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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: 121
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: 83

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 transdiagnostic 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 (121 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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