responsive care) after it is born (Bergman et al, 2010).

Many aspects of postnatal maternal care have been shown to adversely affect the infant's cortisol reactivity, like lack of maternal responsiveness, abuse and neglect (Tarullo et al, 2006). For example, one study found that the speed with which a baby's cortisol levels settled down after

being bathed depended on how sensitively the mother responded during this mildly stressful, everyday experience (Albers et al, 2007). Cortisol levels of toddlers can be badly affected by being left with strangers in groups of other toddlers, such as in group daycare (see Review 3, James. 2010). In one study of 18 month-olds, levels doubled during their first week in group daycare, compared with levels at home before experiencing any daycare (Ahnert et al, 2004). This is one of ten studies which have found dysregulated cortisol in under-three year-olds in day care, compared with levels at home (Vermeer et al, 200; Bernard et al, 2015).

Children of disharmonious parents are more likely to display symptoms of what are known as ‘externalizing’ problems, like screaming and shouting, fighting, disobedience and delinquency. But not all children of rowing parents react like that. Children exposed to repeated parental conflict have been shown to react physically. Their heart rates, the sweatiness of their hands and their cortisol levels are all affected. One study explored whether different children react with Sympathetic (fight-flight – SNS) rather than Parasympathetic (rest and digest – PNS) systems (El-Sheikh et al, 2009).

It found that children developed externalizing behaviour in response to parental conflict if both PNS and SNS were simultaneously switched on. If the ‘fight or flight’ responses were going full blast with the ‘rest and digest’ doing the same, the child was liable to be reported as externalizing by both parents and teachers. The SNS system seems to override the PNS, the child becoming angry, even chaotically furious, and getting involved in fights with parents, who then start using extreme measures to control the child, up to and including hitting. The pattern now established, the child takes it to school, with teachers reporting them to be more liable to fight, disrupt classes and be prone to inattention.

Equally, if the child’s response to parental conflict was for both systems to shut down, it was unable to produce adequate emotional responses, neither reacting actively, nor chilled. Instead it went into a state of passive vigilance, leaving it wide open to the nasty scenes of parental disharmony and unable to express its distress or anger. Such children were more prone to delinquency and inattention at home and school.

By contrast, when the children reacted through either one or other system going into action, they were much less likely to externalize or internalize. They seemed to be protected by active coping responses,

like becoming healthily distressed or keeping a safe distance but trying to calm everyone down.

Given the considerable evidence showing that these neuro-chemical systems are heavily influenced by nurture, from before birth onwards, prior experiences (and not genes) would seem to establish the basic pattern with which they respond to later exposure to parental conflict: if you row a lot with your partner in front of the children, how they differentially react will depend on their earlier experiences.

Another factor is the contemporary pattern of parenting a child is experiencing day-to-day. A large cross-national study (Bradford et al, 2004) showed that the way that parents care for the children also predicts how they react to parental disharmony.

There is little doubt that there are long-term effects into adulthood of cortisol reactivity caused by childhood maltreatment, complex though the relationship may be (Alink et al, 2008; Bremner et al, 2010; Read et al, 2014). There is a strong likelihood that having high levels of cortisol during the early years, or blunted levels (where the system has shut down), establishes destructive patterns of brain waves and interferes with the full growth of crucial parts of the brain, to which we now turn.

Childhood Maltreatment Damages Brain Development

Dozens of studies have shown that infants and toddlers of depressed mothers have different patterns of brainwaves from those of non-depressed mothers (Diego et al, 2010). This is hardly surprising, since one might expect that, for example, if your parent is consistently irritable and unresponsive, as many depressed ones are, it would be mirrored by consistent brain patterns in their offspring. The impact of maltreatment on brainwaves endures into adulthood. For example, adults who were traumatized as children have decreased activity in the parts of the brain which are believed to enable thought and the capacity to take action (Lanius et al, 2007; Hopper et al, 2007). Trauma makes the child freeze, becoming a frozen adult. This is but one of many findings which suggest that patterns of maltreatment cause the brain to adapt to it.

Multiple studies have identified reductions in the size of key parts of the brain in the abused and neglected (Teicher et al, 2002; Teicher et al, 2006; Teicher et al, 2010). Compared with non-maltreated people, the maltreated have 5-16% less volume in affect-related areas, like the

hippocampus and amygdala. It seems that cortisol reactivity is a major reason why. Stress chemicals can cause the loss of neurones, or lack of growth of them (De Bellis, 2001; De Bellis, 2010) .

The traumagenic model of ‘mental illness’, with its important implications for treatment, proposes that excess stress chemicals caused by early maltreatment creates a heightened sensitivity to threat (Read et al, 2014). The child’s brain becomes adapted to expect adversity and distressing experience. It takes less subsequent adversity for the adult to be tipped into ‘mental illness’, including psychosis.

The Myth of Inherent Resilience

Not all maltreated children go on to become distressed children or adults. Many studies have seemed to show this (Widom, 1999). For example, one large study of abused or neglected children found that one fifth of them seemed unharmed by the experience in adulthood (Mchloin et al, 2001). It is often maintained that such resilience in the face of adversity is caused by a genetically inherited capacity to cope (Rutter, 2003). This role of genes is now highly questionable, given the findings of the Human Genome Project (James, 2014, 2016).

There is abundant evidence that, insofar as resilience does exist, it is caused by benign people and events in the person’s early and later environment. Amongst other things, in childhood a loving adult, like a relative or a teacher, have been shown to help (Haskett et al, 2006), so has living in a supportive community (DuMont et al, 2007).

However, there are good reasons to suspect that many studies which purport to have identified resilience in the face of adversity have failed to adequately measure either the outcome or the level of adversity. The very few studies which have frequently assessed children from birth onwards into adulthood, carefully measuring as many as possible of the adversities which might have occurred and their damaging consequences, find very little resilience. For example, the definitive study of 180 high risk children (Sroufe et al, 2009) found that in childhood all the maltreated ones, without exception, had higher levels of anger, frustration and non-compliance than the adequately cared for children. Followed up at age 18, 90% qualified for a diagnosis of a psychiatric disorder.

The mothers in that study who had been abused but managed to provide adequate care for their own children were found to have been

protected by any or all of three experiences: having had a supportive, loving adult other than their parents when they were small; at least six months of therapy; and a partner in their life who was supportive and provided a satisfying relationship.

The results were very similar in another study (Massie et al, 2008), one that followed the children from birth to age 30. In childhood, all the maltreated ones showed serious signs of distress, compared to the non-maltreated. The authors provided examples to show that much of what is regarded as resilience is simply a failure on the part of researchers to look closely enough at how people have turned out. What can pass for normal or outwardly fine, like having a job and a marriage, do not mean a person's inner life is calm or sane. One woman in their study had achieved a successful career in her profession and a happy marriage but was still haunted by the ghosts from her parents' supposedly amicable divorce. Another such woman had witnessed terrible scenes between her parents which had led her to decide never to marry.

The authors go on to question the shallowness of most concepts of normality, offering the concept of 'emotional health' as a more fruitful alternative (see James, 2013). They point out that whilst some maltreated children may not display signs of full-scale 'mental illness', when studied more closely, they turn out to be suffering, emotionally. Deciding to avoid relationships altogether, as in the case of the woman who never married, can result in loneliness and despair which may not show up in conventional psychiatric interviews. It is claimed that the resilient have particularly strong egos, or that their brains are born with a particularly good capacity to regulate cortisol reactivity. Rather, the authors suggest that many, or the vast majority, of maltreated children turn into people who are just surviving or keeping a stiff upper lip, but who are suffering considerably, even if this is not expressed in symptoms of 'mental illness' as measured by psychiatrists.

The key point is that a child should not need to be resilient, one made by my father in 1960 (James, 1960). He suggested that if the needs of babies are not met, they engage in 'premature ego development'. Unable to rely on the parent, they have to develop a false self long before they know what their 'real' one is.

Cross-National, Cross-Cultural and Social Causes of 'Mental Illness' (see also James, 2008, Chapter 1)

The above review provides strong support for the theory that childhood maltreatment and relational distress are major causes of adult distress, although no studies find that these factors explain it all. The conventional response is to turn to genes or other biological alternatives. Much more significant may be societal forces.

The greatest social causes of 'psychopathology' are industrialization and urbanization. Whilst these bring many advantages – are the foundations for advanced medicine, sophisticated technology, scholarship and sundry other desirable boons – they also lead to a substantial increase in 'mental illness'. People living in pre-industrial societies who do not have settled agriculture, living in the African Savannah (as did all humans for our first three million years) or in jungles, have far lower rates of schizophrenia. There are no characters like the depressed and anxious Bridget Jones – depicted in the eponymous Hollywood film – in such communities. Nor are there aimless, jobless young men on street corners, because there are no jobs or street corners. They die much younger, on average, than people in developed nations, but they are much more mentally healthy.

Once villages and settled agriculture arrive, broadly speaking, the more developed a nation becomes, the greater its rate of 'mental illness'. Although people in rural communities in contemporary developing nations have vastly lower average incomes than developed ones, they have startlingly lower rates of schizophrenia (WHO, 1973). Industrialization creates factories and service industries, bureaucracies and patterns of living which create huge pressures. This coincides with living in towns and cities, which fragments families, increases crime and melts social cohesion. As consumerism grows, so does dissatisfaction. Whole industries, like advertising and marketing, are devoted to increasing it and exploiting it. The explicit goal of advertising and marketing is to create displeasure with your existing possessions or services, even with your very self ('because you're worth it'), so that you will seek new ones.

There are large differences in the prevalence of 'mental illness' around the world. America tops the league table, with 26% of its population having suffered in the last twelve months. The average income of an American is about 40,000 times higher than that of the average Nigerian, yet Nigerians are six times *less* likely to suffer a 'mental illness'. It has been estimated that three quarters of all the 'mental illnesses' listed in

the Diagnostic and Statistical Manual, are found only in Americans or in the Americanized ruling elites around the world (the rulers of China, Russia and so on, many of whom have attended American or British universities).

Citizens of developed nations suffer from a sense of relative deprivation: there is no such thing as enough. As expectations grow, so does the sense of entitlement. Televisions, fridges, screen devices and cars become a bare minimum, it seems so unfair not to have the latest gizmos. In a developing nation you are delighted just to have electricity in your home. Survival materialism, where the possessions sought are food and shelter rather than ipads and *Netflix*, leaves much less room for such disgruntlement, people are more grateful for what they get.

Within developed nations, it is true that people on low incomes are about twice as likely to suffer as the wealthy. The struggle for survival is real, but beyond the USA, it is rarely a matter of life and death: the deprivation is relative. Not only is it hard to pay the electricity bill, the internet and mobile phone bills, it can seem intolerable not to be able to afford a new car.

In the individualistic system of developed nations, it is your fault that you are a 'loser'. Big differences open up in the proneness to different kinds of mental illness for men and women. Women are twice as likely to be depressed and four times as likely to attempt suicide. Men are twice as likely to abuse substances and five times more likely to kill themselves. This is heightened by some kinds of gender role difference: American 'Men In Skirts' feminism is much more harmful than the 'men must pull their weight' mainland European version.

Comparing between developed nations, the English-speaking ones have twice as much 'mental illness', a remarkable difference (23% vs 11.5% for mainland western Europe, averages). Particularly in America and England, there is a hunger for money, possessions, good appearances (keeping up with the Joneses, as well as physical) and fame. Powered by deregulated corporations and banks, huge personal debts are racked up, not just the massive mortgages to pay for rising housing costs, but credit card debt too (credit cards are much less used in Germany, for example; home ownership is far less in mainland Europe). A person with six or more debts is six times more likely to suffer mental illness than one with none.

Partly, the reason is that the deregulated financial services in the 'Neoliberal', Free Market Economies of the English-speaking nations –

which nearly caused the global economy to crash in the credit crunch of 2008 – also ramp up individualism at the expense of collectivism. The ‘me-me-me’ of popular culture and the pressure to put Number One first atomizes us, fosters loneliness and emptiness, converting ordinary citizens into Marketing Characters. This makes for impulsive, aggressive personalities, ones which are much commoner in America than in more collectivist societies. Compared with America, Impulsive-Aggressive personalities are 53 times less common in Japan, 18 times less in Germany (Table 26.1, Chapter 26, Kessler et al, 2008).

Whilst these large historical and cross-national trends profoundly affect which populations suffer most and in what ways, childhood experience undoubtedly partly explains why some individuals are more vulnerable than others, within any given society. It is a complicated relationship: the way some societies are configured leads to greater childhood maltreatment, resulting in higher levels of mental illness. For example, there are four times as many people on low incomes in America and England, compared with Denmark. For a variety of reasons (such as lack of education and working long hours for low pay) low income parents in developed nations often struggle to meet the needs of their children, so having a higher proportion of families with low incomes is likely to result in greater maltreatment. Practical support for parenting in Denmark is far greater.

In America, about 40% of people have suffered at least one traumatic event (witnessing or being the object of sexual or physical abuse) by age 13 (Koenen et al, 2010). If infantile and subsequent emotional deprivation of love and responsiveness were added to these surveys, the figure would be far higher – abuse is only one of many forms of maltreatment.

However, there is no simple relationship between childhood maltreatment and subsequent suffering, albeit that the one greatly increases the risk of the other. It is believed that there is a greater likelihood of maltreatment in developing nations (Belsky, 1993; Koenen et al, 2010), although in pre-industrial, traditional societies that may not be the case as much. In hunter-gatherer communities with few possessions and much less pressure to consume or work (to pay for the (often unnecessary) possessions we take for granted in modern life), parents may not feel so much need to control children (Sahlins, 2003), reducing the need for discipline (Konner, 2005). But in modern developing nations (as opposed to pre-industrial, hunter-gatherer ones), where food and water may be scarce, and where much of the population may be living in huge urban conurbations, like Cairo or Lagos, abuse is

likely to be commoner (although open affection may be commoner too).

Overall, the World Health Organization estimates that 29% of 'mental illness', worldwide, is attributable to childhood maltreatment (Kessler et al, 2010). This is very likely to be much less than the true proportion because the measures of maltreatment in the survey on which this statistic is based are crude. This gross figure is also based on surveys of 15 very different nations. The normal and healthy in some societies counts as maltreatment in others.

Physical punishment, for example, is extremely common in poor societies, or in poor classes in rich ones. It has different meanings, depending on context, to some degree. If you live in a slum in Lagos and your father whacks you when he catches you doing something wrong, it may be less humiliating and damaging to your self-esteem than a blow delivered with exactly the same force in a middle-class household where it is rare, done behind closed doors and for not getting top marks in an exam or as an expression of parental irritability or depression. Given that violence is common in slums, learning to fight or evade blows could even be seen as a useful skill (Belsky, 1993). By contrast, at elite private schools in the developed world it would be regarded as an appalling failure of *Savoir Faire* to hit someone – if violence is an expected and necessary part of daily life, it has a different meaning. Hence, the far higher levels of abuse in poor nations may be experienced quite differently than in wealthy ones, because they seem normalized outside, as well as within the family, and may not be experienced as so rejecting, as a sign of parental hostility or lack of love.

An illustration of the cross-cultural power of love is found in a recent paper demonstrating the moderating effect of parental warmth, when accompanied by intrusive, overcontrolling parenting (Raudino et al, 2013). Samples of British and Italian families were compared. Whilst the Italian mothers were significantly more overcontrolling, they were also warmer. This compensated for the overcontrol, making their children no more at risk of suffering anxiety disorders.

A study of the impact of maltreatment in Nigeria also illustrates the power of cultural differences (Oladeji et al, 2010). Bearing in mind that there is six times less mental illness in Nigeria than in America, it is interesting that the study found a similar amount of child maltreatment in the two nations. There may be no simple 'early maltreatment always causes 'mental illness' equation': if Americans and Nigerians experience similar levels of maltreatment, there should be similar amounts of mental

illness, rather than six times more in America. The authors pointed to some big differences in the two societies which could explain this.

The amount of divorce and separation is far less in Nigeria. There is powerful evidence that maltreatment has far worse effects when combined with family disruption. For example, in one large American study (Afifi et al, 2009), abused children who also had divorced parents were 10 times more likely to become 'mentally ill' as adults than children who had suffered neither. Abuse alone only doubled the risk, compared with no abuse. Interestingly, in the Nigerian study, even where there was divorce it did not increase the risk of 'mental illness'. This could be explained by the fact that there are extended families which reduces the disruption to care of the child. Where maltreatment does occur, the fact that there are numerous carers provides the maltreated child with much more opportunity to seek solace from alternative sources of nurture if they are feeling neglected, unloved or abused, support from older siblings (usually the families are large), aunts and grandparents. In the atomized nuclear families of the developed world, the absence of daily contact with the extended family means that there may be no alternatives available for solace if maltreating parents are present.

Having said all this, despite its over-simplified measures, the WHO worldwide study (Kessler et al, 2010) found that child maltreatment predicted 'mental illness' in all societies. This was also true in Oladeji et al's (2010) Nigerian study: maltreatment did lead to more 'mental illness', overall. The conclusion seems to be that everywhere, the more childhood adversities a person has suffered, the greater the likelihood of 'mental illness'.

Implications of the current evidence for future research and forms of treatment.

It may be seen from this brief review that there is considerable reason to suppose that childhood relational adversity and maltreatment is a major cause of psychopathology. But is it the major cause?

Alas, we are not yet in a position to answer that question in its full complexity although its importance is abundantly clear. Whilst the HGP has proved extremely helpful in establishing the minimal role of genes, there is still a need for much more fine-grained longitudinal and cross-cultural studies in order for the question to be resolved. The role of non-genetic biological factors also remains to be seen.

Until recently, the vast majority of psychiatric and academic psychological research has been starting from the premise that genes are the major factor. Many studies exploring the role of nurture have not paid attention to the early years, starting the investigation when children are as old as 5.

The time has finally come when there can be no excuse for research bodies around the world not to unite in contributing to large-scale, intensive, prospective studies of whole families, including all the siblings for purposes of comparison, starting during each pregnancy. Particular attention would need to be paid to the early years, to ensure that they were given the attention that the evidence now demands that they should. Decades of resistance to the role of the early years has been perpetuated by key influential figures, like Professor Sir Michael Rutter, whose own study of adoptees has finally forced him to acknowledge their crucial importance for emotional development, after his tenacious opposition to John Bowlby's theories (Rutter, 1972).

On a wider plain, the new studies would need to be cross-cultural and will, correspondingly, require treatment models that are cross-culturally flexible and sensitive, unlike programmes to roll out CBT in places as far-flung as sub-Saharan Africa. Psychosocial factors, like low income, gender roles and inequality (Wilkinson and Pickett, (2009) are clearly major factors in vulnerability to mental disorder in most societies.

If the relevant research governing bodies of the developed world were led by psychodynamically and psychosocially trained professionals, rather than by medically trained ones or those from the academic psychology, neuro-science and psycho-pharmacology establishment, as is largely the case today, carefully planned international research projects could construct long-term research programmes which would tease out the relative role of these factors.

As regards treatments for those who experience often highly disabling psychological damage and distress, the already existing evidence clearly supports those broadly relational and psychodynamic approaches to understanding the origins and nature of so-called 'psychopathology' and to its treatment, including formal trauma-processing approaches. Ideally service provision based on such understandings should also include early and/or 'preventive' interventions (see e.g. Mrazek and Haggerty (1994), or more recently, e.g. Chanen et al. (2017)).

Rather than approaches which explicitly reject exploration of the early years and see 'psychopathology' as a technological problem

occurring inside people's heads – such as offered by CBT or biomedical models – we need every distressed person in this country and around the world to have access to culturally-appropriate therapies. They can help to understand how the past is affecting the present, and enable beneficial psychological change, notwithstanding the challenging societal circumstances in which clients might live.

These are the therapies that turn the lead of childhood relational adversity and maltreatment into the gold of emotional health. □

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'What role am I playing?': Inpatient Staff Experiences of an Introductory Training in Cognitive Analytic Therapy (CAT) Informed Care

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Abstract: The current paper aimed to ascertain multi-disciplinary team (MDT) staff's experiences of a two-day introductory training to Cognitive Analytic Therapy (CAT). This training was specifically designed for MDT staff working in inpatient services for women with a diagnosis of personality disorder. 45 MDT staff completed the training. Following this, each participant completed a feedback questionnaire. Responses were examined using thematic analysis. The results indicated the training had been positively received by staff and was anticipated to have a range of benefits across their work in inpatient services. This paper particularly focuses on one of the main themes: the practical applications of the CAT model to everyday clinical practice. The results are discussed in relation to previous research in this area, focusing on the unique impact within this training of the use of sequential diagrammatic reformulations (SDRs). The conclusion emphasises the need for relationally based training to be available for staff working in inpatient services to meet the complex and changing needs of the client group. Furthermore, it is argued that CAT meets such a demand by providing a comprehensive and unified model of working which can offer a helpful and containing way of reformulating clients, while allowing staff to understand their own responses to the work. Limitations and areas for further work are also discussed.

Keywords: multidisciplinary team work, staff, inpatient services, training, cognitive analytic therapy, personality disorder, thematic analysis

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Introduction

IT IS well recognised that working with people who have complex needs, particularly those with a diagnosis of personality disorder, can challenge staff teams (Caruso, Biancosino, Borgni, Marmaj, Kerr and Grassi, 2013; Newton-Howes, Weaver and Tyrer, 2008). These challenges can include: demanding interpersonal dynamics, burnout, competing priorities, and the constant anticipation of crisis (Cleary, 2004). There can often be little time for reflection and supervision and staff don't always have the necessary knowledge and understanding to respond effectively to challenging ways of relating (Cleary 2003; Carradice and Round, 2004). Such difficulties are evident in a variety of settings, including inpatient services. The inpatient environment can be particularly difficult for teams due to the frequency and intensity of the care that is offered and the nature of the staff-client relationships.

