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Evaluating the Covid Struggles List:

A CAT scaffolding tool for supporting staff well-being

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Abstract: This paper describes the evaluation of a CAT-informed tool to support reflective practice, the Covid Struggles List (CSL). The tool captures the experiences of staff in a UK Mental Health NHS Trust early in the Covid-19 pandemic, framed as CAT 'procedures'. The evaluation aimed to explore how the tool had been used, the experience of those using it, and the potential implications for future use of CAT-informed approaches with staff, teams and organisations.

Across 19 responses to an online questionnaire, thematic analysis produced six themes: *'I see me; I feel seen'; 'Widely applicable and accessible'; 'Collective validation'; 'Permission to talk, and to feel'; 'Opening up possibilities'; and 'Developing psychological skills'.* An unintended benefit of the CSL was the emotional benefit described by the scaffolders for themselves. The evaluation confirmed the potential acceptability and applicability of CAT-informed tools to support staff well-being across settings and professions, and that this can be done quickly, effectively and at low cost.

Keywords: COVID, Scaffolding, CAT, wellbeing, reflective practice

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Introduction

The Covid-19 pandemic

The spread of SARS-COV2, the virus that causes Covid-19, was declared a pandemic by the World Health Organisation on March 11th 2020. During March, the governments of the United Kingdom called a national lockdown. By the end of March 2020, 23,539 people in the UK had been admitted to hospital with Covid-19, 4,425 people had died and 38,436 had tested positive for the virus (UK Government, 2020).

Against this background, healthcare workers continued to work, and to adapt and deliver health services in unprecedented circumstances. Retrospective research (e.g., Rains et al., 2020) found the concerns of staff working in mental health services at the time to centre on anxieties about infection from Covid, lack of access to Personal Protective Equipment, difficulties in moving from face-to-face to remote working, staff sickness absence and worries about potential re-deployment to meet changing service demands. Simultaneously, many staff were supporting patients grappling with their own worries, as well as seismic shifts in their social contact, routines and activities. Staff working in in-patient settings had additional challenges, such as how to confine patients to their rooms to isolate. Services and staff were required to adapt quickly in a context of personal and professional uncertainty.

Cognitive Analytic Therapy as a model for teams, organisations and systems

CAT–informed approaches are becoming well established in work with teams, organisations and systems (Corbridge et al., 2017). '5 Session CAT' is a consultation model for psychologically informed care planning, involving client and care co-ordinator (Carradice, 2013). CAT has been used for team formulation, such as on an in-patient unit for women with a diagnosis of personality disorder (Stratton and Tan, 2019). It has supported the management of difficult relationships and the resulting governance issues in health teams (e.g., Walsh, 1996). Kirkland & Marshall (2021) identify a wide range of ways CAT can support reflective practice in forensic settings. Carson and Bristow (2015) make the case for how CAT can help colleagues, teams, leaders and the NHS at a systemic level. The CAT-informed 'Helper's Dance List' (Potter, 2013), which inspired the Covid Struggles List (CSL), emerged from conversations with those caring for people with intellectual disabilities about their common experiences, framed as CAT 'procedures'.

The Covid Struggles List

In the context of the distinct challenges facing health service staff during the pandemic and given the potential of the CAT model and its tools to support and contain staff, the second author developed the CSL (Jefferis, 2020) (see Appendix). Working in a specialist CAT therapy service within a UK Mental Health Trust, there was a systemic pull to dive in as 'psychological experts' to offer staff psychological interventions. However, there was emerging evidence from China (Chen et al., 2020) that organisational presumptions about what support was needed did not always match staff ideas of what was helpful. Accordingly, in the first month of lockdown, reflective consultations were held with individual staff and groups of team leaders about their experiences, capturing their views on what could support staff well-being. During these consultations, the process of reflection itself appeared to be most helpful, including naming struggles and hearing others' experiences. There were striking similarities in the challenges described by staff members from different teams. From these conversations the staff experiences were summarised in the form of CAT procedures (here renamed 'struggles') on a simple, two-page document, intended for use as a tool to scaffold reflective practice.

The main themes of the struggles were adaptation, identity, connection, threat, authority, exhaustion, heroism, home vs work, boundaries and overwhelm. In writing the procedures the emphasis was on accessible description, and largely avoided technical CAT language, with the exception that some struggles were explicitly framed as either/or 'dilemmas'. The original consultees had named some 'exits' including voicing and normalising struggles, self-permission, compassion and connecting. These were included on the CSL as a way of offering hope and opening up discussion of possibilities. However, the main aim was to promote reflection rather than find solutions. The CSL was refined through further staff consultation, and then distributed freely and widely; through internal trust networks, by email through professional CAT networks, and on social media via the second author and via ACAT. Informal feedback from health professionals across the country indicated that they and others were using it in their workplaces, which suggested more in-depth evaluation would be beneficial.