CAT aims to provide a common language which can increase consistent team practices, the development of shared goals and overall team function (Thompson, Donnison, Warnock-Parkes, Turpin and Turner, 2008; Kerr, Dent-Brown and Parry, 2007). Client's difficulties are understood in terms of an individual's personal history and life experiences, including trauma, and are seen as developing out of the necessity to find ways of coping (Ryle, 2004). Patterns of relating to self and others and their relationship with presenting difficulties and distress are explored and worked with within therapy (Carradice, 2013). Developing this relational understanding of clients can be beneficial to teams and so the CAT model has been extended, beyond an individual therapy, to provide an overall framework for service delivery (Shannon, Butler, Ellis, McLaine and Riley, 2016). This is in line with key strategic drivers in mental health, where there has been an emphasis on healthcare which values compassion and human connection (Ballatt and Campling, 2011; Department of Health, 2012).

Previous studies have demonstrated that providing training based on CAT principles has been effective in working with clients sometimes deemed as 'challenging' and can assist staff in reducing their levels of work-related stress, increasing therapeutic skills and confidence, and supporting the development of a shared team dialogue (Thompson et al., 2008; Jones, Annesley and Gilley, 2012; Caruso et al., 2013). CAT training has included awareness and skills training for teams as well as adaptations of the model for its use within consultation (5 session CAT) and reflective practice (e.g., Thompson et al., 2008; Carradice, 2013; Annesley and Jones, 2016).

The current training sought to adapt and develop a traditional introductory CAT training (where the focus would be on understanding and using CAT as a therapy), to more explicitly meet the needs of multidisciplinary inpatient staff, who were primarily working with women with a diagnosis of personality disorder. For these staff, CAT was being developed in their services as an overarching clinical model to support the work of the MDT (via supervision, consultation and the use of individual reformulations).

Overview of the training

The aim of the training was to introduce staff to the CAT model and to learn about the ways it can be used to inform thinking and practice within inpatient environments, leading to improvement in practice at both the individual and team level. It was hoped that staff would feel more able to know how to avoid unhelpful enactments with clients, enhance therapeutic relationships and feel more positive about their work (see Table 1).

Table 1. Key learning objectives

- To develop an understanding of the theoretical basis of CAT to develop a relational framework for inpatient work.
- To become familiar with the use of CAT formulations in teams, including their use in supervision and relationally informed care-planning.
- To use CAT principles to develop relational thinking, in order to avoid collusive responses and improve engagement.
- To use CAT understandings to think about staff's own responses to their work.
- To use CAT principles to identify unhelpful patterns and help clients to find other ways of relating and coping.
- To develop a shared language that can be used to support reflection and communication in inpatient settings. To improve team functioning by reducing negative/unhelpful attitudes and conflicting approaches to care.
- To provide information on CAT as a therapy, in order to understand a client's experience of therapy with a view to supporting the goals of therapy in-between sessions.

The training was designed to give a working knowledge of the main concepts of the CAT model, with an emphasis on applying the concepts to inpatient working. This included exploration of reciprocal roles, procedures, dialogue, the zone of proximal development (ZPD), use of self, exits and endings. It also described a CAT informed understanding of personality disorder, highlighting developmental and traumatic origins, including the importance of dissociative processes and the multiple self-states model. The 4Ps model (Annesley and Jones, 2016), a CAT derived reflective practice tool, was also briefly reviewed.

A core part of the training was the emphasis on understanding and using SDRs ('maps'), developed by the team's psychologists, where possible in collaboration with clients. Exercises were designed throughout to facilitate their use by the whole team as a tool to enhance shared understanding and working, anticipate enactments, and predict issues that may arise including at transition points and endings. Participants were also supported to use the maps to inform care plans. Emphasis was placed on the concept of ruptures and enactments, with the encouragement to understand and work through them when they arise. As part of this, participants were asked to consider their own reactions to their work.

Method

Participants

All MDT staff working across two inpatient services (for women with a diagnosis of personality disorder) were offered the opportunity to take part in the two-day workshop. 45 MDT staff completed the training (consisting of: 21 support workers, 13 nurses, five psychologists, three occupational therapists, two social workers and one consultant psychiatrist).

Procedure

The training took place over two consecutive days, and was repeated on three occasions. Following completion of the training, all staff were provided with a semi-structured questionnaire. Participants were asked to rate the acceptability of the training, across five domains, using a Likert scale. They were also asked four additional open-ended questions in order to gain an understanding of their subjective experience of the training: What did you find helpful? Was there anything you would

change? What (if anything) will you be able to take back to your work with clients? Any additional comments? The training was designed and delivered by two of the authors (RT and LJ). Feedback was provided anonymously, and the data was analysed and interpreted by the first author (NC) to minimise researcher bias.

Analysis

Mean scores were calculated for each of the 5 quantitatively rated questions (Table 2). The responses to the four open-ended questions were analysed using Thematic Analysis (Braun and Clarke, 2006). The initial stage involved the first author (NC) immersing themselves in the data through multiple readings and keeping a reflective journal to log emerging ideas and patterns within the data. This process allowed for the formation of codes. Each code was given a definition of its meaning and a process of coding each line of data took place. The first author then began searching for, reviewing and naming themes. The process of agreeing themes was conducted by two of the authors (NC and RT) who independently organised the data into themes and then made comparisons. Once the overarching themes were agreed, sub-themes were identified based on the content and number of items in each theme.

Results

Table 2. Acceptability of the training: Mean ratings (n = 45)

Question 1-4; Rating 1 = very poor, 5 = excellent	Mean Rating
1. How relevant was the content of the session?	4.87
2. How well structured was the content?	4.93
3. How appropriate were the methods used to convey the material?	4.62
4. How adequate were any materials provided?	4.58
Question 5; Rating 1 = very little, 5 = very much	
5. How much did you learn?	4.80

Thematic analysis of open ended questions

From the analysis of the four open ended questions, three themes emerged within the data, and each theme incorporated subthemes (see Table 3).

Table 3: Main and sub themes

Theme	Sub-themes	No. of items coded
1. Practical application of the CAT model	● Everyday Practice: Use of tools/concepts in everyday practice	54
	● Team Function : Impact on team function	14
	● Psychological Process: Increased understanding and awareness of the process of the work	53
		Total: 120
2. Theoretical understanding of the CAT model	● Understanding the core principles of the CAT model	46
	● Interest in further learning/training in the CAT model	10
		Total: 56
3. Format of training	● Content	47
	● Learning environment	36
		Total: 82

The themes are discussed below and extracts from the data provided for illustration (where [P] denotes participant number). Themes 2 and 3 indicated that participants felt that they had been given a clear and useful introduction to the model and this had been delivered in a way which was accessible to all those who attended (regardless of level of experience / qualifications):

‘The workshop was packed full of information while simultaneously concise. It covered all the principles of CAT and did so in a way that was easy to understand and likely to stay with us.’ [P26]

Both themes also incorporated feedback suggesting participants were able to understand, and make sense of, the core theoretical principles of the model and highlighted the training package stimulated interest in further learning. The rest of this section will now focus on the Theme 1.

Theme 1: Practical application of the CAT model

The training intended to allow participants to familiarise themselves with the main principles of the CAT model and to support their thinking around how these could relate to inpatient work. From the feedback, it is clear participants valued the opportunity to think about how this could improve everyday practice, team functioning and psychological understanding:

Everyday Practice

Several participants indicated that the model was both relevant, and of benefit to their current practice. This was most evident in comments made around using their knowledge to work directly with clients:

‘Given me some effective dialogue for one to one sessions and I will be able to produce better care plans.’ [P36]

This participant felt the model would be useful when opening up conversations with clients as well as informing the way they write care plans. Similarly, another participant indicated that following the training, their confidence in knowing how to deal with more challenging interactions with clients had improved:

‘I feel a little more confident about dealing with ruptures and difficult conversations.’ [P9]

Participants also commented on the relevance of the model as an overarching framework for the service:

‘. . . I think it is extremely relevant and I am looking forward to the next stages of implementing it as a model for the whole service.’ [P1]

It was felt that this model would improve the delivery of care on a daily basis:

‘How CAT can be used within the ward environment on a day to day basis to offer structure and encourage support.’ [P44]

Team Function

In addition to the comments made about the model's relevance to working directly with clients, feedback also suggested participants felt it could have a positive impact on consistency and communication within the team:

'... writing care plans to maintain a consistent approach on the ward.' [P39]

This participant thought the training would increase the level of consistency offered by staff by informing the way care plans are written. It was also suggested by one participant that the ability to discuss ideas with other staff using the shared language offered by CAT would allow for more effective team responses:

'Discussing ideas with other staff on how to respond to patients in more effective ways to address unhelpful reciprocal roles.' [P18]

It was also highlighted that using the 'maps' (reformulations) as a way of reflecting together as a team would be important for maintaining a shared understanding and consistent team approach:

'The use of the map. . . I am looking forward to using these more when working with the team and sharing the learning and understanding we have developed.' [P1]

In particular, a participant noted the maps would allow staff to reflect on their own emotional responses and to support each other more effectively:

'Use of the maps with staff team. . . reflecting on feelings which patients elicit with staff.' [P12]

Psychological Process

There were a considerable number of reflections within the feedback that indicated participants had been able to consider the psychological process that takes place within client work. These participants were able to demonstrate they had been able to use the model to think differently about both the clients, and themselves:

'The training has allowed me to reflect more on myself and my relationship with the [client] which I think will benefit the therapeutic relationship.' [P13]

This participant emphasised the knowledge and understanding gained from the training would improve their self-awareness and ultimately their therapeutic relationships.

‘Using the map to understand the clients more and looking at the map when frustrated with clients. . . looking at any enactments [and] being aware of our reciprocal roles.’ [P16]

This participant indicated they would begin to take a wider view of their interactions with clients and spend more time understanding the relational patterns and responses these elicit. In turn, it was suggested this increased understanding and capacity for reflection would directly impact on the way staff responded to clients:

‘I will try to pause and think about my responses to clients.’ [P15]

There is an acknowledgment that often in the moment it can be difficult to respond in an effective way, and a suggestion from some participants was that they may be more able to consider their own reciprocal roles in the moment:

‘Think about what impact your role is having at that present moment.’ [P31]

One participant emphasised that being aware of the role you are currently taking in any situation can allow you to approach a problem differently and possibly more helpfully:

‘Approaching problems and thinking about the reciprocal roles, what role am I playing etc?’ [P9]

Discussion

The current paper aimed to ascertain MDT staff’s experiences of a two-day introductory training to CAT. This training was specifically designed for MDT staff working in inpatient services for women with a diagnosis of personality disorder. Traditional models of professional mental health training often do not incorporate a relational framework for understanding client difficulties and so CAT can provide a way of conceptualising some of the most challenging aspects of mental health work (i.e., interpersonal dynamics) using an accessible and trans-diagnostic framework (Kerr et al., 2007). There is a growing body of evidence suggesting CAT can also have a positive impact on stress, burnout and therapeutic confidence, leading to more positive relationships with both clients and colleagues and the overall functioning of an MDT (Caruso et al., 2013).

The results of the thematic analysis suggested the training was well-received by MDT staff taking part and the positive impact and anticipated

benefits of the training were in line with that of previous research. From the analysis, the largest theme (120 items of coded data) related to the 'practical applications of the CAT model' and from these items three sub-themes were identified: 'everyday practice', 'team function' and 'psychological process'. Some respondents indicated they felt the knowledge and understanding they had acquired during the training could help them in their everyday practice. This supports evidence that has shown CAT's efficacy as a framework for service delivery beyond that of an individual therapy (Shannon et al, 2016). The feedback suggested the CAT model could benefit practice in several ways including providing useful tools for focusing 1:1 discussion (i.e., the use of 'maps'), increasing confidence and skills in managing difficult interactions and more effective care planning. This finding is also supported by research conducted by Thompson et al. (2008) who found that a 'skills level' training in CAT had a positive impact on individual practice/confidence and Caruso et al (2013) who indicated that feelings of individual accomplishment increased following similar training.

The central focus on the understanding and use of SDRs ('maps') was a unique feature of the training. It was designed specifically for maps to be a core part of guiding a client's care in an inpatient service, within the context of ongoing MDT supervision. The results indicated participants felt maps could be beneficial to their practice; they suggested that using maps during one-to-one sessions would help to increase effective dialogue and aid the development of psychologically informed care. Maps were also seen as a potentially helpful tool to facilitate reflection with colleagues, to enable more effective work with clients and more awareness of staff's own emotional responses. Additionally, it was suggested that maps could be used to share learning across the team and encourage consistent approaches to practice. The flexibility and use of maps (including within inpatient settings) has been highlighted by Potter (2010); the current evaluation supports the notion that maps can be a tangible and accessible way of facilitating relational understanding within staff teams that supports 'side by side' working as opposed to oppositional and conflicting approaches to care, which can exacerbate difficulties (Potter, 2010; Barnes, 2016).

The link between the implementation of CAT training for MDTs and increased team cohesion and functioning has been demonstrated in the literature (Kerr et al, 2007). This may be particularly important when thinking about teams working in inpatient settings as there are more opportunities for difficult and challenging interpersonal experiences for

staff (Moore, 2012). The feedback indicated participants were positive about the influence the training could have on the team, with several staff indicating they felt it could allow for a more consistent approach. Participants also thought the shared learning would be helpful when considering how best to respond to challenging situations or difficult interpersonal dynamics as a team. It has been argued the training staff receive in psychologically informed approaches to mental health is limited, as is the support and supervision offered (Kerr et al., 2007). Therefore, training initiatives, such as that outlined in this paper, may be of significant importance when working towards building a relationally skilled workforce.

A number of participants commented on how the training allowed them to develop an increased awareness of themselves and what they bring to their work. It was clear from the evaluation that some participants felt they may respond to clients in a more effective and thoughtful way following the training. This was demonstrated by participants considering strategies such as taking a 'pause' before responding to a client, using the map to understand feelings of frustration and reflecting on reciprocal roles. Participants also identified the training could have a positive impact on their therapeutic relationships and on their level of compassion. Previous research has supported the notion that CAT training can have a positive impact on the therapeutic relationship and has argued this is an important finding as the link between quality of the therapeutic relationship and clinical outcome has been clearly demonstrated (Caruso et al, 2013).

The current paper demonstrates face validity and acceptability to staff teams who have the intention to utilise CAT within their work setting as measured at the point of delivery of the training. This work could be extended to include baseline and follow-up data (to assess individual change in staff knowledge and understanding as well as the impact of the training on subsequent working practices). Exploring the impact of this training on staff's relationships with clients (particularly levels of compassion and the quality of the therapeutic relationship) would be areas for further consideration. The training was evaluated using a standard service feedback questionnaire. It would be useful to develop this further to ascertain more specific information on how the sub-themes in Theme 1 reflected the mechanisms at work in CAT, by using a more focused questionnaire/interview process.

In conclusion, there is a clear need for inpatient services to develop the skills and knowledge of their staff to attend to the increasingly

complex and challenging needs of clients. CAT can provide a helpful and containing way of formulating complex presentations such as personality disorder, while also providing a framework for understanding staff's own responses to their work. The impact of such work on client outcome, the therapeutic relationship and the containment of staff needs further research. However, the current evaluation, suggests staff have responded positively to the introduction of CAT principles and their application to personality disorder, and the CAT model could be an acceptable, accessible and meaningful approach to enhance psychological work within inpatient settings. □

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Relational Patterns in Adolescents with and without Emotional Dysregulation and their Parents from a CAT Perspective

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Abstract: The radically social concept of self in the Semiotic Object Relations theory of Cognitive Analytic Theory (CAT) offers a clinically important understanding of the development and expression of relational patterns that characterise emotional dysregulation. The current study aims to examine shared relational patterns between adolescents with and without emotional dysregulation and their parents. It explores how such patterns influence responses to hypothetical critical, ambiguous and empathic Vignettes. Six emotionally dysregulated and six non-emotionally dysregulated adolescents and both parents ($n = 36$) completed personality integration, trauma and dissociation measures and were interviewed about their early parental relationship experiences before responding to Vignettes. Emotionally dysregulated families reported significantly less OK relational patterns with regard to parental relationships and significantly more abusing patterns in response to the critical Vignette compared to non-emotionally dysregulated families. The impact of problematic patterns in terms of how they may affect present relating are discussed in light of clinical and theoretical implications.

Keywords: Adolescents, Emotional Dysregulation, Relational Patterns, Cognitive Analytic Theory, Mixed Methods

ACCORDING to the Fifth Annual Child and Adolescent Mental Health Service Report (HSE, 2013), the majority of illness burden in childhood and more so in adolescence, is caused by mental disorders

and the majority of adult mental health disorders have their onset in adolescence. The handful of studies that have been completed with adolescents however (Buist, Dekovic, Meeus, & van Aken, 2002; Lieberman, Doyle, & Markiewicz, 1999), have focused largely on single parent dyads and the transmission of specific behaviours and attachment styles while research exploring relational patterns with this population is absent in the literature.

Emotional dysregulation is postulated to be a central mechanism of borderline pathology and the disorder is characterised by marked problems regarding interpersonal relationships, self-image, affectivity, and marked impulsivity (Staebler, Gebhard, Barnett, & Renneberg, 2009). Benjamin (1992, 1996) argues that instability in interpersonal relationships and affect dysregulation in BPD are an extension of childhood environments in which the child was exposed to traumatic experiences, simultaneously idealised and devalued, and encouraged to be and rewarded for being dependent upon the family. As a result, emotional sensitivity becomes heightened to a pathological level resulting in misinterpretation of interpersonal stimuli (Burgess & Hartman, 1993) or may lead to tendencies to construe others' motives as malicious (Arntz & Veen, 2001). Thus, it appears that early experiences of co-regulation, or lack thereof, provide the foundation for continued regulation into adulthood (Hughes, Crowell, Ujeyji, & Coan, 2012). It seems therefore, that despite child and adolescent mental health having been extensively studied over the past two decades our understanding of the development and manifestation of child psychopathology within the family context is far from complete (Bertino, Connell & Lewis, 2012).

Despite the specific relevance of problematic patterns between parents and children with BPD, there is a clear dearth of research into the nature of such problematic patterns (Connell & Goodman, 2002). Research that does exist with regard to parental influence has tended to focus its lens primarily on mother-child dyads, and in the direction of behavioural characteristics and attachment styles (Kretchmar & Jacobvitz, 2002). However, as both parents clearly contribute to the genetic and social context in which children develop, ignoring the unique influence of each parent in the development of the clinical presentation of emotional dysregulation is a serious omission in empirical research (Capaldi, Pears, Kerr & Owen, 2008; Connell & Goodman, 2002).

Traditional cognitive approaches tend to lean towards a more one-dimensional view of the individual and appear to have paid very little attention to either the interpersonal style or environmental context in

which the person lives (Bamber, 2004). Modern psychoanalytic thinking on the development of the borderline self views borderline pathology as a problem of separation and individuation (Kernberg, 1967), and posits that BPD originates in the childhood failure to integrate conflicting images of self and other due to difficulties in key relationships. Attachment theory (Bowlby, 1969) posits that parenting interactions influence attachment patterns (which include reciprocal, social, emotional, cognitive, and behavioural characteristics of both the infant and caretaker) and regulatory capacities across the lifespan and thus shape the emerging adult personality (Diamond, 2006; Levy, 2005). However, apart from the caretaker-infant dyad, it must be borne in mind that there exists a whole social and cultural context that cannot be ignored in terms of etiology.

The role of social and cultural factors in individual development is emphasised in Cognitive Analytic Theory (CAT; Ryle & Kerr, 2002). The key element of this semiotic object relations model in CAT is concerned with the idea of internalisation. Central to the model is the reciprocal role procedure (RRP), or dialogical pattern which originates in the interactions between each individual child and his or her caretakers (Ryle & Marlowe, 1995). What is inside a person's mind therefore is a continuous internalised dialogue and not a static set of schemas (CBT) or internalised objects (Llewellyn, 2003). The Multiple Self States Model (MSSM) of BPD (Ryle, 1997b; Ryle & Kerr, 2002) posits that trauma and deprivation in the early years of life can lead to the internalisation of relational patterns which shape both self-management and relations with others. This is believed to account for many of the features of BPD such as deficient and disrupted self-reflection, dissociation and a fragmented sense of self. The model points to the ways in which humans actively construct unique cognitive representations of experience by identifying the specific interpersonal patterns linked to their own particular construal style developed through early caregiver-child interactions.

Bakhtin (1973) refers to the traces of early experiences as 'voices', reflecting the observation that they are not passive parcels of information but agentic parts of the person able to act and speak (Honos-Webb & Stiles, 1998; Osatuke, Gray, Glick, Stiles & Barkham, 2004; Stiles, 1997, 1999). From this perspective, a person's personality is thus understood as an organisation of voices representing significant people, events, and other constellations of experiences. Experiences are typically assimilated, unproblematically linked together, so that they are smoothly accessible and can serve as resources in daily living. Voices of problematic experiences however, may remain dissociated or at least partially

dissociated from the rest of the person's experiences, being held apart by the negative affect engendered by encounters between them (Stiles, 2002; Stiles, Osatuke, Glick & Mackay, 2004). The positions a person takes are understood as the observable manifestations of the internalised voices of others. This suggests that what makes a voice problematic to the person does not reside within the voice itself but in how it positions the person with regard to self and others. The real or imagined presence, or anticipation of abusing, criticising, and or neglectful others becomes the background for many of the individual's activities. The voice of the other, as already indicated is for the most part, expected rather than heard (Lewis, 2002; Lewis & Todd, 2004) and it is these internal dialogues that affect both how others can be experienced and external actions.