Evaluation rationale and aims

With the take up of the CSL via these networks came an opportunity to evaluate its use: to inform future development of the use of CAT with staff, to consider the use and value of CAT tools within reflective practice, and to contribute to the growing evidence base for CAT scaffolding and consultation approaches. The evaluation set out to look at how the CSL had been used to scaffold reflective practice across different settings and professions, and to explore perceptions of the CSL and its impact.

It was in effect a proof-of-concept exercise, centred on what could

be learned from the experience of the CSL that could be applied more widely and in the future.

Kirkpatrick and Kirkpatrick (2006) set out four levels of impact evaluation that apply here: reaction, learning, behaviour, results. This evaluation focuses primarily at the levels of reaction and learning, touching on subjective perceptions of behaviour change.

Method

Procedure

A10-itemquestionnaire was developed and hosted on www.survey monkey.com. This asked about the respondent, their views on the CSL, how they had used it, their perceptions of its impact, others' reactions to it and their thoughts on what makes 'good' scaffolding tools. The questionnaire collected quantitative and qualitative data; three questions had closed options and the rest were free text.

The target participants were professionals who had used the tool in their own work settings to scaffold others' reflective practice. They were recruited through convenience sampling (Cresswell & Clark, 2011). The link to the survey was distributed by email by the second author to those who had expressed an interest in the CSL, shared on Twitter, and circulated through internal NHS trust networks. The survey was open for one month during mid-2020, and 19 responses were received. Participants answered anonymously.

The evaluation formed part of the first author's course requirements for a Doctorate in Clinical Psychology. Authorisation was given by the course's university host, and by the host NHS trust Research and Development team.

Analysis

Descriptive statistics were developed from the closed response questions. Thematic analysis was conducted on free text using Braun and Clarke's (2006) steps: familiarisation with the data, coding, generating initial themes, reviewing themes, defining and naming themes, and writing up. NVivo 12 for Mac aided analysis. Comments on the original Twitter and Facebook posts distributing the CSL were used to triangulate the findings, as was a word frequency word cloud generated from survey responses.

Results

A. Descriptive statistics

The majority of respondents (7 of 19) were Clinical Psychologists. The remainder came from other professions including different therapy modalities, a psychiatrist, an assistant psychologist, an administrator and a librarian. As regards levels of familiarity with CAT, there was 1 CAT supervisor, 8 CAT practitioners, and the remainder had either a non-specialist general awareness, or no awareness, of CAT. 11 were from mental health NHS trusts, 5 from acute NHS trusts, 2 from non-NHS organisations and 1 unstated. Most received the CSL indirectly from colleagues or via social media or the internet, with Twitter the most common route of access. All respondents from outside the local area were CAT practitioners or supervisors and found the CSL through social media.

B. Thematic analysis[1]

The six themes emerging from the analysis are described below.

1. I see me; I feel seen

One of the most striking elements of the feedback is the near universal resonance of the CSL to how the respondents themselves felt at the time, both personally and professionally. In seeing this named, it helped them to feel 'seen', validating and normalising their feelings and experiences during the early stages of the pandemic. It also enabled them to realise these were widely shared:

> 'OMG, that's me! Exhausted and jaded, wanting to hide away.' (P3)

> 'It was most helpful to have a list making the common struggles easily accessible and helping me to think and make things I was already thinking but hadn't really named.' (P10)

> 'it was incredibly normalising to read the range of responses.'(P19)

Explicit recognition of the personal resonance of the CSL was most common amongst those with senior roles and those who were CAT qualified. This resonance appeared to be the impetus to share the CSL and to use it with colleagues and teams. It contributed to the 'removal of "other" status', and was 'a tool for all.' (P11)

[1] Participant reference is given after each

2.. Widely applicable and accessible

The CSL had been used in a wide variety of ways. Some respondents explicitly mentioned its influence on their own thinking and practice, in helping them reflect personally and professionally. A number had used it with clients. Most had used it as a tool to start discussions with staff: in reflective practice sessions, in team meetings and in individual meetings, as well as distributing it by email. Two had not shared it further.