The Current Study

The current study adopts a Cognitive Analytic Theory perspective. It examines and compares relational patterns in families of emotionally dysregulated (ED) and non-emotionally dysregulated (non-ED) adolescents. It is designed to add to the limited literature in this domain by describing how the experience of early relationships through interactions with significant close others leads to the internalisation of dialogical patterns that affect how individuals relate to themselves and others. It further considers how internalised patterns of relating might potentially influence responses to therapeutic dialogues involving critical, ambiguous and empathic therapist responses to a client. Data is approached from a mixed method perspective on the basis of its suitability as a methodology with regard to accessing an enriched understanding of familial relational patterns. The following hypotheses and research questions are proposed based on an extensive reading and analysis of both the theoretical and empirical literature in this area:

- Adolescents and their parents in the ED group, both separately and combined, will obtain statistically significant higher scores on measures of personality (dis)integration, trauma and dissociation compared to adolescents and parents in the non-ED group.
- ED families are expected statistically to share significantly higher frequencies of abusing and or/ idealising patterns, and significantly lower frequencies of OK patterns compared to the non-ED group on the basis of qualitative interviews.
- Exploration of the shared familial abusing, idealising and OK patterns elicited in response to a series of critical, ambiguous and

empathic hypothetical Vignettes will determine whether there are statistical significant differences within and between groups with regard to the frequencies of patterns elicited.

Method

Participants

Female adolescents and their parents who took part in this study were drawn from a purposive and convenient sample within the child and adolescent community and mental health services in the Dublin region over a ten-month period. Adolescents in the ED group were between 13 and 18 years old and attending regular outpatient therapy in secondary mental health services on account of emotion regulations difficulties. All adolescents referred for inclusion in the ED group had a primary diagnosis of ED according to DSM-V (2013). The control group adolescents were also between the ages of 13-18 years and engaged with primary mental health services. Data was collected from the twelve families ($n=36$) who agreed to participate and all subjects provided written consent.

Procedures

Families meeting inclusion criteria were informed of the research during a routine meeting with the Consultant Psychiatrist or Clinical Psychologist to both explain the nature of the research and to inform as well as assess their interest in taking part in the study. Informed consent was obtained from all interested participants. Given the sensitivity of the subject matter being discussed and the fact that all three family members attended at the same time, three interviewers were required. Interviews were conducted by the researcher and two experienced Psychologists. Following a qualitative interview, participants completed an identical battery of measures, which involved listening to a series of three randomly presented hypothetical therapeutic Vignettes. Following the presentation of each Vignette, participants were requested to select any descriptors that they felt were elicited and thus applicable. All procedures were approved by the local CAMHS, Health Service Executive, and University Ethics Committees.

Measures

Qualitative Interview: The Qualitative Interview on family relationships was based on both CAT (Ryle, 1997a; 1997b) and elements of attachment theory as outlined in the Adult Attachment Interview (AAI; George, Kaplan & Main, 1984, 1985, 1996).

Personality Integration: The Personality Structure Questionnaire (PSQ; Pollock, Broadbent, Clarke, Dorrian & Ryle, 2001) was administered as a measure of personality (dis)integration. The PSQ is based on the Multiple Self-States Model in CAT (Ryle, 1997a). Scores on the PSQ correlate significantly with measures of identity disturbance, dissociation, and multiplicity, and high scores indicating an awareness of instability are characteristic of borderline patients (Ryle, 2007). The PSQ consists of eight bipolar self-rated items with a range of possible responses from 1 to 5. Scores of 28+ are considered to be within the clinical range. Test-retest reliability for the PSQ has indicated stability across a six-week period with a correlation of .75). Convergent and discriminant validity for this instrument has been demonstrated through multiple regression analyses and its correlations with measures of dissociation, depression, interpersonal difficulties, general psychiatric symptomatology, sense of coherence, self-concept and mood variability among four non-clinical samples (total $n=155$) and four clinical samples (total $n=117$) (Bedford, Davis & Tibbles, 2009; Pollock et al, 2001).

Childhood Trauma: The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) was used to assess the level of trauma in the sample given that items on the CTQ reflect common definitions of child abuse and neglect as found in the childhood trauma literature (Crouch & Milner, 1993; Finkelhor, 1994; Knutson, 1995; Malinosky-Rummell & Hansen, 1993). The CTQ is a 28-item self-report inventory that provides brief, reliable and valid screening histories of five clinical trauma scales pertaining to emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect on a 5-point Likert scale ranging from 'never true' to 'very often true' to enhance item sensitivity for low-intensity events. The CTQ has demonstrated good evidence of reliability and validity. The CTQ has been found to be a sensitive and valid screening questionnaire of childhood trauma with adolescents in psychiatric settings (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997).

Dissociation: The Adolescent Dissociative Experiences Scale Second Edition (ADES-II; Armstrong, Putnam, Carlson, Liebro & Smith, 1997) was used to determine the levels of dissociation present in the personality of young people in the study. It is a brief 30-item questionnaire suitable for young people aged between 10 and 21 years. The respondent circles statements on an 11-point scale ranging from 0, labeled as 'never,' to 10, labeled as 'always.' The high split-half reliability and Cronbach's alpha provide evidence that the measure has good internal consistency. Furthermore, high test-retest reliability indicates that the A-DES-II is able

to measure consistently over time (Zoroglu, Sar, Tuzun & Savas, 2002) and has good construct validity. The Dissociative Experiences Scale Second Edition (DES-II; Carlson, Bernstein & Putnam, 1993) consists of 28 questions that help in determining the degree of dissociation present in the adult personality. This scale was administered to all parents taking part in the present study to assess levels of dissociation. Responses on the DES-II are recorded from 0 (never) to 100% (always) rated on what percentage of time the person experiences symptoms. Good reliability has been demonstrated. In 16 studies a mean Cronbach's alpha of .93 has been reported. A test-retest correlation of .93 over a period of 2 weeks was found in a sample of 78 patients at a dissociative disorders clinic (Dubester & Braun, 1995) and in 30 patients with a dissociative disorder across a 4-week period (Frischholz, Braun, Sachs & Hopkins, 1990).

Hypothetical Vignettes: The hypothetical *Vignettes* used in this study were all taken from the book *Cognitive Analytic Therapy and Borderline Personality Disorder* (Ryle, 1997a). The roles identified and discussed regarding these sample dialogues were considered to be critical, ambiguous or empathic following both an examination and rating by three Clinical Psychologists.

Reciprocal Roles/ Dialogical Patterns: The States Description Procedure (SDP; Bennett et al., 2005) was used to identify and record subjective dialogical patterns elicited in participants following the presentation of the hypothetical *Vignettes* detailing the dialogue of a therapeutic encounter. The SDP is a self-report procedure, non-psychometric test designed to identify and describe recognisable states and the dialogical/ relational patterns that occur within states and the switching between them. The ten states outlined in the SDP refer to an experiential state characterised by mood, behaviour, sense of self and others and is designed for the participant to identify and select those states which more-or-less resemble their own (Ryle, 2007). Consistent with Ryle's (2007) investigation of relational patterns in borderline states in which patterns were categorised into positive, negative, idealising and dissociative features, and for the purpose of the present study, relational patterns selected within each state were divided on the basis of their face value into categories indicating predominantly abusing, idealising and OK relational patterns in liaison with two CAT therapists and on the basis of the theory of CAT. The patterns that became evident were noted and coded as being within one of these three dominant categories.

Overview of Analyses

Preliminary analyses were conducted to test for distribution shape and to determine the most appropriate measure of central tendency. Non-parametric tests were considered the most appropriate in this instance given both the small sample size (i.e. Tomkins, 2006) and because medians are less sensitive to outliers in the data and thus a more accurate value of central tendency than means (Wilcox & Charlin, 1986). There were two parts to the overall process:

- a) Qualitative interview data was analysed using Dialogical Sequence Analysis (DSA), (Leiman, 1997, 2004, 2011). DSA is a method of analysing utterance. An utterance is composed of 3 structural (the author, the addressee and the referential content) and 3 expressive (intonation, composition and stylistic devices) aspects. It was considered the most appropriate form of analysis for the qualitative data in this study since it was developed as a descriptive unit in CAT. Throughout transcript analysis, the dialogical patterns comprising the dominant relational repertoires of individuals within the families of each group began to emerge. As this study was only concerned with examining the dialogical/relational patterns (i.e. the patterns of reciprocation) and not the sequencing of those patterns, DSA was used for this purpose alone. The data of each participant was read and reread with the goal of identifying dialogical patterns and the process of identification was an iterative procedure.
- b) Once participants' individual dialogical patterns were identified, it was decided that the shared patterns within families of both groups would be organised into salient themes on the basis of CAT theory and available literature (i.e. abusing, idealising, and OK; Ryle, 2007), that were then added together to obtain a total score for each group. Mann Whitney U tests were conducted to compare the prevalence of shared dialogical patterns under these themes between groups. Shared familial dialogical patterns elicited in response to a series of hypothetical Vignettes and identified using the SDP were also added together under each of the salient themes and the frequencies of these shared familial dialogical patterns elicited in response to Vignettes were then explored within and between groups using a series of Friedman and Mann Whitney U tests respectively. Analyses were conducted using SPSS version 21. The qualitative analysis was conducted so as to meet Miles and Huberman's (1994) five benchmarks of reliability and validity in qualitative research.

Results

A statistically significant difference was found in PSQ scores, (ED *Mdn*=36.0; Non-ED *Mdn*=16.5; $U=.00$, $p=.004$, $r=.08$ (very small effect) and in ADES-II scores, (ED *Mdn*=4.35, Non-ED *Mdn*=1.35; $U=4.0$, $p=.025$, $r=0.64$ (large effect) between adolescents indicating significantly higher levels of identity disturbance and dissociation in the ED adolescents. No statistically significant differences were found between adolescents on the CTQ in both groups or between parents in both groups on the PSQ, DES-II or CTQ. See Table 1 below.

Table 1. Medians and p values of PSQ, CTQ domains and ADES-II; DES-II in adolescents and parents between groups

Measure	Adolescents		p	Parents		p
	ED (n=6)	Non-ED (n=6)		ED (n=6)	Non-ED (n=6)	
(Ranges)	<i>Mdn</i>	<i>Mdn</i>		<i>Mdn</i>	<i>Mdn</i>	
PSQ (5-40)	36.0	16.5	.004**	23.75	17.5	.19
CTQ (5-25)						
Emotional Abuse	14.0	6.5	.076	9.0	8.25	.872
Physical Abuse	5.0	5.0	.399	7.5	6.0	.293
Sexual Abuse	6.0	5.0	.25	5.25	5.0	.39
Emotional Neglect	11.0	7.5	.469	9.0	8.5	1.0
Physical Neglect	5.0	5.0	.702	7.0	6.5	.871
ADES-II; DES-II						
(0-10; 0-100)	4.35	1.35	.025*	6.75	7.25	.74

Note: Higher scores on the PSQ, ADES-II & DES-II, and CTQ are indicative of personality disturbance, dissociation and trauma severity; * $P<.005$; ** $P<.05$

A series of Mann Whitney U tests were conducted to compare total PSQ and CTQ scores between the ED and non-ED family groups indicated a statistically significant difference in PSQ scores between groups, (ED *Mdn*=27.4; Non-ED *Mdn*=17.3, $U=1.0$, $p=.006$, $r=.78$ (large effect). No statistically significant differences were found on any of the CTQ trauma domains between family groups. See Table 2.

Table 2. Medians and p values of PSQ and CTQ domains between family groups

Measure	ED (n=6)	Non-ED (n=6)	p
(Range)	<i>Mdn</i>	<i>Mdn</i>	
PSQ (5-40)	27.4	17.3	006**
CTQ (5-25)			
Emotional Abuse	11.15	7.45	.078
Physical Abuse	7.6	5.65	.196
Sexual Abuse	6.5	5.0	.104
Emotional Neglect	7.9	8.6	.630
Physical Neglect	6.45	5.9	.373

Note: Higher scores on the personality integration measure and trauma domains are indicative of personality disturbance/ severity of trauma respectively; *P<.005.

Shared Abusing Dialogues in ED vs non-ED Group

Shared abusing dialogues in the form of abusive control, emotional disavowal, neglecting and distancing were present to varying degrees within all families in the ED group. Four families in the non-ED group shared abusing dialogues in the form of neglecting, abandoning, controlling, demanding, uncaring and distancing to Counter-positioned abused Positions. Below is an example of a shared emotionally disavowing dialogical pattern that emerged within the realm of abusing experiences in the ED family group as participants talked about their relationships with their parents. The abbreviations D, M and F are used throughout to identify daughter, mother and father respectively.

Referent – Mother

D4 She told me to stop telling lies and smacked me and told me I was really bold and should never say things like that about my uncle. . . that made me feel really shit. . . I couldn't say anything to her about it ever again. . . until I went to CAMHS because I was cutting myself.

M4 She never showed us love. . . I think she blocks out the lack of relationship.

Referent – Both parents

F4 I'd get in trouble and get a beating. . . oh yeah you'd get a wallop from the mother and then you'd get another one from my father when he'd come in and she'd tell him. . . I can't really remember much ya know – I don't know if I blocked it out or something.

Emotional disavowal as a form of abusive control is illustrated in D4's example above. Upon disclosing sexual abuse, she was Positioned as dismissed, disbelieved, abused and silenced to a Counter-positioned dismissing, disbelieving, abusing and silencing mother. This section of transcript also demonstrates how an internalised (m)other to self-abusing pattern is now enacted self-to-self through deliberate self-harm. When discussing her mother, M4 highlights her lack of emotional responsiveness; emotional expression was not permitted. Similarly, F4 was unable to express normal emotions to both his parents, as the consequence of such activity would result in trouble and abuse. This participant describes his abuse by both parents, but then there is silence (intervening voice) and he can't remember. This section of transcript highlights how a voice can intervene and cut off the memory (dissociation) of threatening and menacing experiences, as a way of coping.

Shared Idealising Patterns in the ED vs non-ED group

Shared idealising dialogues including Positions of ideally caring, admiring and smothering leading to Counter-Positioned blissfully cared for, admired and overwhelmed positions were present in three families in the ED group. This was compared with only one shared idealising pattern in the non-ED family group involving Positions of ideally caring to Counter-positioned blissfully cared for experiences. A shared idealising pattern in the ED family group is presented below.

Referent - Mother

D2 She never left my side. . . she does everything with me we don't like being without each other. I don't really have friends but it's ok because my mam is my best friend and we always say we don't need anyone else but each other. . . I feel she needs me too.

M2 So I'd look after her. . . I'd look after the house when my dad was out at work and look after things for her, look after her.

F2 She'd never have said no to you.

Here, both D2 and F2 exhibit internalised dialogical patterns from their mothers, which involve being Positioned as blissfully close to and ideally cared for. D2 describes a sense of vulnerability shared by herself and her mother as she identifies with dialogical patterns in which both of them are needy while being needed. In looking after her mother as a child (self to other), M2 exhibits an ideally caring parental child pattern; in doing everything for her daughter (self to other) she demonstrates the ideally caring to ideally cared for dialogical pattern. However, in providing ideal care to others she also engages in a neglecting to neglected self-to-self dialogical pattern.

Shared OK Patterns in the ED vs non-ED group

Dialogues constituting shared OK dialogical patterns were evident in four families in the ED group. These Positions typically included realistically caring and loving to Counter-Positioned realistic caring and feeling loved. It is of note however, that some of these individuals also Positioned themselves as both loved and confused to Counter-Positioned conditionally caring, distancing and/or neglecting caregivers, as is demonstrated below. Shared OK dialogues (example below) were present within all families in the non-ED family group and included Positions of realistically caring and respecting and loving to Counter-positioned realistically cared for, respected and loved positions.

Referent – Father

D4 He's kind. . . he gives me money when I need it.

M4 He'd give me hugs and things like that you know it was nice. . . really nice.

Both D4 and M4 gave evidence of cared for Positions in relation to Counter-positioned caring fathers.

M5 as highlighted below describes her alcoholic father as 'loving' while simultaneously Positioning herself as neglected, ignored and distanced by him (Counter-position).

M5 I'd have liked to be closer to him but I never felt I could be, he just wasn't made that way.

Prevalence of Shared Patterns Between Groups

A series of non-parametric Mann Whitney U tests were conducted. Analyses revealed a significant difference in shared OK relational patterns, (ED group *Mdn*=1; Non-ED Group *Mdn*=2) ($U=4.0, p=0.02, r=.67$ (large effect), but no statistical significant differences in abusing or idealising patterns between groups was found.

Patterns Elicited by Hypothetical Vignettes Within and Between Groups

A series of Friedman tests indicated that there was a significant difference in the frequency of OK patterns elicited within the ED group across the Vignettes. Comparing the ranks of OK patterns elicited across Vignettes in this group, the Critical Vignette elicited a significantly lower number of OK patterns than the ambiguous and empathic Vignettes. See Table 3.

Table 3. Patterns elicited in response to hypothetical Vignettes within groups

Group	Patterns	Vignette (Mean Ranks)			<i>p</i>
		Critical	Ambiguous	Empathic	
ED	Abusing	2.67	1.33	2.0	.069
	Idealising	1.83	2.25	1.92	.692
	OK	1.17	2.42	2.42	.038*
Non-ED	Abusing	2.58	1.33	2.08	.066
	Idealising	1.5	2.33	2.17	.229
	OK	1.42	2.33	2.25	.172

Note: * $P < .05$

A series of non-parametric Mann Whitney U tests revealed a statistically significant difference in the frequencies of abusing patterns, (ED *Mdn*=38.0, Non-ED *Mdn*=19.0; $U=6.0, p=.05, r=.5$ (large effect), but not in idealising or OK patterns, elicited in response to the critical Vignette between the ED and non-ED groups. No statistically significant differences were found between groups in frequencies of abusing, idealising, or OK patterns elicited in response to the ambiguous or empathic Vignettes.

Discussion

The significant finding with regard to identity (dis)integration and dissociation in the ED adolescents compared to non-ED adolescents is consistent with the literature on BPD with regard to personality (dis)integration and dissociation as patterns indicating identity disturbance including markedly persistent unstable self-image or sense of self, as well as dissociative symptoms that have been found to be core features of the disorder (DSM-V, 2013, Pollock et al., 2001; Ryle, 1997a; Ryle & Golyunkina, 2000). No statistically significant differences between ED and non-ED adolescents were found in relation to abuse domains on the trauma measure. It must be borne in mind however, that non-ED adolescents were derived from a clinical population and were therefore likely to have varying degrees of adverse and traumatic experiences in their early histories, which may account for the non-significant finding across trauma domains between adolescents in both groups. This is supported by the qualitative data, which further indicated victim-abusing relational patterns in parental relationships in both family groups and has been highlighted in the literature (Ferenczi, 1932; Johnson et al, 2002; Macfie, Rivas, Engle, Hamilton & Rathjen, 2005; Ryle, 1997a; Zanarini et al, 1997). Dissociation as a coping strategy in the face of overwhelming adverse experiences is also a common finding in the literature (Van der Kolk, McFarlane & Weisaeth, 1996) and helps explain the significant difference between ED and non-ED adolescents' scores on the dissociation measure in this regard. The findings above and DSA are also consistent with the MSSM model of BPD in CAT (Ryle, 2007), which attributes a central role to adverse and traumatic relational experiences in inducing dissociation.

As parental psychosocial impairments have implications in terms of their ability to effectively attune and relate to the emotional needs of their children (Schore, 1994), this may also explain the significant differences between adolescents' scores in both groups on the measures of personality (dis)integration and dissociation. The ED family group scored significantly higher on the personality (dis)integration measure than the non-ED family group. This is consistent with the literature that has found high levels of psychopathology and intergenerational transmission of BPD and its coaggregation with other disorders in parents of children with ED (Bradley et al., 2005; Serbin & Karp, 2004; White et al., 2003). The qualitative findings support the quantitative data gathered suggesting that a fragmented sense of self (disintegration) and disruptions in self-reflection (dissociation) could be set in motion through

more severe and or pervasive repeated and internalised negative early caregiver-child dialogical interactions. This was evident in the ED family group dialogues that appeared to be more negative, pervasive, ingrained and entrenched compared to the dialogues of the non-ED family group, consistent with CAT theory (Ryle & Kerr, 2002). ED families shared significantly less OK patterns compared to non-ED families. Although no significant difference was found between groups with regard to shared familial abusing and/ or idealising patterns, it must be noted as mentioned above, that the qualitative data revealed victim-abusing relational patterns in both family groups. Furthermore, not all abused children who internalise such relational patterns necessarily become emotionally dysregulated; it seems probable that both the varying nature of abusive experiences and the level of accompanying dissociation may play a role in determining the development of ED and account for differences in personality (dis)integration and dissociation scores between adolescents in both groups. This is supported by the qualitative and quantitative data. The significant finding with respect to the higher frequency of shared OK patterns in the non-ED family group suggests the presence of a greater range of more adaptive dialogical patterns that are capable of being utilised in a more flexible and integrated manner both intra and interpersonally. This is in keeping with the finding of a significantly lower level of personality (dis)integration in the non-ED family group. Qualitative analysis of the dialogical patterns in both family groups provided an important lens into the nature of the OK patterns reported and identified. For example, the lower level of OK dialogical patterns in the ED family group were often accompanied and characterised by confusion. According to the CAT model, this is considered to be the result of attempts to form adaptive responses to difficult early relational experiences (Ryle & Kerr, 2002)

Given that no statistical differences were found in any of the patterns elicited across the Vignettes within the non-ED group, it is possible that in keeping with CAT, this group had a greater range and flexibility of dialogical patterns to deploy to the presented Vignettes (Ryle & Kerr, 2002). Additionally, the ED group identified a significantly higher number of abusing patterns following the presentation of the critical Vignette only. This is congruent with literature that has demonstrated how individuals with emotional difficulties are likely to process information in a more negatively biased way (i.e. Meyer, Pilkonis & Beevers, 2004; Veen & Arntz, 2000) as well as having difficulties disengaging from threatening stimuli (Derryberry & Rothbart, 1997). Connecting the qualitative and quantitative results of this study provide support for CAT,

which contends that internalised dialogues (in this case, abusive dialogues) affect external actions (the significant number of abusing patterns reported by the ED group in response to the critical Vignette). The significantly higher number of abusing patterns elicited to the critical Vignette and significantly lower number of OK patterns reported on the basis of qualitative interview on early relationships with parents in the ED family group suggests that this group possess a more restricted and less flexible range of dialogical patterns than the non-ED family group. This is consistent with the MSSM model and with the notion in CAT that the voice of the other is for the most part, expected rather than heard and that the real or imagined presence, or anticipation of abusing, neglectful or criticising others affect both how others can be experienced and external actions (Bakhtin, 1981; Holquist, 2004).