The range of settings and staff the CSL had been used in and with is notable in its breadth. Settings included: in acute and urgent care, the Frontline19 support service for NHS staff, an administrative team, a community brain injury team and adult social care. Those it was shared and discussed with were: Nurses, healthcare support workers, Occupational Therapists, Doctors, Community Psychiatric Nurses, Managers, Clinical Psychologists, Psychiatrists, a Benefits Advisor, Fundraiser, shielding staff, staff who had been redeployed, housekeeping staff and schools. Its accessibility to non-psychologists was seen as a strength:

> 'I was slightly apprehensive about sharing it with a ward team (not psychologists) because of the level of self-reflection needed, however everyone was able to use and relate to it.' (P12)

A number of respondents mentioned that being located remotely from team members hindered their ability both to use the CSL more pro-actively and to gauge others' response to it. There were other limits to its usefulness for some:

> 'Others [colleagues] either weren't bothered, had their own ideas in place or just didn't want to admit that there were problems with themselves or the workplace.' (P1)

> 'We were all just trying to adjust to offering therapy remotely and incredibly busy. Conversations (when they happened) tended to be kept light and focused on practical problems.' (P19)

3. Collective validation

The CSL helped to validate and normalise teams' and colleagues' feelings and experiences. Seeing these written down and named had been powerful:

> 'I used it to present to my team as a CPD session during lockdown. It was extremely helpful and resonated with a lot of people in the team. It helped us make sense of our experiences.' (P12)

In many places the CSL had been a conduit for people sharing feelings, difficulties and experiences with each other, and to make collective sense of these, allowing for both similarity and difference:

> 'Feedback was. . . it was good to be able to talk through their experiences and that the struggles list made sense of a lot of what they had been feeling.' (P10)

Perceptions of the impact included staff feeling: less angry and anxious, more listened to, energised and connected with and understanding of each other, and able to open up conversations that carried on after the session:

> 'It has helped them think about how they work with their teams, re-charged their batteries to an extent.' (P4)

> 'Received very positive feedback on the sessions, some people in the team said it almost felt like therapy and created a safe space for us to think/ reflect and share experiences/ thoughts /feelings.' (P12)

> 'Tools like this normalise distress and help people share connections with each other.' (P10)

4. Permission to talk, and to feel

The CSL normalised the unprecedented personal and professional struggles of staff during the pandemic:

> 'Staff found it humanising and it gave permission for staff to voice previously unvoiced feelings.' (P1)

> 'I remember people being more forthcoming in sharing examples about not feeling like a hero and it was really validating.' (P8)

It enabled conversations to happen that may have been difficult or avoided, at a time of uncertainty and pressure:

> 'It helped open discussion about the way difficult team dynamics had emerged.' (P7)

> 'It was a way to scaffold a conversation in teams where talking about feelings are seen as a weakness (prison setting).' (P14)

It provided a structure for reflection, a 'tool to invite conversations' (P11), that was unthreatening, easily accessible, reflected difference and resonated emotionally:

> 'Knowing what's normal makes things that feel shameful, embarrassing or unspeakable, possible to talk about.' (P10)

5. Opening up possibilities

The CSL was intentionally non-directive, giving ideas to explore not instructions.

> 'They present different possibilities – thus enable exploration of difference – not everyone thinks or feels like me. They give ideas, points for discussion – not rights or wrongs.' (P4)

> 'It was not at all patronising. It did not make grand claims but gave practical, uncomplicated ideas to try as suggestions only. It did not tell us what to do, which I always appreciate.' (P20)

Conversations based around the CSL had been a springboard to changes in ways of working: setting up a 'wobble room', instigating a team check in at the end of the week, and thinking about Covid's effect on the service, its clients and the team:

> 'We then made our own document of neurorehabilitation struggles to share within the team, tracking how Covid affected our population and some of the barriers we faced. This was not in a CAT style, but it was a space for reflection and documenting what was happening at the time and how we felt about it.' (P8)

Through collective use of the CSL, new and shared understandings emerged:

> 'I used it with a team of nurses who had been redeployed. It provoked lots of really helpful discussion and a sharing of feelings and experiences. Particularly helpful was the 'hero' pattern. None felt they were frontline staff and that the 'others' were heroes. All members of the team had been ill with Covid. This discussion helped them see that there were no heroes but that they were all heroes.' (P10)

6. Developing psychological skills

The tool supported staff to develop psychological skills such as reflection, acceptance, problem solving and flexibility. It also helped to develop this capacity within teams, helping them to stop and reflect collectively:

> 'Lots of people identifying with the themes, individuals feeling empowered to reflect on their professional and personal journeys in relation to COVID, greater willingness to accept the situation/ look for positives.' (P5)

> 'It helped them observe what was happening without being pulled into it to the same extent.' (P7)

For those respondents less experienced in CAT, their resonance with the CSL and the validation it provided that their own experiences were shared, seemed to give them the confidence to share the CSL more widely and with enthusiasm. A librarian, for example, shared it with their family who then shared it with colleagues. An Assistant Psychologist used it to facilitate a discussion within their own team:

> 'It was validating and also gave me more courage to discuss this with colleagues!' (P8)

The CSL's accessibility was described in its being 'of the moment', as well as short, simple and clear. Suggestions to make it more accessible included use of visuals such as maps, more simple language and updates to reflect the changing situation as the pandemic progressed.

Discussion

This evaluation set out to explore how the CAT-informed CSL had been used to scaffold reflective practice across different settings and professions, along with perceptions of the CSL and its impact. A summary of the perceived impact of the CSL by respondents against three levels of Kirkpatrick and Kirkpatrick's (2006) evaluation framework is shown in Figure 1.

Reaction:	Accessible, adaptable, timely, validating, normalising and flexible. Less angry and anxious, more connected and energised
Learning:	About own and others' emotional experiences, and similarities and difference in theseIndividual and collective psychological skills of reflection, acceptance, problem solving and flexibility
Behaviour:	Sharing of experiences and feelings, including where different Exploring possibilities and coming up with solutions

Figure 1 Impact of the CSL against Kirkpatrick and Kirkpatrick framework (2006)

What can CAT offer to support staff well-being?

The conversations the CSL enabled were described by respondents in ways that suggested they felt unusual in their openness, validation and collegiality. In their survey of the mental health workforce, Johnson et al. (2011) describe the emotional strain, exhaustion and burnout that can damage morale, exacerbated by 'unhealthy' team and relationship dynamics. Foster et al. (2020) found this workforce affected by bullying, workplace tension and feelings of a lack of organisational support. Against this background, there is an ongoing need for support beyond Covid. This evaluation shows how CAT could potentially scaffold reflective practice on an ongoing basis in a way that is experienced as unthreatening and productive, helping to strengthen well-being and create a greater sense of psychological safety at work (Summers et al., 2020).

The equalising nature of the CSL was seen as positive. It enabled identification with rather than distancing from others. Multiple layers of 'us and them' are often apparent in mental health services (MacCallum, 2002); between staff and 'patients', qualified and non-qualified staff, 'management' and others, and different professions. The CSL was able to cut through these. The CSL seemed to bolster the confidence of a range of differently qualified staff to have a voice and to use the CSL as a tool to support others, both of which had been identified by Stratton and Tan (2019) as barriers to psychological working in teams. Evidence from this evaluation suggests the potential of CAT to scaffold reflective practice in mental health in ways that are non-threatening and normalising.

How applicable and acceptable are CAT informed concepts and tools to a wider audience?

The evaluation confirmed early potential for the acceptability and applicability of CAT-informed approaches to staff across settings and professions. The primary focus of the CSL on validation and Figure 2 normalisation of experiences and feelings by naming and documenting them, appeared a major strength. This is in line with the value Ryle and Kerr (2020) place on CAT's close and accurate description of states and problems being of value in itself, as illustrated in figure 2.