Limitations and Strengths

The small sample size meant that the power to explore the hypotheses accurately was significantly decreased and all results must therefore be interpreted with caution, at best providing a platform upon which further research with larger samples can be built. It is possible that some effects have been missed or inflated due to sample size and in all analyses the margin for error is greatly increased (Clark-Carter, 2010). Previous research with adolescents has highlighted the difficulties of recruitment and noted a significantly longer period for data collection would be needed to achieve a large sample size (Meyers, Webb, Frantz & Randall, 2003). The study was also exclusive to female adolescents and their parents and although females tend to be overrepresented among patients with ED in clinical settings, it remains unclear how the present findings relate to males with ED. The use of a mixed method approach in this study provides an alternate perspective on how human development occurs through the reciprocal exchanges between individual growth and social contexts (Bronfenbrenner & Morris, 1998; Thelan & Smith, 2006); and triangulation of the data increases its reliability and validity (Creswell, 2003). Investigator triangulation was also used in order to enhance the trustworthiness of the results. DSA, the qualitative analysis previously described in this study, has been used in psychotherapy process research and it has been noted that evidence of traumatic events are frequently apparent in the dialogical patterns emerging within the individual's core repertoire later on (Leiman, 1997; 1999). Moreover, the fact that the qualitative data is generally supportive of the quantitative findings in

this study indicates that they may be tentatively accepted. Given that these noteworthy trends were observed despite a small sample size suggests that they warrant future investigation. The study also conforms to the criteria of fruitfulness in terms of providing a new way of looking at a subject matter and increasing understanding of that subject matter (Madill & Barkham, 1997). Future research would benefit from following up larger samples, perhaps including male adolescents with ED, over a longer period examining the impact of adverse early relational experiences and the mediating factors that contribute to the potential for individuals to move in and out of a diagnosis (Glen & Klonsky, 2013).

Conclusion

This novel study moves away from the previously highlighted over-reliance on adult literature (Fruzetti, Shenk & Hoffman., 2005) and focus on studies in which parental influence in the development of ED is considered from a merely behavioural and/or attachment, or single parent perspective (Capaldi et al., 2008; Kretchmar & Jacobvitz, 2002). Using a CAT perspective, the study corroborates and extends the findings of previous research (Honos-Webb & Stiles, 1998; Osatuke et al, 2004, Stiles et al, 2006) in relation to how the nature of problematic parent-child patterns may be reactivated by circumstances that recall the conditions under which they were formed. The study provides a more holistic picture as to the importance of the parent-child relationship in the development and maintenance of ED thereby providing information as to where the therapeutic lens should be focused (relational dialogues) when working with this population and adds to the wider literature base on ED adolescents (White et al, 2003). □

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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 RPPs 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, err (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 uncertainty 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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Introduction

MEDICALLY unexplained symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory, structural, or other specified, pathology (Guidance JCPMH, 2016). They are a common reason for referral to liaison psychiatry services and form a significant percentage of patients seen in the General Hospital. Studies of hospital outpatients suggest that between 49% and 60% of patients still have no organic explanation for their symptoms despite investigations (Nimnuan et al, 2001). The overall cost to the NHS of treating these patients is estimated to be around £3 billion per year (No Health Without Mental Health, 2011). Symptoms may vary from short term, stress-related symptoms, which are likely to improve with education and reassurance, through to those with moderate difficulties who are still able to function in work and social roles, and to those with severe and complex difficulties. While there is some evidence that brief interventions in primary care (Edwards et al, 2010) and Cognitive Behaviour Therapy (Nezu et al, 2001) can be helpful to those with mild or moderate symptoms, there is little evidence of efficacy for therapy approaches in the more severe end of the spectrum or those who report little benefit from Cognitive Behaviour Therapy.

A recent commissioning guidance issued jointly by the Royal College of Psychiatrists and the Royal College of General Practitioners suggests a multidisciplinary approach for these patients, which should include General Practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy, with an emphasis on education and training of all staff (Guidance JCPMH, 2016).

In the absence of such a comprehensive team approach, we have been offering Cognitive Analytic Therapy as an outpatient treatment for those with complex MUS. Reasons for referral for CAT, rather than CBT, are that the patient has already had CBT, that they express a preference for CAT when both therapies are explained, or where there is a history of early neglect or abuse and the patient is able to acknowledge a possible link between this and their symptoms. Sometimes the first few sessions are carried out while the patient is still in hospital, with a view to engaging the patient before discharge. We report on the outcomes of a group of patients treated in this way.

The Usefulness of Cognitive Analytic Therapy (CAT) in Physical Health Settings

Cognitive Analytic Therapy is a brief, semi-structured integrative therapy which focuses on the relationship patterns that an individual has developed in relation to others and towards themselves. This idea, developed from object relations theory, is that early relationship experiences become the template for how the individual expects relationships to be and how they are likely to treat themselves. So, for example, a child growing up with very critical parents will be learning what it feels like to be criticised and to feel as though he or she is not good enough but is also learning how to be critical. This reciprocal relationship of 'critical to criticised' is likely to become a relationship pattern that they fall into both with others, and with themselves, and is likely to drive their behaviour. CAT therapy involves the therapist and patient exploring collaboratively which relationship patterns the patient tends to fall into and drawing these out in a letter and a visual 'CAT diagram'.

This diagram, or CAT map, becomes a tool for reflection, facilitating recognition of unhelpful patterns and enabling identification of new, healthier ways of relating. In working with physical and medically unexplained symptoms, the symptoms themselves may be able to be linked to certain roles or stressful feelings on the diagram. So, for example, the person who is constantly critical of themselves, and feels not good enough, may put themselves under extreme stress to perform perfectly leading to stress-related physical symptoms. They may then be unable to rest or pace their activity, to listen to their body and recover. As the patient starts to recognise these links they can begin to make changes to the way they manage their health.

The CAT approach to MUS is described in more detail elsewhere (Jenaway, 2011). One advantage of CAT is that it has not been designed for use in patients with a specific diagnosis. Therefore, it is not necessary for the patient to be convinced that their symptoms are medically unexplained. Many patients are unsure about the cause of their physical symptoms and are still hoping for a physical diagnosis. In CAT both explained and unexplained physical health problems can be explored in the same way, and the process of therapy is the same whether the symptoms have an organic basis or not. It is therefore also possible to use CAT when patients have a comorbid organic condition alongside suspected MUS (this is true for 20% of the patients referred for CAT in our department). In addition, partners or family members can be invited

to join therapy sessions to help them understand the patient's relationship patterns, and to think about how they might also be pulled into unhelpful ways of relating. This can be particularly useful where the patient is very cut off from their emotions. The model can also be used as a consultancy tool with staff teams who are struggling to cope with complex patients (Kellett et al, 2014).

Description of sample

Patients were referred to the therapy team of the liaison psychiatry department in Cambridge University Hospital by liaison psychiatrists assessing both inpatients and outpatients. We describe a series of consecutive patients treated by qualified therapists in the department with CAT. Additional patients with less complex presentations were treated by trainees, often junior psychiatrists who needed to take on a psychotherapy case as part of their training, or trainee clinical psychologists. However these have not been included as they were considered less complex at assessment, we are less confident about the quality of the therapy provided and data collection was poor. Over three years, 32 of those patients who were referred for CAT were seen by qualified CAT therapists, of which 28 were formally engaged in therapy. Of these 28 cases, 4 dropped out later in the therapy. The overall drop-out rate from CAT in our department has been reported previously as 27% (Channer and Jenaway, 2015). In that sample of patients, the drop-out rate was higher in patients seen by trainees than in those seen by qualified therapists, and higher in those travelling from outside the Cambridge area. This high rate probably reflects the practical difficulties of travelling to the clinic for those with MUS, as well as ambivalence, which we frequently see, about accepting a psychological therapy for what is experienced as physical problems. It is likely that more experienced therapists are more able to maintain the therapeutic relationship through the early sessions when the patient is still not sure that therapy will be helpful.

Of the 24 patients who completed therapy, 3 had incomplete data. Therefore, only 21 individuals (of whom only 2 were male) completed pre- and post-therapy CORE34 questionnaires, following an average of 17 sessions of CAT ($SD=2.42$). The CORE34 is a self-report questionnaire with 34 questions, designed for use as an outcome measure in any psychotherapy. Each question has a maximum score of 4, indicating high severity. Patients were referred from various departments in the General

Hospital, with the majority suffering from functional neurological symptoms or chronic, unexplained pain. As can be seen in Table 1, most patients had experienced symptoms for more than 2 years. Table 2 shows rates of previous psychological therapy, with just over half the sample of patients having had previous psychological or psychiatric treatment.

Table 1 Reported duration of medically unexplained symptoms

	Duration of symptoms		
	1 yr	2-5 yrs	5-10 yrs
Patients	7	8	6

Table 2 Reported historical psychological input

	Previous psychological treatment			
	None	CBT for MUS	Non-specific counselling	Multiple psychiatric input
Patients	9	6	3	3

Results

Overall, CORE34 scores fell from an average of 1.87 per item ($SD=0.77$) to 1.09 per item ($SD=0.60$). Jacobson and Truax's (1991) methodology was applied to the data, to identify the extent to which this difference represented an effective move towards more normative data (clinically meaningful index), and the confidence with which such a change could be attributed to factors external to measurement error or chance (reliable change index). As shown in Figure 1, the observed decrease in CORE34 scores represented a clinically meaningful change; post-therapy scores fell below the clinical cut-off mark (females=1.29; males=1.19; CORE manual). However, with a reliable change index calculated at 1.06 (using reliability co-efficients reported in Evans et al, 2002), this difference falls short of a statistically reliable change. The number of patients is small, but the change in average CORE34 scores in those who have had previous psychological therapy (1.79 at start to 1.21 at end, $n=12$) was similar to those with no previous experience of therapy (1.79 at start to 1.21 at end, $n=9$).

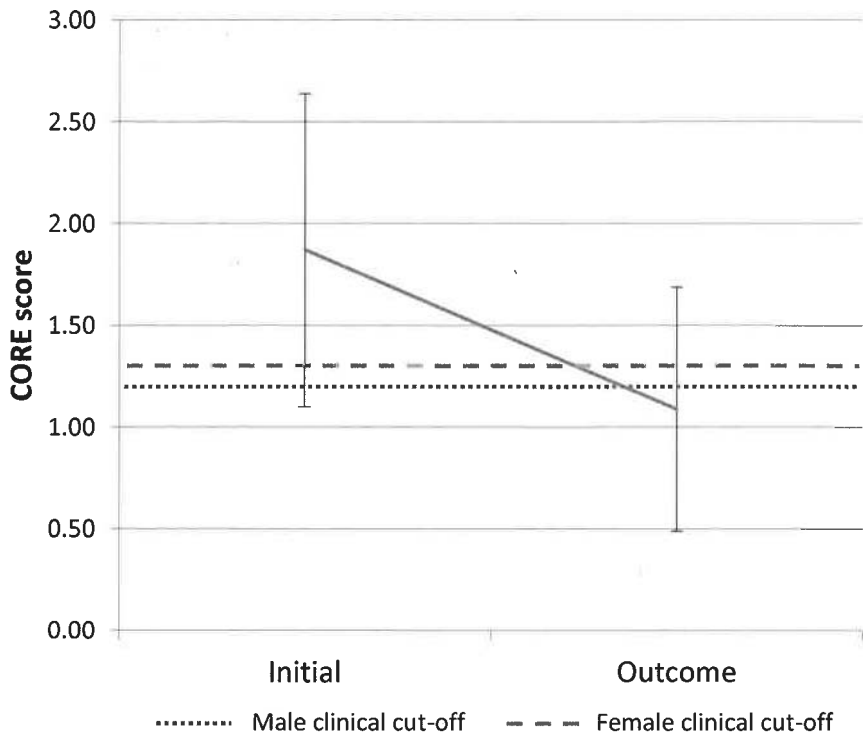


Figure 1. Change in CORE scores following CAT therapy

Discussion

We describe a service where it has been possible to introduce CAT as an alternative therapy model so that patients, and clinicians, have increased choice. This is particularly useful since many of the patients referred to us with complex medically unexplained symptoms report little benefit from previous cognitive behaviour therapy. Cognitive Analytic Therapy appears to be acceptable to patients with complex MUS and shows promise as an effective outpatient therapy in terms of reducing psychological symptoms as measured by the CORE34. One problem with self-report questionnaires, such as the CORE34, is that some patients with MUS show low scores initially. These patients have been described in the Health Psychology literature as ‘Repressors’ as they fail to report negative affect and appear to be out of touch with their feelings (Myers, 2000). These same patients sometimes report an increase in distress as therapy proceeds, as they get back in touch with warded-off feelings. This phenomenon may have reduced the average before and after differences in our sample.

Two of the patients reported here appeared to fit this description, both were female with severe physical symptoms and disability, but surprisingly low initial CORE34 scores (both scoring below 0.5 per item at the start). Neither had previous experience of psychological therapy, and both scored higher at the end of therapy, despite reporting it as helpful. Further research is indicated, using a larger sample and a randomised controlled design, with more objective measures of functioning included. Our intention is to start collecting outcome data using the Brief Illness Perception Questionnaire (a scale which provides a picture of the patients' cognitive and emotional representation of their illness) (Broadbent et al., 2006) as well as the CORE34.

In summary, we feel that CAT is a useful addition to Cognitive Behaviour Therapy in a service designed for complex patients with MUS. It offers both patients and the treating team a choice and may be more effective for those patients with significant history of early childhood neglect and abuse, and where problems in relationships are part of the clinical picture. Because the CAT model also provides a structure for understanding problematic relationship patterns, it is often helpful in assisting family and staff members in coping with the complex interactions which can occur with these patients. □

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Therapists' Experiences of Facilitating Cognitive Analytic Therapy Groups

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Abstract

Background: Cognitive Analytic Therapy (CAT) is an integrative relational therapy with psychodynamic and cognitive roots, subsequently transformed by Vygotskian activity theory and Bakhtinian notions of a dialogical self. CAT groups have been described as being successful, although there is a limited evidence base. This study sought to research the views and opinions of therapists involved with CAT groups.

Methods: Ten respondents took part in an online survey to answer the question 'what is it that you feel CAT groups offer and individuals gain that they don't from other psychological interventions?' Thematic analysis was used.

Results: All respondents reported positive outcomes from facilitating CAT groups, describing an environment of support and safe containment. This led to individuals being able to access deeper seated and more challenging aspects of their problems, allowing for 'real time' examples and active commentary on their problematic relational styles. CAT groups were described as a unique and rewarding experience for therapists and patients alike. Further research is needed and limitations are discussed.

Key words: Cognitive Analytic Therapy; groups; therapists; qualitative; relational

Introduction

Cognitive Analytic Therapy

Cognitive Analytic Therapy (CAT) facilitates the clinical integration of psychodynamic therapy and personal construct/cognitive psychology (Ryle et al, 2014). As a time-limited relational therapy with a focus on

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ending, it is applicable to a wide range of psychological problems seen in public mental health settings, and has recently been included in United Kingdom national guidelines for treatment of personality disorder in the NHS (Roth & Pilling, 2016). Its relational model of pathology well describes interpersonal facets of abuse, particularly disturbances of self, affect dysregulation and interpersonal behaviour (Pollock, 2001). It provides a coherent model of development and psychopathology (Ryle & Kerr, 2002). CAT's emphasis on joint activities and procedural thinking is helpful in working with patients whose motivation and insight are ambivalent (Denman, 2001).

Kerr et al. (2003) state that CAT is based on an explicitly collaborative therapeutic position involving the active participation of the patient. They argue that therapeutic change depends on a non-collusive relationship between patient and therapist, informed by collaborative formation of letters and diagrams and contained by a phased and time-limited relationship. This supports the development of CAT from Bakhtin's dialogic view of mental phenomena, which states we continually are exposed to dynamic, relational and ongoing re-descriptions of the world, which continually inform and are re-informed by experiences (Leiman, 1997).

Group therapy

Group therapies are gaining recognition in the NHS, reducing waiting times and reaching large numbers of people simultaneously. Yalom and Leszcz (2005) state eleven therapeutic factors which allow change within groups. These underlying factors include: support providing psychological glue which encourages risk-taking for self-disclosure; realising that imagined negative consequences do not occur; and the group suggesting new ways of feeling, perceiving and behaving (Yalom & Leszcz, 2005; Covington & Bloom, 2007).

This viewpoint is supported by an intensive Group Cognitive Behavioural Therapy programme, finding reduced anxiety, stress and depression scores as well as increased self-esteem (Parker et al, 2013). Dugas et al. (2003) also found that general anxiety disorder groups not only showed immediate improvement, but after a 24 month follow up were showing further gains, with worry and intolerance of uncertainty significantly decreased. Bastien et al. (2004) reported improvements in sleep for an insomnia group, again maintained at six months follow up. They argued that groups provide cost-effective alternatives to individual

therapy. However, group therapies have not been found more successful for social phobia, with Kingsep et al. (2003) arguing therapy effectiveness is diminished by delivery in a group format.

Clarkson (2003) proposed a five-relationship framework for successful group integration, including working alliance; transference and countertransference relationship; developmentally needed or reparative relationship; person to person relationship; and transpersonal relationship (Wright, 2010). This focus on psychodynamic factors and the interpersonal relationships is well supported. For instance, variables such as alliance and cohesion are associated with better results for patients after group therapy (Dinger & Schuenberg, 2010). Oei and Dingle (2008) state that as well as learning and receiving feedback from group members, peers may be a more valid source for people to receive challenges to irrational thinking, than from therapists. Modelling is likely to play a key role, with people who are functioning better on a given day being able to demonstrate adaptive strategies and encourage others (Parker et al, 2013; Yalom & Leszcz, 2005).

CAT group therapy

Although there is a limited evidence base, CAT groups have been found to provide advantages that individual therapy cannot, including reducing feelings of stigma, isolation and shame in sexual abuse survivors, with reduced symptoms of depression, anxiety and post-traumatic stress persisting at six month follow up (Sayin et al, 2013).

Ryle et al. (2014) argue this is due to its core relational grounding, with CAT well positioned to be applied to teams for formulation and practice. This is supported by Hepple (2012), stating as CAT is a psychotherapy based on relational understanding of human development, it has much to offer in groups. Caruso et al. (2013) reported CAT based training facilitates team cohesion and patient engagement, reducing burnout levels for therapists working with 'difficult' patients. Mitzman and Duignan (1993) also found that written and diagrammatic reformulation of patient's problems, when shared in the group, served to help the group process.

There is evidence of benefit for patients, including Duignan and Mitzman (1994). Completing a twelve weeks long CAT group with eight patients, they found the time-limited nature and use of sequential diagrammatic reformulations (SDR) resulted in early development of a high level of participative activity and commitment from both patients

and therapists. They reported that these factors accelerated the therapeutic process whilst providing an adequate level of containment for patients. Maple and Simpson (1995) found that group interpretations were facilitated by use of the SDR; where comparisons from the diagrams were explicitly drawn from dynamics between group members and 'real world' relational dynamics. Calvert et al. (2015) reported that, following a 24 session CAT group for female childhood sexual abuse survivors, experiencing high levels of psychological distress, participants showed significantly improved interpersonal functioning, lower anxiety and greater well-being, with only 19% dropout. It is important to note that the structure and process in CAT groups is variable, with some therapists constructing group letters and maps, whereas others use only pre-existing individual maps, for instance, which are shared.

The process of changing relational dynamics and procedural sequences can be challenging within a CAT group context. Although participating in and witnessing peers' experiences, can encourage others within a safe environment. However, there is still limited formal evidence to ascertain this.

Therapists using CAT

Hepple (2012) argues in order to manage the process of change, therapists need a great deal of 'agility', such as trying not to re-enact unhelpful reciprocal role-play and providing a human and authentic response to things that occur within the group. He states for patients with trauma, it is vital for both therapists and the group to contain any individual members in a trusting and mutually supportive environment before any technical work takes place (see Clarkson's (2003) developmentally needed therapeutic relationship). CAT's reciprocal roles are helpful in naming transference enactments and containing disturbance, which allow reflection and a quick return to therapeutic work (Hepple, 2012). Experiencing these processes within a group with peers can increase normalisation of individual experience and reduce stigma, allowing them to cope with the demands of the therapy and helping to accept their own feelings.

Containment and transference are challenging for any therapist working with CAT, particularly within a group setting. Furthermore, as with individual psychological therapies, group therapies may not be for everyone. Evidence for their effectiveness is relatively scarce compared to one to one therapies and the authors have found that groups are

often seen as ‘second rate’ clinical choice by patients. This is experienced across different psychological modalities, not just CAT. Therefore, more research into effectiveness, efficacy and processes of group therapies is needed to be able to compare them to individual therapies.

Rationale for the Study

As there is a limited evidence base for the effectiveness and efficacy of CAT group therapy, there is no measure for therapists’ commitment to group work. Qualitative research may be of more value, to examine the benefits of providing group therapy from those who have facilitated and experienced group processes and dynamics. This study used thematic analysis (Braun & Clark, 2006) to examine potential themes and patterns *a priori*. Thematic analysis also benefits questions in relation to individual’s views, experiences and perceptions (Braun & Clark, 2006).

From discussion with CAT therapists the aim of this study was to answer the following question – ‘what is it that you feel CAT groups offer and individuals gain that they don’t from other psychological interventions?’ This one question was open ended, with space for free text and the only question within the survey, apart from a section for any further comments.

Methodology

Participants

The respondents in the study were all members in the UK of the Association for Cognitive Analytic Therapy (ACAT), community practising or having practised CAT groups. Ethical approval was obtained and guidelines adhered to.

Procedure

A survey was established using SurveyMonkey and disseminated to members of ACAT via email through the ACAT administrator. The email and link explained the purpose of the study and the question to be answered. By accessing the link and answering the question, respondents were aware they had consented to take part and they had the opportunity to withdraw at any time. It was made clear that involvement was entirely voluntary and would not affect their association with ACAT in any way.