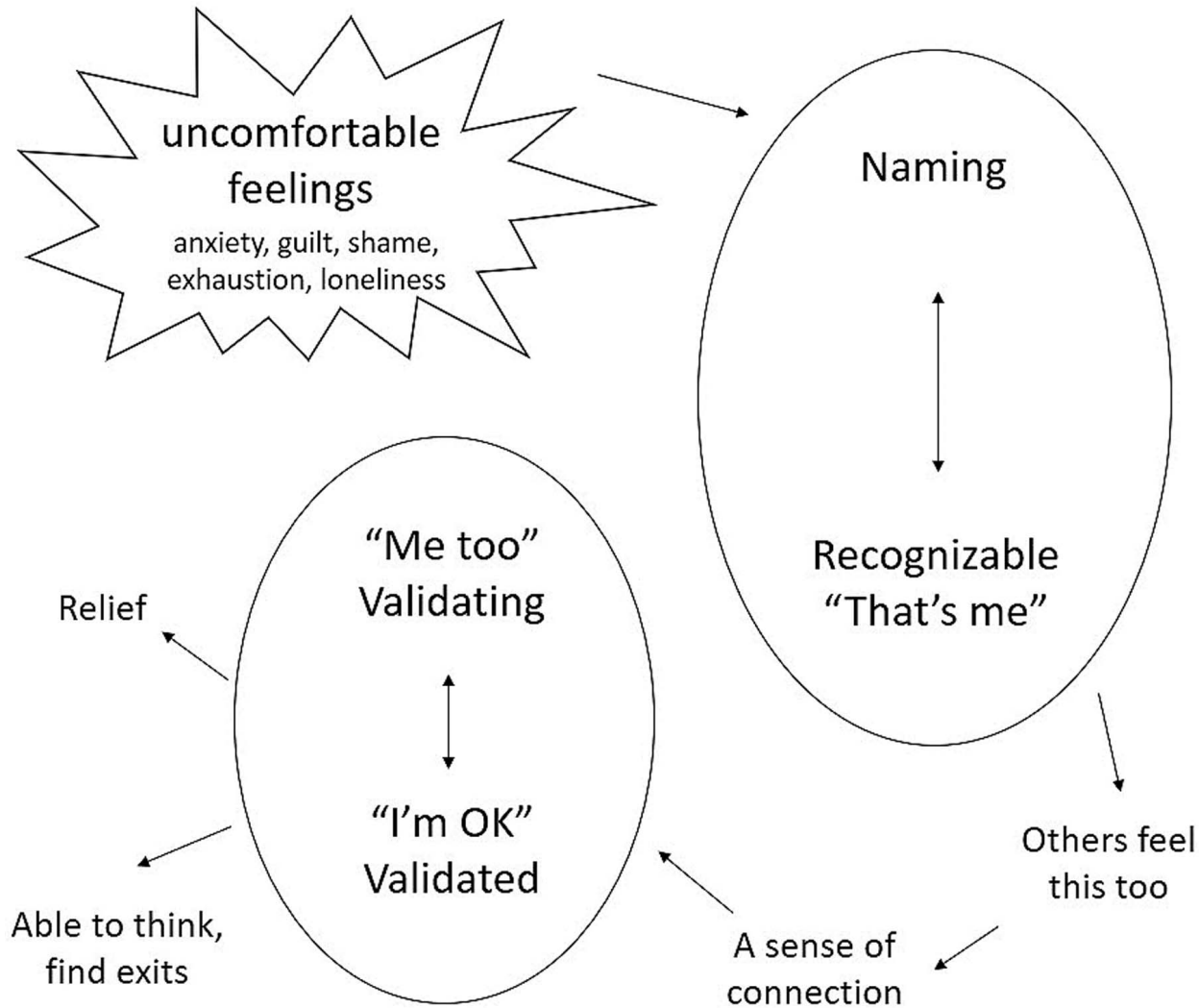

Figure 2 CAT Map of Evaluation Findings (Jefferis, 2021)

One of the CSL's strengths was in its reflection of different potential positions. It was not seen to prescribe a particular approach or 'answer' and solutions grew organically with the'CSL providing the space for these to emerge; it was encouraging not telling. Relational and collaborative aspects are core to CAT and the collective use of the tool was particularly powerful for teams in creating shared sense-making, legitimising discussion, and opening up possibilities for further conversations, connections and alternatives. CAT concepts can be difficult to grasp and understand, even for those who are training in the approach (Catalyse, 2013). However, the CSL seemed to strike the right balance for wider accessibility, as seen in the high number of respondents to the survey who were not CAT practitioners. The CSL's normalising and non-pathologising approach to distress felt a good fit to support staff well-being, even with those who had had no or limited prior experience of CAT. The Covid pandemic has seen a range of 'expert' psychological help offered for NHS staff; the development of this tool based on consultation with staff and wider feedback suggests other collective approaches also have efficacy.

What can we learn about how to best 'scaffold the scaffolders'?

An unintended benefit of the CSL was the emotional benefit described by the respondents for themselves, in line with figure 2. It was not just a tool for scaffolding others. Summers et al. (2020) identified the psychological practitioner workforce as an at-risk group for mental health issues. The CSL gave scaffolders permission to feel, and to struggle, as well as the scaffolded.

Psychology remains loyal to the traditional in its dissemination and sharing; speaking at conferences, publishing in academic journals and writing a book are still career milestones to be ticked off. The CSL has shown the potential of free social media, in this case Twitter and Facebook, to reach a wider audience quickly, effectively and expansively.