The researcher's contact details were included. If interested in participating, the individual then answered the question via the survey link, which the researchers could then access. Once they provided typed responses, the link took them to further information (also detailed in the original email) on who to contact if any queries arose.

Confidentiality

All participation was entirely confidential. The above process meant that all information was kept confidential with all responses being given respondent codes for identification purposes. As the question was in survey format and emailed confidentially to the ACAT community by the administrator, potential respondents therefore decided anonymously whether to participate. Thus, a consent form was not needed, as answering the question would provide consent to their taking part. Debrief was also not necessary as the study aims were clearly stated within the email.

Data collection

The email was only disseminated once, with no reminders. A leaflet containing the same details was disseminated at the ACAT Annual Conference in June 2016. Data were collected between April and August 2016.

Data analysis

Thematic analysis was used (Braun & Clarke, 2006), which identified key concepts and themes from the written data. Primarily, the researchers read respondent's responses and made notes about presenting themes. The responses were analysed by line, with key ideas and words highlighted. Repetitive ideas were then used as part of data analysis, informing the interpretation of remaining data and developing thematic categories. A coding scheme was developed, using In-Vivo to manage and retrieve the codes. These codes were amalgamated into categories, further discussed under results. Any results that did not fit the thematic categories were dismissed from analysis. The thematic categories were considered in relation to respondents' responses to provide a further level of analysis. Each response was read on multiple occasions so that once the final respondent submitted their results, researcher LS was confident that thematic saturation had been reached.

Researcher LS (a trainee clinical psychologist) conducted the coding and identification of themes. They were not involved in CAT groups nor have any formal qualification in CAT in order to limit expectations from overly influencing analysis. No triangulation of data was implemented.

Results

Overall, 10 participants responded. The email was disseminated to 850 members of the ACAT community who were on the ACAT mailing list. All responses were relevant and included in analysis.

From the analysis, 7 themes were produced, discussed below.

Accessibility

Respondents spoke of the applicability of CAT groups and how they are '*accessible and understandable to most people*' (respondent 1) and relevant to everything brought to sessions. They discussed how reciprocal roles unfold within a group dynamic and are more easily understood, as well as how more difficult aspects of reciprocal roles are often discussed.

Respondents explained CAT groups as fully understanding group members' stories, travelling well with each individual's story and allowing time for their narrative to unfold. Respondent 9 stated groups '*tend to be good at bridging between a process/analytic stance and a psycho-educational one*', highlighting that CAT groups are accessible and understandable.

Support

A shared notion from respondents was that group members were able to provide an experience that the therapist could not, often being more direct and frank with each other, helping identify problematic relational patterns quicker. The group format was described as allowing each member to support one another and to '*provide a language each can understand so they are able to then quickly learn to become their own and one another's therapists in the group*' (respondent 8). Using shared resources was seen as fostering this support, such as group reformulation letters, which offer commonality and universality. By being able to understand each other's relational patterns, individuals are seen as being better able to support each other. Respondent 9 stated '*people see others*

struggling with their [reciprocal roles] and procedures and are able to offer and provide exits and questioning to the group as whole'.

Safe

Respondents spoke about CAT groups being safe and containing, which facilitates group dynamics and allows individuals to discuss feelings that they may not have accessed in one to one therapies. Groups were described as having '*potential to provide participants with a safe emotional platform*', which leads to '*additional relational experiences from peers*' (respondent 4). The therapist was also highlighted as being a '*safe-enough container*'. By feeling safe, it was acknowledged that good rapport develops, contributing to changing problematic relational patterns. Groups were discussed as a non-threatening way to explore and understand dynamics and explore conflict safely.

Feeling safe allowed group members to '*provide additional opportunities for feedback to one another, noticing things the therapist may not and often saying things a therapist may not be able to say – often more candidly*' (respondent 8). Respondent 3 stated '*it feels like we get to the painful place using CAT which other models can take longer to get to, or feel clumsier accessing*'. It was argued that using a scaffolded approach provides a safe experience for people who find discussing feelings difficult, allowing them to achieve it to some degree and then know it is possible in the future.

The relationship between feeling safe and interpersonal awareness was considered, stating that CAT groups provide '*. . . a working model of thinking and feeling. . . grounding feeling in inter-relational experience, i.e. dialogue*' (respondent 10).

Relational

Being a relational model, respondents discussed helping individuals develop positive ways of relating to themselves and others. Relations were seen as '*instrumental to the therapy, perhaps more so than with other therapeutic modalities*' (respondent 4). Relational patterns were described as being triggered more quickly, more obviously and with a much wider variety. Groups were described as making problematic patterns explicit, so individuals could work with them openly and directly within the group. Respondents then felt group members could empathically understand origins of relational patterns, on an

interpersonal and intrapersonal level. Most discussed the versatility of CAT groups and how they are applicable to everything patients bring. They discussed the innate drive in people to connect with others, stating that groups allow individuals to connect with others, helping their intrinsic motivations and studying their reciprocal roles in detail. Respondent 8 cited:

‘Patients seem to understand reciprocal roles, and I’ve found that using [reciprocal roles] allows us to get to difficult aspects of a presentation in an easier way, e.g. being able to speak with patients about how their actions/reactions could be considered as controlling, abusing, neglecting etc.’

Respondents stated that group members trigger specific responses between one another, providing the opportunity to mirror and model positive relational styles. Being in a group was seen as providing new experiences relating to one another, even relationally isolated people.

The aspect of normalising was often discussed, with groups showing that other people also get caught in problematic patterns, allowing members to help shape themselves. Being able to observe and learn from others was seen as beneficial for the individual to apply to their own skillset. This included problematic and positive relational styles.

Observation

Every respondent spoke of the benefits of individuals being able to observe others in similar situations in order to benefit their own journey. The majority felt groups help facilitate self-observation and to witness their own interpersonal ways first-hand, to help encourage self-compassion and the inner self-to-self relationship, as well as a heightened clarity of understanding. Respondents stated that being in a group allowed ‘live’ examples to help facilitate understanding and practice traps, snags, dilemmas and exits in a safe space. They were called ‘*tangible and visual methods*’ (respondent 10), allowing reciprocal roles to be played out and changed.

Mapping

The majority of respondents referred to how mapping the individual’s relational patterns is particularly beneficial within a group format. By using a group map, more reciprocal roles were seen emerging, which were seen as ‘*making clearer the cyclical nature of people’s difficulties*’ (respondent 5). Respondent 8 stated:

'A CAT group also enables identification of patterns which may never have become apparent in individual CAT therapy because the presence of other patients and their personalities or ways of relating trigger specific responses in patients that would not have come about in a one to one interaction.'

By being able to map and provide letters '*provides containment and removes anxiety associated with a more analytical style group*' (respondent 9). Mapping was seen as allowing '*the more difficult to speak stuff to be drawn/written onto the map*' (respondent 6).

Beneficial for therapist

Several respondents referred to CAT groups as being special, rewarding and enriching for the therapist, creating a '*unique experience which is highly valued by attendees and facilitators alike*' (respondent 7). CAT groups were discussed as helping therapists in being agile and the importance of this, so as not to be drawn into and enacting unhelpful reciprocal roles with the patient. However, respondents believed that when this does happen, it is useful within the group context to map the reciprocal roles in the moment with others present.

Discussion

Results overview

All respondents were unanimous that CAT groups are of great benefit to attendees and therapists alike, providing a unique source of support and understanding. The findings suggest that CAT groups are able to help a wide variety of complex disorders to gain understanding of their difficulties, in a quicker, more relevant and less intrusive way. This can provide therapists with a clinically useful format to understand and approach a range of different problems in a group setting, being able to provide support for several people simultaneously. Notably, respondents highlighted that reciprocal roles were emphasised as they were played out more frequently and could be commented upon in real time. This is in line with previously discussed literature from Duignan and Mitzman (1994).

Themes

The accessibility theme links back to Yalom and Leszcz's (2005) therapeutic factors, specifically universality, which one respondent

referred to. Most respondents discussed the relational nature of CAT, which is increased in groups when more relationships are available to be viewed and learnt from. Literature previously discussed from Hepple (2012) on CAT being a relational model of human development supports this, as well as then also reducing stigma and shame within the group, which in turn accelerates the therapeutic process (Duignan & Mitzman, 1994) and fosters a sense of alliance and cohesion, all acting as active components for understanding. Maple and Simpson (1995) highlighted the importance of real life dynamics to be able to contain and act as references, which all respondents mentioned as a powerful therapeutic tool.

The supported and safe themes were in line with literature on the use of reformulation and collaboration, making individuals actively involved in treatment. This could be argued as an active component for understanding, developing a sense of control and fostering a sense of independence; one of the aims of CAT. Hepple (2012) also argued that being agile within groups allows reflection and a quick return to positive work to help accept one's thoughts. By being in a non-judgmental containing space, most respondents stated that this was allowed to develop naturally and encourage understanding.

Several respondents also discussed the theory of dialogism as a framework to understand relational patterns, highlighting the importance of examining in detail individuals' communications with one another. This is consistent with CAT literature, linking problematic patterns of behaviour and communication with a range of psychological difficulties. Respondents discussed how shared experiences and support can lead to more helpful and positive relational styles and the ability to internalise new relationship patterns. This is relevant, given the need to reduce waiting times and for the UK, and no doubt internationally, to have psychological therapies offered to people with severe and enduring mental health problems (Burke et al, 2015; Department of Health, 2011). Duignan and Mitzman (1994) support this, stating that CAT groups may be an effective and economical use of scarce resources.

Another key factor was the use of mapping as another form of communication. Respondents agreed that this provided a sense of normalisation, again linking to the relational aspect of their difficulties and allowing for more difficult patterns to be approached. It could be argued that mapping keeps up to date with relational patterns between group members. It is consistent with the notion of universality from Yalom's therapeutic factors, helping group members realise that their

feelings, thoughts, impulses and problematic patterns may not be individual to them.

This research appeared to be the first to acknowledge that CAT groups are beneficial and a special and rewarding experience for the facilitator. Several respondents noted their feelings of honour at being able to experience the dynamics in the room and witnessing problematic patterns being considered differently, with patients gaining understanding and self-compassion.

Implications and future suggestions

Currently, Cognitive Behavioural Therapy is suggested as the first line psychological intervention for the majority of adult mental health issues in England by the National Institute for Health and Clinical Excellence (NICE), which is also seen further across the United Kingdom and worldwide. This preliminary research, however, suggests that for more complex issues, CAT groups can often help individuals gain a thorough understanding of their difficulties, be able to discuss and formulate difficult and distressing problematic patterns, as well as providing real life examples to experience and observe what has been formulated. It could be argued that issues arising in groups can be thought through differently in group settings compared to individual work. This then provides the NHS particularly an opportunity for time-limited sessions with multiple participants.

Strengths and limitations

This study presents preliminary results for the support of CAT groups as a valuable and unique intervention for patients. It has been helpful in examining CAT therapists' perspectives on CAT groups, which is a currently untapped source of information.

As inclusion criteria detailed participants having experience with CAT groups, this inevitably reduced the number of potential respondents who were eligible for participation. It is a relatively homogeneous set of respondents, potentially influencing the results, as it could be argued from only receiving positive responses, that only those committed to CAT groups participated. Further research is needed with a larger sample size to assess both positive and negative experiences of CAT groups and with different cohorts of therapists.

Conclusions

This research has highlighted group leaders views that CAT groups are able to provide a forum in which to form supportive relationships, which individuals are then able to develop self to self, a greater capacity for self-reflection, leading to self-compassion. Results of this study suggest that CAT groups are a unique and rewarding experience for patients presenting with any mental health difficulty, as well as for the facilitator, giving a true and thorough understanding of their personal difficulties whilst experiencing examples in real time. This research is the first of its kind and drawn from a relatively limited sample. □

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The Emerging Psychological Trauma Paradigm: an Overview of the Challenge to Current Models of Mental Disorder and Their Treatment

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Abstract: Increased understanding of the widespread role of emotional traumas, especially those embodied early and pre-verbally as deeper, unconscious, procedural memories in subcortical systems, sets out a major paradigmatic challenge to both conventional biomedical and cognitive behavioural approaches (including those ostensibly trauma-focussed), as well as to more relational talking therapies. Neuroscientific and psychological research, in association with observational and epidemiological studies, has in recent decades documented the profound impact of early trauma through relational adversity, maltreatment, abandonment, emotional neglect and/or humiliation. This research is also beginning to document the mechanisms by which trauma processing approaches may be effective. It is anticipated that future psychotherapeutic work will increasingly be guided and informed by such understandings of the underlying neurophysiological processes involved in memory reconsolidation therapies. While there is debate about how much activation is required to make a memory trace accessible to transformational change through mismatch experiences, many psychotherapeutic approaches rely on the body components of trauma memories to facilitate engagement with re-experiencing and processing of the distress held in implicit learnings derived from emotionally powerful experiences.

Therapeutic interventions for severe post-traumatic disorders need to be longer term and often require detailed attention to the

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evocation and amplification of resources beyond the safe and trustworthy relationship with the engaged and attuned therapist. However, these additional resources should be seen only as a non-intrusive framework that allows the brain's organic healing processes to flow naturally to completion, erasing the implicit learning and associated disturbing affects at their source without modification of the autobiographical memory content. There are then fundamental implications for many existing therapies which, while stressing empathic attunement, collaboration, meaning making and emotional processing, can be seen to be failing to deal with the deeper, 'ultimate' causes of many mental health problems.

When employing transformational trauma approaches it is possible that 'therapy interfering behaviours' are less commonly encountered as the patients are motivated to engage with an aetiological perspective that gives hope of complete resolution of symptoms rather than simply the management of them and a temporary relief. It is readily acknowledged that relational, socio-cultural and existential factors may play a role nonetheless in important aspects of patient 'psychopathology', and that these will also require attention during therapy. However, actual 'erasure' of the traumatically-induced learned memory or schema which has been generating the emotional distress underlying the presenting symptoms offers a profound enabling of the Self in the process of healing; perspective shifts can then be endorsed through the juxtaposition of interpersonal validation, psychosocial support and encouragement. Trauma processing is certainly not a quasi-surgical procedure detached from issues of purpose, relatedness, meaning and existential significance.

It is suggested that undue and partisan acceptance of, and adherence to, the current dominant 'evidence-based' paradigm, alongside classification systems based in an atheoretical, syndrome-based nosology, is actively unhelpful in addressing such complex disorders, and skews our focus away from the need for active treatment of 'ultimate' causes of emotional implicit learning, such as events and interactions experienced as deeply traumatic. The implication of this is that numerous patients are likely to be suffering from potentially treatable trauma-related problems but are currently deprived of effective treatment. In this overview, the authors argue that the paradigmatic shift underlying the argument for the necessary transformation of integrated mental health services to meet the needs of individuals with complex post-traumatic reactions is a massive challenge requiring considerable research and service support, rather than the passive acceptance of the status quo or dismissal of innovation on the basis of a selective attention to limited and/or flawed research findings. Those responsible for commissioning of services may be concerned about the potential for an enhanced burden on services through the

requirement for longer-term psychotherapies, with the inevitable impact on waiting list targets and on the training of existing staff. However, to better meet the needs of severely traumatised individuals, obstacles to innovation, service development and treatment require priority attention if practice and services are to evolve to be fit for purpose.

Keywords: psychological trauma, neurobiology, psychotherapy, treatment, service provision.

IN RECENT years there has been an increasing recognition of the role played by, and the effects of, emotional trauma in a wide range of mental disorders – not simply those such as Post-Traumatic Stress Disorder (PTSD) that are overtly construed as resulting from traumatic events (Sara & Lappin, 2017). This represents a considerable challenge to conventional treatments of whatever modality but also provides an opportunity to improve the treatment offered to very many patients whose underlying ‘pathology’ is still not recognised, and thus to improve the quality of their lives. Deeper levels of traumatic memory formation – often related to early life experiences – are recognised as requiring therapy developments, e.g., the Early Life Protocol (Paulsen 2016) for Eye Movement Desensitisation and Reprocessing (Shapiro 2001), Lifespan Integration (Pace 2003), Coherence Therapy (Ecker et al 2014), the Comprehensive Resource Model (CRM, Schwarz et al 2016). Other body-based trauma therapies such as Sensorimotor Psychotherapy (Ogden & Fisher 2015), Somatic Experiencing (Levine 1997) and Brainspotting (Grand 2013) will also often find themselves dealing with symptoms whose ultimate roots are in childhood events. These therapeutic approaches all offer hope to patients struggling with affective and mood responses which have been there ‘for as long as I can remember’ without obvious explanation.

However, therapeutic innovation and developments which challenge the current dominant conceptualisations will struggle to obtain research funding, and perhaps initial publication, as without sufficient empirical support any reviewer will likely be negatively influenced by a different paradigm and novel conceptualisation. Thus many obstacles to the dissemination and implementation of innovative practice exist; the scientifically absurd circularity of the argument – that new therapy modalities cannot be researched because there is no evidence that they work – is not recognised as unreasonable. It is simply ‘the way things are’. It is telling that committed therapists working in an evidence-based

arena still seek out innovative practice and skill advancement when the therapies they are using are simply not effective for the patients in their clinics. Trauma therapy developments from creative, theoretically-sound, clinical expertise, however under-studied, arguably represent, through their insistence on attention to the healing of the 'ultimate' cause, a whole paradigm shift in the thinking about psychological symptoms, mental disorder and their treatment.

In this overview some background to this evolving paradigmatic challenge is provided, mainly through the lens of affective neuroscience findings relevant to deep traumatic memory formation and subsequent therapeutic involvement with the clinical sequelae. There are obvious and far-reaching implications for current conventional ways of working – both biomedical and psychotherapeutic. While this cannot be fully referenced in a brief opinion piece, nevertheless it is hoped that this overview will stimulate appropriate debate beyond the inevitable resistance from proponents of those models which have failed to deliver much-needed clinical benefits, despite their ostensible evidence base. Therapeutic developments – including those neuroscientifically based – need to be encouraged and embraced, although it will also ‘. . . inevitably mean that the techniques pioneered will be replaced’ (Corrigan & Hull, 2015). There is a great need for further comparative, long-term, outcome research, as well as research into underlying recovery and healing processes, and for the associated service developments, if clinicians are to carefully extend the range of therapeutic skills and modalities to better help those who are not responding to standard approaches.

The Neurobiology of Traumatic Experiences

The affective neuroscience perspective, applied clinically, emphasises the role of the basic affects in traumatic experience. Events get ‘stuck’ in the psyche when the rage, terror, grief, shame, horror and/or shock experienced in response to them are so overwhelming that they do not dissipate without leaving residual symptoms. It is recognised that emotional arousal enhances the creation of lasting memories; stress hormones acting on the amygdala being one of the mechanisms for this (McGaugh, 2013). Learning related to fear and safety that is guided by projections from discrete neuronal populations in the locus coeruleus to the amygdala and prefrontal cortex can have the discriminative functions disrupted by strongly aversive stimuli (Uematsu et al, 2017); another possible way in which trauma memories become stuck and

unresolved. It is argued that another mechanism for lasting implicit memory with resulting symptom formation is a failure to complete the emotional response when neurochemical dissociation is precipitated by a physiological state of the body so extreme as to be unsafe; then a neurotransmitter capping of the excitation is engaged (Corrigan, 2014b). Other mechanisms will include attentional re-orientations, of various types, that take the focus away from the affective overload, preventing completion of the emotional response at the time of the instigating experience.

Following Panksepp & Biven (2012), it is necessary not only to consider the upper level learning derived from intensely affective experience but also to attend to the origins of the basic affect generated in the midbrain periaqueductal gray (PAG) and hypothalamus. The earlier in the brain's development that the traumatic experiences occur, the less cortical regulatory capacity there is to modulate their impact. Trauma may lead the brain to modify its development so that the enlarging cortex becomes adept at suppressing awareness of emotions and body responses as is seen in the dissociative subtype of PTSD (Frewen and Lanius 2015). Some of that suppressive, or regulatory, ability of the cortex may diminish as years, or decades, pass, so that memories previously unavailable to everyday awareness begin to intrude as flashbacks, somatic pains and discomforts, and the individual's tenuous equilibrium is challenged by inexplicable changes in mood and emotional state. There is a sudden intrusion of terror, rage, grief or shame that is incomprehensible in the current circumstances and people who have been high-functioning are suddenly stricken with an inability to perform in their usual way. Triggers become active and the person responds to particular stimuli or contexts with emotional states that make no sense to them. There is then disruption of interpersonal relationships and occupational functioning followed by the prescription of medication for symptom relief without any awareness of the aetiology of the clinical presentation.

In extreme cases, where there has been disorganised attachment in infancy (Lyons-Ruth et al 2006) prior to severe abuse, there is amnesia for behaviours in the present, and these are seen as out of character by friends and family. The recognition of self-states by clinicians, erroneously considered to lead to iatrogenic fragmentation of the personality (Brand et al, 2014), is essential for effective treatment of severe complex PTSD (e.g. Fisher, 2017).

As suppression of trauma memories and their associated emotional and body states, however involuntary, becomes more difficult to maintain,

and flashbacks, nightmares, intrusive thoughts and images become more distressing, there is almost inevitably a lowering of mood and an emergence of anxiety. To ignore the aetiological factors, neglecting the art of formulation, and elect to treat for depression, even though it would likely not meet the criteria applied in drug studies of major depressive disorder, or an anxiety disorder, as if this is a free-floating state spontaneously generated by an idling brain, is not good medicine. It also represents a denial of the human cost of adversity and the long-term implications of this.

Perhaps it is easier for much of society to have a cultural dissociation from the harsh reality that trauma is emotionally painful – and the earlier the trauma the deeper may be the woundedness which presents polymorphically later in life. This is not to deny the benefits of symptom-amelioration approaches which can work quickly and effectively, at least in the short term, but to emphasise the need for alternatives if and when gains are not maintained or are followed by further deterioration. There is a need for research that examines the process of healing, its relationship to clinical outcome measures, to the individual's functioning and quality of life, and, crucially, to the patient's priorities in treatment.

Affect Regulation, psychopathology and therapist characteristics

‘ . . . (A) clash of psychotherapy paradigms can currently be seen, especially in the more severe disorders that present with a history of relational trauma and thereby a deficit in affect regulation. In such cases emotion more than cognition is the focus of the change process, and so CBT is now being challenged by updated affectively focused psychodynamic models. . . ’

Schore 2012, page 5

The key word in this quote from Schore (2012) is ‘thereby’ as it effortlessly links relational trauma with consequent impairment of affect regulation. In so doing it defines an aetiological factor that is seen as remediable by therapists using trauma therapies which embrace early attachment disruptions as targets for the healing of states of emotional distress. While the wonderful evolution of the human brain has conferred a limitless capacity for states of conscious awareness, there are many of these that provoke discomfort, dis-ease, discontent – if not more severe distress – when people *feel* that something is wrong with them. If there is no

capacity for emotional responsiveness to the contents of one's mind there will be no felt need to seek help in psychotherapy.

'Top-down' therapies that focus on thoughts and the responses to them nevertheless are aiming for a shift in the feeling of well-being, or the lack of it, even when they offer a curiously restricted range of moods and feelings to be considered dysfunctional, and avoid consideration of what feels good or not so good. The therapists engaged in these modalities for the treatment of, for example, anxiety and depression and the maladaptive behaviours associated with that one emotional state and that one mood state, may be themselves functioning in an almost entirely cognitive mode and have little perceived need for awareness of their own emotional responses and the accompanying body states. In contrast, psychotherapists expert in sensorimotor psychotherapy (Ogden et al, 2006, Ogden & Fisher, 2015) or somatic experiencing (Levine, 1997) or the Comprehensive Resource Model (CRM; Schwarz et al, 2017) require a deep level of attunement to their own level of body activation as well as to that of their patient. It could be argued that it is the blending of different foci of activation in the prefrontal cortex of the therapist that enables the distinction at a neurobiological level; those who are purely cognitive will have primarily dorsal and lateral prefrontal activations, while those who are somatically and emotionally attuned will be primarily functioning from the ventral and medial areas of their prefrontal cortex, in addition to those working memory areas required for theoretical analysis of constructs.

Schore (1994), who highlighted the role of the orbitomedial prefrontal cortex in the capacity for relational attunement in the infant-mother dyad, has stressed the differentiated role of the right hemisphere and how the implicit functions of the right brain develop in the skilled therapist (Schore 2012); and he amasses considerable evidence in support of this view. However, there is a need to consider not only right/left but medial/lateral and dorsal/ventral dimensions for the prefrontal cortex – and the cortical/subcortical for the brain as a whole. If the more ventral and medial areas of prefrontal cortex are engaged in multisensory integration, modulation of somatic responses, emotion regulation, and self-awareness, can a purely cognitive approach by the therapist have a deep impact on the affective valence of the self in the patient? It seems very unlikely. This would apply equally to those trauma therapists who strictly follow a protocol while having little engagement with the harsh emotional reality of the memories facing the person to whom the protocol is being applied – and indeed to therapists occupied only with cognitions

and behaviours as a result of their clinical training or because they cannot encounter and tolerate emotional distress in any other way.

One opposing argument is that if attachment disturbances can be resolved through imagery, metacognitive skills and collaboration in treatment (Brown & Elliott, 2016) – without a need to address directly the emotional pain of early attachment woundedness – that would indeed represent an efficient cognitively-based way to resolution in treatment.

A key question therefore arising from trauma therapies, and posing a challenge to them, is whether there can be full healing without the need to clear the body memories of the originating episodes, whether those are childhood abuse events, single event traumas (e.g. a road traffic collision) or attachment wounds. The impact of attempting to clear all the emotional pain at the brainstem level is that therapy can take a long time as more and more comes to the surface; although those with structural dissociation who work through self-states are often surprisingly rapid processors of years of complex abuse. The risk of working at the purely cortical level, whether through cognitions and metacognitions or through relational constructs, is that there will be a greater suppression of the trauma memories that are underlying. This promotes over-modulated dissociation of the type described in Frewen and Lanius (2015) and is likely to be of temporary benefit only, because it does not clear the core pain.

Affect regulation and outcome in therapy

If the basic affects encountered in traumatic experience, and in the therapy of it, are generated primarily at a subcortical level, is it sufficient to conceptualise them only in terms of the experience of depressed mood or anxious state? Computerised therapy interventions that have been shown to be empirically effective would appear to support this possibility. However, knowledge of the neural substrates of the capacity for affect regulation, and for a coherent and worthwhile sense of self, would counter that it is unlikely to occur in any long-term and/or meaningful way.

Hill (2013), who has developed the clinical implications of Schore's affect regulation theory, considers relational trauma to be the:

'cumulative effect of chronic misattunement, immoderate shaming, and repeated episodes of prolonged dysregulation that occur in

insecure attachment relationships during the critical period in development of the primary affect-regulating system.’

If one considers any traumatic experience, whether relational or less obviously relational (such as the result of accident, traumatic injury, earthquake, flood, war, etc.) to involve the basic affects of rage, grief and terror (Panksepp, 1998), in addition to shame (Corrigan, 2014a), then it becomes clear how traumatic experience of either a collective (disaster) or interpersonal type can overwhelm the affect regulation capacity of the individual. Developmental trauma is that which occurs through relational disruption in infancy and early childhood when the basic affective response exceeds the developing capacity of the brain to modulate it. The unresolved distress may be under the surface of conscious awareness but still gives rise to physical complaints, mood changes, unexpectedly triggered emotional and somatic responses, and a negative valence on the sense of self.

The re-humanisation of psychotherapy that is made possible with the integration of affective neuroscience imposes a duty on the therapist to be as aware as possible of emotional and somatic responses within therapy sessions. The therapist must be fully present and not triggered into their own dissociative response as a result of traumatic experiences that have not been resolved – the reason that therapists often need their own personal therapy.

The neurosequential hierarchy of brain development (Perry 2006) suggests that early relational experience is dominated by the somatic and the affective responses to evolving intersubjectivity, promoting the development of salient internal working models (Bowlby, 1969) that are affectively charged. The infant reacts primarily at a visceral level to vicissitudes in the caregiving provided, and is soothed through being held, nourished, cleaned and attuned to. It is necessary when exploring relational trauma which activates templates created through what was learned in infancy, for the therapist to recognise the somatic, visceral level of the distress and not be entirely caught up in high-level conceptual content.

The natural expression of the urge to attach in the newborn baby is immediately evident through the movement upwards on the mother’s body, resting in the skin-to-skin contact of the upper abdomen and chest, before seeking the nourishment of the breast. As the infant grows the urge to attach is still shown by proximity-seeking. When that urge is thwarted the obstruction of it is painful, as evidenced by distressed

vocalisations (Panksepp, 1998). To extend the observation as a clinical illustration, this thwarted urge to attach can be internalised as the individual's awareness of basic needs 'never' being met and that experience, later in life, colours the adult's view of the world, of other people, and of the self.

Although it might not be considered traumatic by some more cognitive practitioners, the pain of feeling that basic attachment needs are never met can be so overwhelming that dissociation from the agonising aloneness occurs as a neurochemical protection from over-stimulation of excitatory neurotransmitter systems. That pain is therefore unresolved and represents an unconscious trauma that has clinical effects across the lifespan. The awareness of unmet needs for attachment, originating in subcortical structures, may be compounded by the relational activation of basic mammalian affects – grief, rage, fear and shame.

The infant or older child may learn that the experience of being close is always accompanied by sadness when safe proximity is too brief and unsatisfying. Rage is aroused when the protest at the unmet need in an interaction externalises into anger at the other who is seen to be failing; this may manifest later in narcissistic personality traits. Fear occurs when the caregiver is abusive and closeness involves painful intrusions. Shame is activated with the sense of worthlessness that accompanies humiliating or punitive interactions. These deep experiences can leave a mark that is so fundamental to the individual that it may be seen later in life as a personality characteristic or trait.

Using the basic affect terms – seeking attachment, fear, rage, grief, shame – in therapy keeps the discourse at the level of affective consciousness while, neurobiologically, the therapist should be additionally and simultaneously engaging more dorsal and lateral areas of prefrontal cortex in evaluation of what templates for relational experience and interaction are being made evident.

Dissociation that is severe enough to result in the separation of self-states that is structural (van der Hart et al, 2006), often involving amnesic barriers, generally requires the dissociative response to have occurred first in infancy (Lyons-Ruth et al, 2006). The severity of the disorder is then determined by the extent of physical, emotional or sexual abuse in the first seven years of life, as this occurs on a template of dissociative defence, initially neurochemical, to overwhelming affect in the primary caregiving relationship. The affects involved are those mediated by the midbrain and hypothalamus – rage, fear, grief and shame. Corrigan &

Elkin-Cleary (in preparation) argue that shame is in a special category of evolved basic affect, usually requiring corticolimbic appraisal prior to a distinctive pattern of activation in the midbrain and hypothalamus determined by projections from prefrontal cortex. Self-states holding these affects – rage, fear, seeking attachment, grief, shame – enact the associated defence responses of fight, flight or freeze, attach, withdraw and hide.

The distress reduction of protective fight states may be achieved through tension-alleviating behaviours such as self-harm, substance abuse, eating disorders and less obviously 'dysfunctional' but nevertheless damaging actions in relationships. This last group of behaviours may include: interpersonal submissive, compliant, humiliating, angry, fearful, shaming, and/or grief-stricken interaction patterns that functionally endorse the relevant self-state to the extent that change may be seen as unsafe and therefore unwelcome. Strategies specific to the internal self-states, such as those found in Internal Family Systems (IFS; Schwartz, 1995), EMDR for early trauma (Paulsen, 2016), CRM (Schwarz et al, 2017) and other models, are then brought in to break the deadlock. Each self-state likely has its own prefrontal cortical profile with an affective content linked to the outputs to the amygdala, the hippocampus, the hypothalamus, and the midbrain PAG (periaqueductal gray). Neuroimaging studies of the dissociative subtype of complex PTSD demonstrate that it differs from the primarily re-experiencing subtype through activation in the medial prefrontal cortex; increased in the dissociative subtype, decreased in the re-experiencing subtype (Lanius et al, 2015). The medial prefrontal cortex has projections to, for the modulation of, the affect-generating areas of midbrain and hypothalamus (Price, 2006) – so these differences reflect the extent to which awareness of the somatic impact of the affects (integral to each self-state) is either suppressed or under-regulated. These deep structures and processes then have established templates for sequences of responses to relational adversities.

It is possible to understand these procedures, defined extensively for example in Cognitive Analytic Therapy (CAT), in terms of stored affective responses and their associated defence actions. This understanding facilitates therapeutic interventions, especially when the affectively-charged cognitions are paired with present-day mismatches as in, for example, Coherence Therapy (Ecker et al, 2014).

Affect regulation and therapist congruence

In effective talking therapy the collaborative and empathic therapeutic relationship underpins the conceptual analysis of the presenting problem and therefore offers the possibility of a multi-level attunement – if, in the therapist’s brain, the orbitomedial prefrontal areas for empathic attunement are simultaneously engaged with the more cognitive, working memory functions. Clinical conceptualisations that focus on narrative, existential, and diagrammatic reformulation likely involve more dorsal and lateral areas of prefrontal cortex in the therapist and could lead to the experience of intersubjectivity failure if done without attunement within the therapeutic relationship. That is, while these understandings may be valuable at a conceptual level for the patient through the involvement of self-related areas (Northoff et al, 2006) of the default mode network that are more autobiographical, there is also the potential for a loss of the empathic attunement that leads to greater learning within the therapy. The same can happen in trauma therapy that is conducted in a manualised, protocol-focused manner by a therapist who can allow little empathy for the person’s distress.

Mechanisms of healing

Therapy aimed at making sense of current difficulties and historic issues, or interpreting to the patient, is consistent with a long tradition in psychoanalysis and subsequent psychodynamic practices. The problem for many people is that understanding of their difficulties, while helpful, is insufficient for clearing the symptoms which they repeatedly experience. Gaining the insight that a somatic complaint could be an expression of repressed anger may clear neither the midbrain-generated affect with its sensitised responses to specific triggers nor the physical manifestation of it. Of note, in CAT an early emphasis on description rather than interpretation was held to promote the patient’s capacity for self-reflection (Ryle, 1997). Enhanced self-awareness through relational intersubjectivity in therapy, rather than interpretation, promotes reorganisation of the patient’s ‘implicit procedural knowledge’ (Stern et al, 1998), the area of the self, it is argued here, that is derived from emotionally-charged experiences.

Formal trauma processing work, especially with those who have structural dissociation from early attachment disruption and later abuse, has a life and direction of its own as the brain’s capacity for complex and

deep healing is engaged. It is therefore important that any focus on misunderstandings and ruptures within the therapeutic relationship does not distract from this process. In any therapeutic relationship, but especially when the work is longer-term, it is essential that patients have sufficient trust in their therapist, and the therapy itself, to continue in treatment even when the content leads to painful emotional states. This may also provide an experience of secure and boundaried attachment that is novel, beneficial, and potentially revelatory.

In formal trauma work such as with EMDR (Shapiro, 2001), for example, the aim is often to keep therapist involvement to a minimum while the patient processes the trauma memories. The therapist is non-judgemental, containing, boundaried, and respectful while simultaneously aiming to be an empathic support during the patient's processing of their trauma memories. However anything in the interaction that recapitulates an early experience of not being seen, not being listened to, or not being valued will interfere with continuation of therapy – although that itself may become a target for processing if acknowledged and worked with by a patient willing to continue with treatment rather than drop out.

To what extent repair of deep relational wounds can occur through the empathic attunement of the therapist during only a brief course of treatment is unclear. In CRM it is observed that deeply attending to, 'stepping into', the intense affect arising from the midbrain PAG and hypothalamus on return to the original trauma allows the deconsolidated memory to clear, with permanent erasure of the associated symptoms; meaning-making follows the physiological change rather than the reverse. While there are mismatch experiences through resources held on eye positions in CRM, the change in physiological activation, for example through altered respiratory sequences, when the distressing memory is active in the body's awareness appears to be sufficient to achieve complete clearing of the distress. We argue that the physiological mismatch, occurring almost immediately when the deconsolidation window of healing opportunity opens, leads to a re-orienting at a brainstem level followed by a new belief about the self which serves as the continuing schema variant. The memory reconsolidation literature (e.g. Ecker et al, 2014) suggests that erasure of the painful early experience would only occur when it was activated at an experiential level during the therapy session in which there is the juxtaposition of the affectively-charged, or affectively-neutral, mismatch experience. The deconsolidation period of neuroplasticity, of approximately five hours duration, requires a mismatch

to promote reconsolidation and erasure; the distress of trauma memories is not indelible.

Being with the pain of being alone, feeling it fully in mind and body, while simultaneously being aware of the presence of a caring, attuned other may provide the juxtaposition which erases the impact of the early adversity – if the young self-state that is carrying the woundedness is able to be fully aware of the present-day connection. The adult patient may be aware of the difference in present and past experiences without it translating to the young self-states holding the pain, thereby limiting the benefits. An individual with early life trauma and attachment disruption may be unable to quickly perceive the therapist as caring and attuned, or may instead experience any care as threatening or false. When the template has been laid down in infancy it can be difficult to access the core pain as there are likely to be accretions of dissociative and defence responses which need to be worked through first; this can take a long time.

For the relationship with the therapist to be seen otherwise will take time, experience and, perhaps, specific therapeutic work, although in modalities such as CRM the attachment conflicts are mainly resolved through the interactions of traumatised self-states with their attachment resources. In CRM the young self-state is helped to form a deeply attuned connection to an attachment resource whether that be one or more of an animal, spiritual being or natural element, before accessing the emotional pain. This resourcing allows not only the strength and support that makes access to the pain possible but also, simultaneously, is providing a mismatch juxtaposition that promotes healing.

In services which have rigid timescales for treatment and, therefore, a focus on ending therapy well within a fixed number of sessions it would be unrealistic if not contraindicated to aim to access the deepest relational wounds. Where circumstances dictate a strictly limited quantity of therapy the conceptual level understanding fulfils the requirement of providing an insight which can become more embedded as it is lived with. It can provide a validating understanding of how the person came to a particular way of being in relation to self and other, of how he or she has acquired particular meanings that are deeply felt as true.

When the patient is able to get to the originating memory, and its affective and somatic load – how can healing then occur? What is the essential mechanism of change? The dominance for some decades of the behaviourist paradigm made axiomatic that any change had to be through

exposure that prompted relearning, even when the therapy is disliked by a large number of therapists and the drop-out amongst patients is high (Corrigan & Hull 2015). Exposure treatment aims to drive new learning from the prefrontal cortex to the amygdala so that triggered responses are suppressed and cease to be troublesome, especially in contexts similar to that in which the new learning occurred. However, relapse readily occurs because the underlying emotional learning is not altered; some of the mechanisms for this are now being elucidated (Marek et al, 2018). When exposure treatments do lead to permanent change this benefit is incidental to the theory (of, for example, Mowrer, 1960, Foa et al, 1986), and occurs because erasure has occurred instead of the relearning in corticolimbic circuits that can be effective in the short-term, especially when the environment is no longer stressful or dangerous. The reconsolidation literature (e.g. Ecker et al, 2014) suggests that the exposure therapy must somehow have induced a mismatch prediction error which allowed the destabilised memory to be reconsolidated. Failing this serendipitous occurrence, under conditions of further trauma, or continuing perception of threat, the temporarily inactivated (through learning of top-down control) circuits between the prefrontal cortex, the amygdala and the brainstem are re-activated and symptoms recur.

Therapies such as EMDR and CRM which aim to get direct to the core of the index memory can be said to be aiming for erasure of the traumatic learning rather than new top-down learning, so that symptoms will not recur at times of stress. The brain's organic healing process will often find a mismatch during processing but the affectively-valenced preferred positive cognition (in the case of EMDR) or the New Truth (in the case of CRM) will have that necessary quality to ensure completeness of the memory transformation.

Psychotherapy can now aim for erasure of the distress of a memory underlying a clinical presentation – leaving the episodic or autobiographical memory fully intact – so anything less than erasure is short-term and incomplete. Erasure of the affective content of the traumatic experience means that symptoms are cleared permanently and will not recur in response to triggers, even at times of further stress. The deconsolidated memory has been challenged by a mismatch which erased the raw, unprocessed affective content. This does not involve behavioural exposure *which does not work long-term*; an unpleasant experience for therapist and patient – reactivating the distress but not leading to reconsolidation – which does not have lasting benefit, unless there is inadvertent erasure.

Erasure cannot be achieved without reactivation of the distress of the original adverse experience (alongside the mismatch experience as noted), so treatment inevitably involves re-acquaintance with the brainstem affects when the implicit memory is destabilized. These have left their mark by being overwhelming so it is necessary for therapy to be sufficiently resourced that dissociation or abreaction, in the sense of uncontrolled emotional expression that does not clear the core affective responses, do not occur and that healing erasure instead has the opportunity to complete. When schemas underlying, and making necessary, symptoms are explored, as they are in Coherence Therapy (Ecker, 2017) there is likely involvement of affectively-charged cognitions, presumed here to engage ventral and medial areas of prefrontal cortex, especially those which have outputs to midbrain and hypothalamus. Significantly, any schema that continues to have adverse effects has almost certainly been acquired through an experience of strong affect at its inception.

Memory reconsolidation in therapy requires not only the memory reactivation, or deconsolidation (the destabilised state), but a mismatch experience during the period of approximately five hours in which there is the neuroplastic susceptibility to erasure. Transforming the emotion generated by, and updating of the knowledge acquired at the time of, the original experience. . .

‘. . . retroactively changes the encoded personal meaning of the experience, which in turn changes the emotion generated by the incident as it now exists in episodic memory. Declarative, factual memory of the concrete happenings of course remains unchanged; it is the (semantic) personal significance and expected contingencies of those happenings that have been transformed.’

(Ecker, 2017)

Coherence Therapy stresses the importance of the change in meaning while CRM argues for a change in affective physiology and a brainstem re-orienting to the content of the memory prior to the change in meaning. Others argue for a new emotional experience during the period of arousal prompted by the reactivation of the significant memory (Lane et al, 2014). Although such debate requires empirical testing via brain imaging, and even molecular neurobiology, the key point is that erasure via memory reconsolidation is the aim in therapy as it leads to a complete and permanent loss of symptoms and an effortless non-response to previous triggers (Ecker, 2017). These changes mean that there is no longer: any emotional or autonomic nervous system response to previously troubling triggers; no behavioural manifestation, such as a momentary freeze, of

the triggered response; and, no recurrence or relapse of these changes with time.

It seems likely – from the observations in Coherence Therapy – that mismatches, at least for traumatic experiences, engage the prefrontal cortex-midbrain PAG-hypothalamus axis in the kinds of parallel circuits seen with the mesolimbic dopamine system in response to environmental changes (Reynolds & Berridge, 2008). Identification of the active ingredients of healing change and their brain substrates should, through the application of neuroscience to treatment, help therapists to direct their efforts in a more focused and targeted way. Some clinicians may attend more to the midbrain/hypothalamus end of the axis, and some others to the ventral and medial prefrontal cortex areas that project directly to the affect-generating subcortical structures. The former will attend to stepping into the affect while the latter will focus more on the affectively-loaded cognitions and schemas. The therapist in both instances will need to be attentive and emotionally attuned while simultaneously engaged with working memory theoretical constructs, but the multi-level involvement will be a testament to the creativity and complexity of the intrinsic healing processes of the human brain/mind self which it is often the privileged position of the therapist to observe and promote. Ecker (2017) writes:

‘The relevance of reconsolidation research findings to psychotherapy is potentially very great because clinical symptoms are maintained by emotional learnings held in implicit memory, outside of conscious, explicit awareness, in a wide range of cases, including most instances of insecure attachment, post-traumatic symptomatology, compulsive behavior, addiction, depression, anxiety, low self-esteem, and perfectionism, among many other symptoms . . . A versatile, reconsolidation-based clinical methodology that targets and reliably nullifies the specific emotional learnings maintaining such symptoms would revolutionize the field of psychotherapy.’ (Ecker 2017)

Classification without cause; diagnosis without formulation; symptom-management without hope

The cognitive-behavioural model of therapy (CBT) focuses on management of symptoms in the present with many therapists preferring to use cognitive restructuring rather than its own exposure techniques (Corrigan & Hull, 2015a, 2015b). A cognitive behavioural therapist working within twenty sessions may deal with an immediately precipitating event but

will be disinclined to look at the ‘ultimate’ cause such as early-life experiences of events and interactions which have been felt as deeply traumatic. These experiences during the brain’s development may be difficult to access and need treatment appropriate to the developmental level at which they occurred. That is, adversity encountered before full functioning of the cerebral cortex may respond less readily to cognitive restructuring and lead to the patient being seen as treatment-resistant or personality-disordered (Corrigan & Hull, 2015 a & 2015b).

There is also the biomedical model that considers psychopharmacology, and other physical treatments, to be the answer to any clinical presentation. Treatable aetiological factors are ignored, unlike in other areas of medicine, in favour of a symptom-based nosology. Rather than acknowledge aetiological factors for a post-traumatic disorder, the occurrence of traumatic events at all, or indeed the very presence of PTSD, proponents of the biomedical approach will favour any other ‘diagnosis’, such as anxiety (a symptom), depression (a non-specific mood state) or, where behaviours are viewed as hard to understand or ‘maladaptive’ they will assign the diagnostic label of personality disorder (a construct with little empirical utility in many clinical settings).

If this purely biomedical paradigm were valuable/valid the discrete categories defined would have specific pharmacological approaches which would be effective. This may be argued for some psychotic disorders but is not true of conditions such as PTSD (e.g. Gapen et al, 2016), and other trauma-related disorders such as Borderline Personality Disorder (BPD), for which drug treatments have very limited value in symptom-management; they are frequently used non-scientifically with the implicit justification that defined psychiatric conditions, which are, after all, described in carefully constructed nosologies, must respond to the currently available psychotropic drugs.

Rewriting the criteria for particular diagnostic groups does not appear to lead to any greater definition of, or rationale for, psychopharmacological agents that are effective or to a better understanding of clinicopathological correlates. Diagnostic biomarkers to guide drug treatments are not in sight and may not be appropriate in trauma-based disorders. Even an event-based case conceptualisation finds the formal categorisation of little help in getting to the index traumatic experiences and the pleomorphic impact they have left in the nervous system. Terror of abandonment in infancy may manifest later with depression, anxiety, obsessive-compulsive symptoms, somatoform disorders, physical illnesses, eating disorders, and other presentations – often co-morbidly.

All of these listed are effective in providing the way into the body memories and the associated affects.

It is impossible to know, because it has not been formally studied, how many of those whose symptoms do not clear with top-down management of their myriad symptoms would instead benefit from a deeper exploration of the origins of their distress. This is a major challenge for the future, as the economic implications of required service developments would be significant, perhaps a latent reason for such resistance to this. Socio-political forces drove the initial nosological acceptance of PTSD, perhaps those pressures will yet play a role in the acceptance (or refusal) of innovative and effective therapy approaches. When the way in is through the body memories rather than through higher-level interpretations or cognitions, it is the patient's lived experience, rather than the therapist's preferred modality or theoretical perspective, that directs the process of healing.

Prescriptive matching and patient preferences

Not all patients are able to be fully aware of their body's affective responses, and some may be unwilling to engage with approaches that require this. When the detachment from body experience is based in dissociation from abusive events in childhood any increase in embodiment is in itself a threat to feelings of safety and comfort. Many will be able to gradually reverse this disconnection in therapy but some will choose not to do so, perhaps, to give one example, because the opportunity presents itself at a time in their life when any destabilisation could be damaging. Progress during individual treatment of complex post-traumatic disorders is rarely linear (Frewen & Lanius, 2015) and patients can choose when to address certain pieces of the work. It is important that there is a range of options so that the individual can make a fully-informed decision based on their circumstances, their symptoms, and their aims in life and living.

Given a lack of training, experience and expertise, the clinician's assessment of trauma history severity is likely to be less than complete, especially when dissociative amnesia is a prominent part of the presentation; it would therefore be impossible to provide services according to a retrospective review of any prior consideration of the history of adversity. If services are provided for those with the most severe disorders of structural dissociation, the treatment programmes that are

then available can more readily adapt to clinical presentations that are based in experiences of adversity that have been less chronically and intensely overwhelming. Those who are most traumatised should be receiving the treatment they need rather than being dismissed as being 'personality disorders'. The brain defines its own level of traumatic experience by defending against the neurochemically, or otherwise neurobiologically, unsustainable; that is why there should be no dismissal by therapists of events that appear superficially to be less damaging. Breaching of the threshold for what can be experienced and assimilated is what determines the later ill-effects, not the manifest content or story narrated.

Conclusion and implications

There is great optimism experienced by patients and clinicians when new ways of working allow life-enhancing progress in conditions that have previously been resistant to treatment. Patients who have all but given up hope can be re-energised in their commitment to their lives when that which had previously been insurmountable becomes first manageable – and then ceases to be a problem at all. The importance of hope in those who have been chronically despairing cannot be over-valued but those colleagues and service leads who do not see the re-ignition of optimism may perceive instead prolonged and painstaking therapy that does not appear to be producing results fast. That perspective may contribute to an apparent reluctance to countenance long-term, body-based, trauma processing therapies.

This paradigm shift would have significant service implications if applied across a wide range of diagnoses, with neurobiological and relational factors therefore included within an aetiologically based formulation. Also, while there may be maladaptive relational patterns that are not based in early-life experience – and there may be higher-level cognitive learning /schemas and existential dilemmas that are not event-based – it is nevertheless striking how often the visceral response to expression of these leads back to adverse experience or 'ultimate' cause. Much depends on motivation to change, as some personality characteristics may be amenable to alteration through attention to their earliest expression, if the person is willing to address these. However, there may instead be a sense of justification in holding on to the traits, especially if it is perceived as others who suffer as a result rather than the individual possessing them.

Other ‘blocks to healing’ (Schwarz et al, 2016) can be identified and worked through before the core pain/ learning is addressed. This may also add to the time required for completion of the therapy; although removal of the blocks allows healing to be successful when progress could otherwise founder.

Treating the trauma of early disrupted attachment experiences can be lengthy and punctuated by periods of increased distress so not everyone will embark on it when given the choice, even when they start from a place of emotional embodiment. For some the realisation of the interpersonal impact of therapy may limit their commitment to it as the changes in relationships may be too much to cope with at once. Others may need to continue to dull their pain with substances, prescribed and otherwise, and will feel that the course of treatment is too difficult and/ or too protracted to commit to. Those who do decide to pursue the treatment will generally have an experience of deep change in early sessions that will give hope sufficient to bolster commitment to further work. The therapist’s knowledge that there is the unquestionable potential for significant long-term healing is also overtly expressed, along with acknowledgement of the difficulties. This openness furthers the collaborative engagement in psychotherapy which is likely a major factor with whatever modality is used. Hope of healing change in a long-term therapy makes for a low drop-out rate and that also has financial implications for health services unconcerned with the distant future of individuals.

Neuroscientific plausibility is an indirect source of evidence as it provides a rationale for innovative treatments for complex post-traumatic reactions, and the concept of what constitutes an evidence base must be expanded to include this (Corrigan & Hull, 2015a; 2015b). The authors accept there will always be an economically derived priority for rapid symptom reduction and limitation of therapy sessions (Corrigan & Hull, 2015a) but any approach for complex post-traumatic disorders must be neuroscientifically credible, and credible to the individuals being treated; they will all too readily know when the therapist, the conceptualisation, and the therapy approach are not aligned with their lived experience, or where the lack of attunement and resources make what is offered something to be feared and avoided rather than embraced – albeit tentatively at first.

Long-term outcome research – as well as research into underlying recovery processes (which the authors confess to finding very intriguing) – is essential, as are the necessary associated service developments.

Moreover, there needs to be support for the clinicians developing these approaches and those who carefully pursue the extension of the range of their therapeutic skills, learning new modalities to better help those who are not responding to standard approaches. Other areas of medicine specify when conditions are too expensive to treat, and it is then open to sufferers to lobby for change. One caveat is that the challenges faced by those with complex post-trauma conditions may preclude their own activism and require assistance through advocacy.

Covert decisions based in economic strictures are a disservice to those whose lives have been blighted by inescapable traumatic experience because the opportunity for change through open debate is denied. Therapeutic developments can bring hope into a clinical area often dominated by negatively-charged cognitions of aloneness, worthlessness, helplessness and hopelessness, making evaluation and further improvement a rich source of clinical creativity and optimism. Rapid treatment as early in life as possible could prevent decades of suffering for traumatised individuals and restore, or provide afresh, a quality of life hitherto unimaginable. □

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Reviews

The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma

Schwartz, L. Corrigan, F. Hull, A. and Raju, R.

Published Routledge (2016)

This book encompasses both a ‘comprehensive’ overview of the CRM model for the treatment of trauma developed by Lisa Schwarz and an exploration, largely based on the work of Dr Frank Corrigan, of the neuroscientific basis of its efficacy. This twin focus makes for a somewhat hybrid reading experience, as we move between neurobiological and clinical themes and implicitly different theories of the Self. However, both trajectories are rooted in what seems to me to be a highly significant development in our understanding of trauma and of the importance of working with it relationally. For the book adds

neurobiological heft to the growing evidence that what is now being recognised as Complex PTSD (as a diagnostic category distinct from PTSD) often has roots in early attachment trauma.

To oversimplify radically, the premise of the book goes something like this: the early trauma of attachment disruption is, by definition, faced alone. It therefore needs to be repaired within and by an experience of relationship, be that interpersonally – other-to-self (therapist to client) or intra-personally – self-to-self (a benign, imagined Other which supports a young part to step into its dreaded traumatic isolation and re-experience it from a resourced position, leading to memory reconsolidation and repair) – though, of course, it is not either one or the other but both. To coin a phrase, the therapeutic relationship is seen here as necessary but not sufficient. In this regard, and for all that there is a chapter devoted to it, it could be argued that CRM underestimates the contribution to healing of the attuned

relationship, which is sometimes described as if it were simply a platform of somatic attunement from which protocols can be delivered, rather than itself a source of reliability, regulation, mirroring and developmental repair. But this is no doubt because the emphasis of the book is on breaking new ground – on hypothesizing the role of mid-brain neurobiology in the experience of traumatic attachment disruption and arguing that only protocols designed to work specifically with these brain systems can be effective in its resolution. Whether what might be described as ‘neuro-therapy’ is the main objective of a healing relationship is open to question. But what is germane for consideration by relational psychotherapies is that these resourcing protocols are themselves fundamentally relational. This is perhaps why I found it possible to integrate CRM organically within a CAT framework rather than its being a useful additional tool for the middle phase.

A CAT practitioner for 8 years, I trained in CRM extensively over several years after surfing what felt like of a wave of developments in the treatment of trauma and in the neuroscience underpinning them. From Sensorimotor Psychotherapy, via EMDR and Brainspotting, I had found myself garnering a whole array of tools for trauma work for use in the middle phase of my CAT work. I found (and continue to find) that each has something to offer, but that none were the ‘magic bullet’ that each maybe claimed to be and none felt particularly coherent with a

relational model. In my view, this is because they do not address the fundamental issue of trauma in early attachment, or more broadly in formative relational experience, as the driver for what CAT might call dysfunctional but aim-directed relational procedures. CRM may not have or be the last word either, but this, its fundamental tenet, is at the heart of why addressing the material offered in this book is an important generic task.

From the outset I found there were natural affinities between CRM and CAT, both clinically and theoretically, especially given their emphasis on relationship, and that interplay between them could be mutually enhancing. This book might not be the most apt instrument for making that case, however, for the same reasons that my perspective might not always be welcomed within CRM. Like any new movement, it can seem more keen to emphasise its uniqueness than to acknowledge links and affinities with other models and in the book this comes over as what Harold Bloom once described as an ‘anxiety of influence’.

On the one hand, one writer (LS) acknowledges that the model is a synthesis of lots of experiences of and in therapy and healing and scrupulously acknowledges personal sources; on the other, there appears to be some difficulty with recognizing the broader matrix of clinical cultures within which this work swims – indeed, Colin Ross’s trauma model is asserted as the only influence on the work. Having embraced

the former, the latter does not make sense to me: I welcomed CRM as a magpie model bringing together – in a new synthesis and with enhanced neurobiological foundations – many tools from my existing kitbag. It felt like a kind of home-coming. From Gendlin’s Focusing (particularly when used to track and attune to somatic experience) to Leuner’s Guided Affective Imagery, with its roots in psychoanalysis and its affinities with some shamanic practices; from parts/ego-state/self-state work to ‘working with the frozen child within’; from the use of clean language to induce Ericksonian trance-like states to the involvement of the visual cortex in EMDR, the genius of CRM seemed to lie in its capacity to draw all these tools together in a way that gave them a more focused purpose and direction, viz. to serve the fundamental premises of CRM. These are as follows:

- that trauma in early attachment is at the heart of what the ICD 11 is about to distinguish as Complex PTSD and that it is also increasingly clear that this is likely to be the underlying cause of what are now classed as Personality Disorders as well as DID, DDNOS and DESNOS and other mental health diagnoses;
- that such trauma is stored in areas of the mid-brain which are not available to top-down reprocessing by cognitive approaches. This challenges the emphasis currently placed on CBT-based treatments for trauma. There is also a challenge to exposure therapy, this being an essentially behavioural

approach to what is now being understood in terms of brain chemistry shaped by and rooted in attachment trauma. The new hypothesis suggests that even consciously embodied approaches like Sensorimotor Psychotherapy do not reach the appropriate level of brain function, since the basal ganglia involved in sensorimotor responses are positioned above the mid-brain, including the periaqueductal grey (hereafter the PAG), where the hard-wired neural networks implicated in human survival responses are laid down.

These arguments are put forward very effectively in the chapters on neuroscience. While clearly addressing a learned neuroscientific magisterium, these are also written with an eye to a relatively lay reader. They set out their hypotheses and describe the neurological processes involved with welcome clarity for the most part. Occasionally the detail is overwhelming rather than illuminating as when, for example, the description of the brain activity underlying ‘Core Self’ turns into a complex list of areas of the brain that may be involved which does little to strengthen the argument for this concept and begs existential questions about it. But elsewhere the detail is invaluable and clearly clinically tested: from the further development of Corrigan’s award-winning work on dissociation to the detailed analysis of the neurological basis for using specific breathing

exercises, the work is persuasive and immediately useful. As I hope will be clear throughout this review, the neurobiological case for CRM is a significant contribution to the current debate on approaches to attachment trauma.

What is missing perhaps is a recognition of this wider debate and of other perspectives within it. Neurobiological sources are amply referenced (especially Panksepp, his research on hard-wired emotional systems being key to CRM theory), but the work of other major thinkers on attachment – Porges, van der Kolk, Stern, Damasio, to name but a few – is not discussed. The omission of Porges seems particularly significant: his polyvagal theory of social engagement maps similar areas of the brain and gives a socio-biological perspective on attachment and bonding. Furthermore, his explanation of vocalization would have underpinned the use of toning in CRM, to help new learning to become embodied. The intention is clearly to focus on the case being made for the importance of the mid-brain, but it seems to me that the effect is to denude the attachment element of CRM of context, thereby impoverishing it somewhat.

But perhaps that is to ask that this be a different book. The focus and task of the one before us is the necessary one of making the case for CRM and making its methods known. Other chapters almost exhaustively outline

all the treatment protocols which make up the core model. While the reader is warned ‘not to try this at home’ without proper training, the address nonetheless resembles that of a training manual, the purpose of which is to explain the ‘why and how’ of every permutation on the resourcing protocols, with menus, caveats, counter-indications and trouble-shooting given for each. This will, no doubt, be very useful, by way of consolidation and as an ongoing point of reference, to people who have done the training – and indeed the book has been welcomed with excellent reviews by members of the CRM family. But for the new reader I fear the wealth of sometimes contradictory detail, the unexplained language (Magic Question? Energy exit?) and the failure to address questions about the provenance of some of the tools (to discuss the terminology of Safe/Sacred Place without reference to its use in EMDR seemed especially odd) might be off-putting in different ways. And the teaching style is relentlessly homogeneous. There are no diagrams (clarifying the scaffolding and building blocks of the model, delineating the parts of the brain and their functions, outlining the processes of attachment disruption) and no actual case studies to illustrate and vary the pedagogical tone. More effective editing might have helped the writers see their material from the point of view of a beginner’s mind and make it more digestible.

But it is important not to allow imperfections in the text to diminish the dance of clinical intertextuality that can emerge from a dialogue between CRM

and CAT. Both emphasize the centrality of formative early relationship experiences – Reciprocal Roles in CAT – and the different valences of the sense of self ('self-states' in CAT, 'parts' in CRM) that are born out of these experiences. For similar reasons, both emphasize the importance of the therapeutic relationship and both work with the intrapsychic self-to-self relationship of the client. In CRM though, there is little or no emphasis on the current self-to-other sequelae of RR experiences, the premise being, I think, that people who have experienced a level of early attachment disruption that impairs their capacity to experience affiliation, will be healed when once the 'dandelion root' of this pivotal experience has been reprocessed and reconsolidated, with ensuing alterations in brain chemistry, and in the hormonal valency of the PAG in particular. This perfuses other areas of the brain leading to changes in experience, behaviour, interaction and the 'field' around the person.

I have witnessed shifts like this occurring in my own clinical work with CRM. Nonetheless, the lack of an explicit lens for exploring current procedures manifesting in self-to-other RRs is a weakness of the CRM model in my view. In particular, I notice that I often rely on CAT to build a collaborative hypothesis with a client, especially where the sequelae of early attachment disruption are such that the establishment of trust between therapist and client is the *prima facie* challenge in the work. Here the client's relational

'procedures' need to be identified, accepted and mutually agreed before any kind of 'treatment' can be consented. There is no substitute for the brave, risky work of gauging the ZPD and skilfully finding a way to name what is happening in the room. In these circumstances, a CRM therapist might advise jumping straight in and teaching breathing, offering a somatic or attachment resource, to begin healing the *sequelae* and their source as they present in the room. And sometimes this might be necessary as 'first aid'. But, for the most part, where I have begun CRM work without a reformulation and a map, without this documentation of an agreed understanding, I have found that the work can start to feel very complicated and rudderless, as we excavate different layers of experience and go from one CRM resource to another. Experience has taught me that shared documented reformulation is a better basis for the work than a therapist's inductive hypothesis, even when this is agreed verbally with the client. While this cognitive element to the work – especially one which documents insights achieved in and about relationship procedures – may not reach the mid-brain/PAG, it seems to anchor the vessel of the therapy while the working couple dive from it into the underwater world. It also maintains a focus on the here and now matrix of the client's other important relationships.

To stay with mapping for a moment, it is also the case, conversely, that CRM can enhance the focus and significance of what is mapped and the depth at which it is possible to work within a CAT framework. I am often mindful of and use Steve Potter's tripartite division of the map into:

1. the central area of procedural traps, self-state switches, snags and dilemmas which is 'chronically endured' but keep us safely out of
2. the lower depths of feeling that are 'desperately avoided' (what CRM, after Colin Ross, would call 'the truth of the life', the limbic experience of survival terror – perhaps, what CAT used to call the Core Pain) as well as preventing us from ever attaining
3. what is most 'desired'.

This description is mirrored almost exactly in the opening paragraph of the CRM book which articulates thus the profound 'trap' that is the legacy of early attachment trauma:

'The harsh reality is that the experience of a chronic, visceral state of fear blocks the capacity for love, which is the very thing needed to heal. . . What can be done to resolve the dilemma that only love conquers fear but fear prevents access to love?' (p.2)

CRM offers a series of protocols which can enable a client to 'access all areas' they have been precisely

'desperately avoiding'. By providing sufficient resourcing in neural loops running parallel to those storing traumatic material in the mid-brain, they enable the client to bring attention to, step into and articulate painful affective and somatic experiences and in doing so facilitate re-processing and repair. And there is emerging evidence of the efficacy of the precise and brain-relevant protocols of CRM in research by Ruth Lanius, recording fMR Imaging of brains before and after CRM sessions. To what extent other factors are at work in these neurological changes, and what these shifts in turn might facilitate, only carefully designed further research could determine.

While it is my experience that the model can indeed enable profound shifts, to claim that clients get 'cleared' in some final way also seems to me to over-egg the cookie. 'Neuro-therapy' alone cannot address the complexity of the human condition. As Porges, writing on social engagement theory, points out, we are all constantly exposed to difficult and shaming experiences in the hurly-burly of socialized living among other human animals. Rather than trumpeting an idealised 'ever-after' in which difficulties are excised, it feels more realistic to hope – with CAT and with Porges – for ever more profound 'exits'. A resource-full therapy, building new synaptic pathways, might bring what was hitherto 'desperately avoided' into the mindful purview of the Observing Eye, giving new perspective on familiar emotional responses, building resilience and enabling different choices. People might

still face difficult here-and-now challenges about problematic relationships, illness, aging; but the resolution of early attachment trauma might release them from the life-limiting trauma responses of submission, fight, flight or fear-driven attachments to bad objects and enable them to access other hard-wired neural networks, such as curiosity, playfulness and the positive seeking of affiliation.

This book might have its imperfections, its focus sometimes seeming laboured and narrow, but it is important to remember that pioneers who break new ground necessarily have a specific focus. It is perhaps for those who come after to see how what is discovered fits into a wider context. Indeed, in their conclusion, and in a change of tone, the authors acknowledge this and issue an invitation to their readers to develop the work further. I would urge practitioners of relational therapies (including CAT) to accept that invitation, integrating insights from this model of attachment trauma work into both their theory and practice. Experienced clinicians will already have many of the skills and tools

that CRM synthesizes and orchestrates in the service of resourcing, reprocessing and reconsolidation. And I hope I have illustrated here how the tools we use in an approach such as CAT already lend themselves to deepening our sensitivity to the out-workings of this kind of early trauma: perhaps they could be fine-tuned further in this direction.

In short, this book is a valuable contribution to the debate around the treatment of trauma and the recognition of its importance, and a strong argument for the importance of its taking place within a relational psychotherapeutic model.

Catherine Shea

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Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions

Johann Hari

Bloomsbury Publishing, Kindle Edition (2018)

This is an engaging and persuasive book written in a journalistic, detective story style with each chapter telling a good and bad science story within the larger story of medicalising grief, lack of meaning, connection and loneliness in life. Forty-three pages in, its author, Johann Hari puts his key question. ‘What if depression is, in fact, a form of grief – for our own lives not being as they should? What if it is a form of grief for the connections we have lost, yet still need?’ Having cast doubt on the scientific foundations of the bio-medical, big pharma driven link between a blameworthy depression gene, a hypothesised serotonin deficit and the effectiveness of anti-depressants the author tracks down expert evidence for eight areas where recovering relational connection (with worthwhile work, meaning, other people, inner self) might be a part of help with depression and anxiety. He cites one of his expert witnesses ‘How different would it be, she said, if when you went to your

doctor, she ‘diagnosed’ us with ‘disconnection’?’ (p160)

Johann Hari makes the story personal without losing sight of the science. He starts with his own misinformed, long term use of anti-depressants from his late teens. The first part of the book looks at what we might now call the fake news of a bio-based view of depression concluding with the loss of connection with life as the driver of the symptoms. In CAT terminology Hari gets off the symptom hook and looks at the wider psycho-social context. Along the way he picks up compelling allies of research here and there. ‘The medicalising of depression and anxiety as an explanation for feeling low and tearful with drugs and blaming your brain is an attractive and tidy story,’ Johann Hari says.

‘I liked this story. It made sense to me. It guided me through life.’ (p 8)

What is missing from the book’s promotion of reconnection as the cure is the deeper relational understanding, familiar to psychotherapy, that we can lock ourselves into narrow and damaging connections that become an ego-syntonic part of our personality or identity solutions.

Lost Connections covers the same territory as the more formally scholarly writing in this issue of this journal. It is a manifesto for a relational approach to mental health. It demands that we also

step out of individual psychology and psychotherapy silos and think afresh about what it is that links changes in the brain with changes in society (and vice versa). It explores how we can influence an innovative and open-minded approach to social policy that may help us address the epidemic of disconnection. The relational thinking needed to take this further is potentially already in the hands of therapies such as

CAT. Perhaps this book can serve as a wake-up call to see relational therapy as offering tools and understanding beyond the therapy room. A vivid encounter with his way of seeing things can be obtained from his TED talk

www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong#t-870191

Steve Potter

The Poet's Voice in the Making of Mind

Russell Meares

Published Routledge (2016)

Meares has written a book that is broad-reaching and ambitious in scope. He writes in a tradition of relational forms of therapy that pays equal attention to the scientific underpinnings of what we do, but also strives to understand the self and relationships in poetic form.

He developed a Conversational Model of psychotherapy, also referred to as Psychodynamic Interpersonal Therapy in the UK (Barkham et al 2017) with Robert Hobson in the 1970s. The Conversational Model (Hobson, 1985) focuses on the 'minute particulars' of therapy out of which a coherent narrative is gradually built as a co-construction between therapist and client. This makes it a sister therapy to Cognitive Analytic Therapy, which also focuses on a personal, co-constructed narrative growing within the therapy.

In this volume, Meares develops a recurring theme in his work over the last forty years – bringing together developmental psychology, language development, neuropsychology and anthropology with his other main passion of poetics. The word 'poetics'

may irritate some readers who see the word representing imprecise meaning, 'flowery' language, or a 'romantic' world-view. But, as we shall see later, it is part of a bigger journey to integrate Enlightenment and Romantic thinking that Meares takes us on (see Ellenberger, 1970).

Can we be rational and think through options with a client but also simultaneously be moved in a conversation that is bigger than either of us? It is to questions of this nature that Meares brings his formidable knowledge and personal experience.

Jaspers, in his great work on General Psychopathology brings into opposition the Erklären (Explaining) and the Verstehen (Understanding) Modes (Jaspers, 1963, pp 27-29). He asks what gives us the tools to understand another person from within, whilst also providing connections to help to explain a shared narrative? Meares is ambitious in this book in trying to synthesise these very different world views.

These are big questions to be covered in a short volume and I hope readers will give a little slack when faced with such condensed writing. As Alice said after hearing 'The jabberwocky':

'Somehow it seems to fill my head with ideas – only I don't exactly know what they are!' (Carroll, 1872)

This makes it a demanding but invigorating read!

But, without seeing this bigger historical context the book may seem to be just a collection of essays. Even at that level, though, we can choose items of interest from a wide conceptual landscape and enjoy them – or sometimes feel mystified, or irritated, by them. However, this volume has a wider purpose – it is the integration of some profound ideas about what makes us human and what can free us to become reflective, image-making, creative persons, and it is worth the effort to try to follow Meares' complex chain of connections.

A unifying theme through the book is the development of the proto-conversation and how this extends into play and the development of a reflexive self. This is true of child development, but, by analogy, it also resonates with how therapy brings about deep change. Meares does a remarkable job of drawing together these disparate themes. At times there were so many plates spinning that I could not see how he could successfully bring them together into a coherent whole. That he does so is a remarkable achievement. It makes for a book to savour and return to, following the complex connections made.

It is not an easy book to summarise, but it can be seen as pulling together Meares' long-standing fascination with the development of the self within a relationship and here he will share ground with most readers of this journal.

Unlike his earlier works, there is relatively little direct clinical material,

but what is there illuminates his ideas well. The main case study comes in the final chapter. Through a series of parallel connections a trainee therapist makes sense of some puzzling somatic symptoms in a middle-aged woman called 'Julia'. She refers in passing to modern architectural design and talks of 'being cramped into little boxes'. The therapist responds by saying simply, 'Not to have that freedom to sort of soar up and out'. She draws attention to the opposite state by analogy, and is using Vygotsky's inner speech in which a child 'tends to leave out the subject and all words connected with it, condensing his speech more and more until only predicates are left. . . promoting what Piaget called 'an atmosphere of communion', a feeling of connection. (page 188).

Meares draws an analogy with speech 'face to face' like a form of questioning contrasted with speech where both are approaching something side by side gazing together at a third space he has likened to 'an empathic screen'. Julia becomes more energised as there is a sense of 'fit' between the personal inner element of what she said and the jointly constructed analogue. She shifts the metaphor to 'a more spacious place' – in her imagination drawing together her imagined room, the actual room they are in, and a metaphorical room where there is space to breathe. The space opens up between the two

protagonists, giving freedom to explore Julia's distressing symptoms. The symptom of itching around her midriff arose in the context of problematic relationships culminating in an assault where an older, obese man had bumped into her deliberately 'thrusting his abdomen into hers in an intimidating way' in a stairwell.

Meares explores the new connections that therapist and client make – he does not reduce the symptom to what the parallel experiences 'mean'. He draws the connection with Hobson's key paper on 'Imagination an Amplification in Psychotherapy' (Hobson, 1977). The example is extended through a series of metaphors as Julia and her therapist explore smaller and smaller spaces 'like Russian dolls', and through this the client with the support of the therapist sees the emergence of her personal myth. It is a pity that the book has relatively little space for such examples.

There is much in this book to interest CAT enthusiasts – from Meares' perspective I suspect that CAT is another way of understanding at a deep level the personal conversation that we call psychotherapy. Specifically, Meares draws on familiar material from Vygotsky and his idea of the ZPD and the therapist providing 'scaffolding' around which an emergent relational self is built (See Ryle & Kerr, 2002). He points out that as therapy develops the

linguistic complexity of the conversation deepens, as common meaning develops.

Where Meares is particularly strong is in capturing the idea of 'little emotions' – subtle feelings for which there may not be words (citing Wood Jones, F. 1931). If these fleeting ideas are not recognised and picked up as the 'minute particulars' of human experience they will 'wither and shrink to the bottom of consciousness'. He captures the spirit of this with reference to dialectal speech:

'Children are especially good at capturing these words like 'creamy' in Berkshire dialect to evoke the feeling of squeezing a baby or fat cat.'

My reaction to reading that is to feel that purring fat cat or the softness of a baby, and grasp in a visceral way what the children mean by a 'creamy' experience. Little emotions are not trivial or faint echoes of coarser categories [like anger] but a different, multi-faceted type of experience (p70). From these multiple micro-experiences and shared language grow a sense of self.

Meares turns to the nature of Myth (see Ch 9, pps 101-118) in an extended diversion into the nature of transmission of ideas in wider culture, but links back to Jung's idea of finding one's own myth:

'After the parting of the ways with Freud, a period of uncertainty began for me. . . I had not yet found my own footing. so in the most natural way I took it on myself to get to know 'my' myth and I regarded this as the task of tasks' (Jung, 1967)

In therapy settings, especially where the primary problem is a disruption of the sense of self. Meares states,

‘The personal myth is a story which has never been told before, created in a certain kind of conversation (see p 187). . . a dynamically evolving personal myth is created that in most cases is unconscious. In the therapeutic situation it typically appears out of an initial state of low complexity and the conversational style of a chronicle, which is a mere catalogue of events, a state of stimulus entrapment. (Meares, p185).’

This fragile, emerging personal myth can then be the seed for a growing sense of self, but it can also trap therapists into premature interpretation which can be experienced as persecutory as the therapist rushes to complete the dots and ‘finish’ the story (See Hobson 1971, Meares & Hobson, 1977).

The book begins by extending his earlier work on conversation and the development of the self. This is a theme that Meares has developed in different ways over many years (see Meares, 2000, 2005), and he extends his description of the development of the duplex self, drawing extensively on the work of William James. ‘I’ have awareness of ‘myself’ in a flickering, shifting, but continuous set of experiences. Meares draws particular attention to the key stage in development when a child can ‘keep a secret’ and in so doing shows awareness of an inner world that can be revealed or hidden from others. This is of great relevance to therapists because great damage can be done by failing to

see when someone has to hold on to a secret part of the self or else risk feeling retraumatised. Meares does not have time to develop this important clinical theme, unfortunately, but it has been described extensively in ‘Intimacy and Alienation’ (2000) and ‘The Metaphor of Play’ (2005).

Intrinsic to the idea of a shared conversation is an understanding of the musicality of human speech, to the minute particulars of rhythm, contour and intonation (page 69, citing Communicative Musicality, Malloch & Trevarthen, 2009). This parallels the rhythmic dance between mother and infant: It has a musical quality – the shape and quality of the musical contours is not coded as precise trajectories and vectors but as a whole shape which is internalised and can be generalised. The key theme in this part of the book is learning afresh how to listen in a developing conversation and not assume that we know what is emerging into the shared space.

There is then an extended detour into the brain-science basis of self, and into the connection between proto-conversation and the development of myth, never losing sight of the central theme of the ‘poet’s voice’ as the expression of meaning. This is a rich exposition, but highly condensed.

Meares draws on the work of established poets to illuminate how

we can recognise the poetic in everyday language as it passes us by. He gives an example of William Hazlitt, the English writer, painter, social commentator, and philosopher, who remembers himself as being a ‘dumb, inarticulate and helpless’ youth.

Why does Meares choose the example of Hazlitt? I suspect it is because Keats’s writing, particularly his key idea of ‘negative capability’ – a key concept in modern psychotherapy – was influenced by the concept of ‘disinterested sympathy’ he discovered in Hazlitt. Meares expertly disentangles these subtle concepts from the example of Hazlitt and ventures beyond literary criticism into the fundamentals of psychotherapy:

‘Personal transformation of a kind akin to that described by Hazlitt comes about by means of a language having the combined structures of familiar conversation and the poetic. It can make analogical representations of inner states that create a feeling ‘fit’, for the listener, such as Hazlitt seems to have felt [when] it left him exultant.’ (page 59)

Hazlitt describes this change point when he heard a sermon being read and began to listen to the cadences of the last words – how they rose and fell and the ‘shape’ of the sounds, and in discovering his own latent language he was able to feel free, ‘. . . that my understanding did not

remain dumb and brutish, or at length found a language to express itself I owe to Coleridge. . .’ who extended Hazlitt’s emerging sense of the poetic in speech (p57).

Meares describes the rhythm and music in conversation,

‘The transformative conversation is one of feeling. It is not *about* feeling but feeling is in the words. To the degree that this form of conversation expresses and evokes emotion, it is poetic. This is not to say that weeping, raging or laughing are poetic expressions. These are uni-dimensional affects [rather than feelings]. The particular kind of conversation that brings about an enlargement of a personal state of existing is one in which a latent complexity of feeling is realized. . . it is as if mankind has devised a special way of representing and so bringing into being the complex feeling states that are at the core of higher order consciousness.’ (page 61)

Meares draws an analogy with the world of psychotherapy saying that for some forms of poetry the poet only discovers what the poem is ‘about’ through writing as a form of discovery,

‘The effort to find the right words and how they should be said, is towards a representation of the half-known or barely known state in order that it becomes more fully known (page 63).’

This reminds me of Stiles’ work on assimilation:

‘The assimilation model

conceptualizes psychotherapy outcome as change in relation to particular problematic experiences—memories, wishes, feelings, attitudes, or behaviours that are threatening or painful, destructive relationships, or traumatic incidents – rather than as change in the person as a whole. It suggests that, in successful psychotherapy, clients follow a regular developmental sequence of recognizing, reformulating, understanding, and eventually resolving the problematic experiences that brought them into treatment.’ (Stiles, 2002)

Problematic ideas shift through stages of being warded off through painful experiences, gradual apprehension, ultimately to mastery. Meares speaks to this process from a different perspective drawing heavily on his work with trauma, and focuses on the (re-)integration of the self as a central component. His Conversational Model is perhaps at its strongest in coaxing into being a warded-off idea and bringing it into a shared space where it can not only be tolerated but built upon.

The building process relies heavily on use of metaphor – literally the carrying across of meaning – to form a key aspect of Meares’ conversational approach to therapy. Elliott and colleagues (1994), used a fine-grained method called Comprehensive Process Analysis to explore how change occurred in different modalities of therapy – the exploratory therapy examined was the Conversational Model where change often focuses around a simple organising phrase or word which carries a huge

amount of shared meaning. As Meares points out, such a metaphor is not a simple analogy; it is a formative symbol which can be amplified to become part of the therapeutic scaffolding to hold a conversation together across time.

Meares lives comfortably in these two atmospheres of reasoned scientific enterprise, and human conversation having the strange emergent property of the poetic. The conversation in the book begins with the creative tension between the Romantic and the Enlightenment at the start of the 19th century. Hazlitt’s absorption with the precise way language is used comes back as a key theme that Meares develops in a 21st century context. The ideas run through the development of the Conversational Model in this book. They embody the difference between a formulaic therapy and one that pays attention to the particulars of the relationship – not just as the vehicle through which information is transmitted, but as the fundamental basis for therapeutic change. This book will appeal to any therapist interested in the minutiae of how people change.

Frank Margison

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The Clinician's Guide to Forensic Music Therapy

Stella Compton-Dickinson and Laurien Hakvoort

Published Jessica Kingsley (2017)

This Guide presents manuals for two music therapy interventions, Group Cognitive Analytic Music Therapy (G-CAMT) and Music Therapy Anger Management (MTAM), set within a Cognitive Behavioural Therapy (CBT) frame. Music therapy practitioners will benefit from a book that contains the practical resources for two contrasting models, and draws upon forensic experience in both the UK and the Netherlands. The models are presented in one volume to promote an appropriate choice for specialist care teams; G-CAMT aiming to create positive change in relating to others, and MTAM aiming to change dysfunctional and impulsive anger behaviours.

The passion and commitment of both authors to develop these interventions is present in the first chapter, laying out the rationale for music therapy in the challenging context of forensic settings, and in the latter chapters, the Guidance for Clinicians and the Epilogue. Elsewhere the book strikes a practical note as a manual for practice, creating in places a flat tone, missing the richly textured orchestration that has no doubt informed the models and perhaps could

have been conveyed through more detailed vignettes and case studies. I also would have liked to hear the voices of these models in dialogue, actively engaging with and critiquing the two models' aims, methodologies and the demands upon the clinicians. It would also have been interesting to hear how patient experiences, in voices and in music, influenced the development of both models. The attention to the patient is reflected in the production of guidance handouts for patients for the different stages of each model and these have stimulated my thinking around how we communicate the therapy process.

I appreciate Compton-Dickinson's work to develop and articulate an extension of the CAT model in this domain. Music therapy, individual or group, offers participants the opportunity of shared, purposeful activity, and the integrating translation of non-verbal interactions into verbal insight and therapeutic gain. Trevarthen has written extensively on communicative musicality, and parallels the exchanges with music therapy with mother-infant communication and jazz improvisation (Schogler & Trevarthen 2007). I enjoyed Compton-Dickinson's description in this volume of the versatile skills needed by the music therapist, '*so that jointly-created musical*

improvisations can be aesthetically pleasing, yet subtly felt to be the creation of the patient within the therapeutic relationship' (p20). As a non-music therapist I recognise and share this challenge. How can we employ our skills to 'improvise' in both senses of the word, to allow and to reap from our spontaneous responsiveness in the moment and to creatively adapt the materials available to the task in hand? We are at our most potent when we join with them in the shaping of their material, building the self-agency of our patient.

Self-agency here refers to the idea that we can influence our physical and relational environment, that our actions and intentions have an effect on and produce a response from those around us, psychological and physical (Knox 2011). It is a key concept for forensic work. Both authors are clear that the aim of music therapy in this context is the reduction of risk and impulsive behaviour and hence reduced recidivism. They do not shy from the challenges posed by the need to create safe structures for this to take place with a forensic patient group.

Herein lies a difficulty of the book. Whilst one might imagine that the CAT model provides a good theoretical and methodological basis for a music therapy, with shared activity and collaboration at its heart, it is the manual for the MTAM CBT model in Chapter Three that conveys

the greater sense of a structured intervention and a scaffolded and safe expansion of the emotional repertoire and regulation of the patient. In this model I enjoyed the structure of developing an awareness of the affective impact of music through the mapping of musical polarities in Appendix 3c, and the way that building competence in tension regulation through music is explicitly linked to outside events using the Anger Management Questionnaire (3b) and Stress Gauge Sheets (3d). This resonated with the conclusions of the very readable and CAT-friendly, although not explicitly referenced, 'How Emotions are Made' (Feldman Barrett 2017). Developing our embodied sense of and our repertoire of words for describing emotions is crucial for the development of affect regulation and relational flexibility. The MTAM model is highly structured and scripted, which will provoke a mixed response, but as a non-music therapist I had a strong sense of the aims, methodology and intended outcomes.

In reading the corresponding chapter on the G-CAMT model, the CAT-inspired music therapy model, I could see more clearly a challenge I recognise from my own efforts to describe embodied methodologies in a CAT frame. In that field, models of trauma therapy have delineated protocols with stages of therapy that can too easily be critiqued as mechanistic and monologic, but nevertheless hold appeal for clinicians seeking containment, clarity and transparency, for themselves and their patients.

Compton-Dickinson outlines a four-stage model (Mindfulness, Emotional Regulation, Distress Tolerance and Interpersonal Effectiveness, titles shared by modules in Dialectical Behavior Therapy). I share Compton-Dickinson's understanding of how engagement in a shared activity and reflection upon the mutuality and subjectivity of these experiences promotes deep self- and relational understanding and contributes to interpersonal effectiveness. Where I feel we part company is in the articulation of this into a staged model. I experience these as iterative processes beginning in the very first encounter. I would value a description of our methodology that describes the particular tasks of the beginning and end of therapeutic processes, and a middle process that more accurately reflects in the lived process of therapy.

In a culture of manualisation, crucial to research, we are challenged to provide clear and transparent descriptions of our methodology to clinicians outside our modality, without losing the essence of our model; our willingness to enter into and reflect upon the improvisations of the relational encounter. As a profession we may be nudged towards manualisation and staged therapies through pressure to provide informed choice for the consumer-client and the consumer-commissioner. Is this a defence against the anxiety of not knowing what might happen next? The linguistic root of improvisation is the unforeseen. In relational therapies we create safe space for the unforeseen, and our shared attention is the '*catalyst for*

dialogue, training, thinking and reflecting' (p18). Compton-Dickinson is ploughing a fertile furrow here. I welcome the challenge for us as a community to find new ways to express the richness and potentiality of a relational approach, which might unfurl and digress from a formal staged approach.

Compton-Dickinson has also chosen to present here a group modality of relational music therapy, without perhaps fully articulating the advantages and challenges of a group approach within a forensic music therapy setting. She advocates a period of individual therapy prior to assess readiness for and to prepare for G-CAMT. She also outlines principles of group therapy as they apply to G-CAMT and the particular contribution a group modality can make to the awareness of self-in-representation and a heightened respect and tolerance for other-ness. I missed the link between these; how is a patient in individual relational therapy assessed as ready for a group intervention, and how can we assess the relative gains and losses of a transition to group intervention? Examples that demonstrate the potency of group therapeutic moments might have brought this to life.

Overall the book has stimulated my thinking and awareness of improvisation, and the challenges of manualising a therapeutic approach in which the unforeseen and

spontaneous offers rich gain. I was reminded of an exchange with a partner many years ago, that covered neither of us in glory. I was berating him for not being spontaneous enough.

‘That’s unfair,’ he retorted, ‘I am planning on being spontaneous at the weekend.’

I believe that relational therapies will be enriched by attending more to the non-verbal, the spontaneous, the moment-to-moment dances. Non-music therapists will not find an advance of our core relational CAT model in this volume but we will learn well from the therapies that have a rich tradition of focusing our

attention on our togetherness and harmonies, our ruptures and discords.

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Durham University Counselling Service

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International Journal of Cognitive Analytic Therapy and Relational Mental Health

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