Further exploration of actual and future potential channels of dissemination would be beneficial. Future evaluation of such tools could take a more formal approach to specifying and measuring desired outcomes.

Strengths

The evaluation contributes to an emerging evidence base for the individual and collective impact of CAT-informed tools across team, organisational and systemic levels. It suggests a 'scaffolder' may not always be needed to support implementation. The evaluation design enabled a rapid turnaround and input from a geographically dispersed range of respondents. An unintended, but valuable, result of the design was that the evaluation reached, and received input from, both CAT practitioners and other types and levels of professional.

Limitations

While the CSL reached a fairly wide audience, the invitation to contribute to the evaluation will have only reached a subset of that group, and those who participated are a smaller group still. This inevitably limits the conclusions which can be fairly drawn from the results. The evaluation could have been enhanced by getting feedback from the 'scaffolded' rather than just the 'scaffolders'. The Covid pandemic was unique in its universality, and potentially the levels of common experience, which may have influenced the resonance of the CSL as a tool.

Conclusion

This evaluation of the CSL shows that there is potential to utilise CAT expertise and tools to support staff well-being across teams, organisations and systems, and to do this quickly, effectively and at very low cost. The development of this tool based on consultation with staff and wider feedback suggests collective CAT-informed approaches to support staff well-being have efficacy. □

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APPENDIX: THE COVID STRUGGLES LIST

Author's note: The version reproduced below is the original list, on which the evaluation was completed. In June 2021 an updated version was created, and reflects the struggles reported by staff once the pandemic had moved beyond its initial phase. This updated version is freely available on the internet via this link: https://tinyurl.com/CovidStrugglesV2

The original list is reproduced from Kirkland, J and Marshall, J. (2021). *Reflective Practice in Forensic Settings: A Cognitive Analytic Approach to Developing Shared Thinking* with the permission of Pavilion Publishing and Media.

Many of us are facing unprecedented challenges in our work. This is a list of common experiences and dilemmas described by staff in a mental health and disability setting in the wake of the pandemic. The aim is to illustrate how many of these struggles are normal, and shared between us – we are all human and doing the best we can. It has been informed by the theory and practice of Cognitive Analytic Therapy.

How do we talk about it? There are stresses around but people are not talking about it. What are people feeling? How do I ask?

Who am I going to be? I want to do my bit, but my normal job may not be possible or may not be needed now. How long will I have to wait to find out? Who will I be then? Was my old job not important? Will I be able to do the new one?

Too much change. So much has changed, in my job, my family and the world, without time to adjust or say goodbye, that it can all feel too much.

Where did the team go? Some of the things that held us together have gone now, because we changed roles, or aren't in the same place now. I miss the team.

How can I help when we're this far apart? I try to adapt and help from a distance but can't be sure if I'm getting it right.

The lost connection. I can feel isolated by my new working life. How do I stay connected with people?

Soldiering on exhausted. The changes to my work have left me tired and drained. I must keep going because others need me.

If I put myself first, **I feel guilty.** I might know I need to put myself first e.g. by having downtime, or protecting myself better from risks, but it's a crisis and if I do that I will feel guilty (or the organisation might make me feel like that)

The 'overwhelmed' dilemma. The volume of information and instructions changes so quickly, and different sources conflict. It is too much. Sometimes I don't know what to do or what to believe. I'either cut off from the flow of information (but something important might get missed) or immerse myself in it (and get exhausted again – perhaps I have trouble switching off)

The 'boundaries' dilemma. The world has changed so maybe we need to be flexible. But it can seem like either I stick to what I would normally do (but someone's needs don't get met) or I change the boundaries but then it doesn't feel OK

'In the line of fire'. My job means I can't socially distance and may be at risk of being infected or infecting others. I try to rise to the challenge, but it might mean I'm putting me, my family, or other patients at risk, which worries me.

The 'authority' dilemmas. With so much uncertainty, I know people want clarity and simplicity. But:

(i) I don't always have the answers, and don't know what to say to help; and
(ii) I can be torn between either telling people what to do (which they may find too controlling) or trying to make decisions together but risk spreading the uncertainty.

All of these may lead to problems in the relationships with people over whom I have some authority.

The 'rush or reflect' dilemma. There is so much pressure to get things decided and done now, I may rush into things without thinking it through. However, if I stop and reflect, I fear it may then be too late.

Are YOU a hero? I may be invited to be a hero: by the world around us (clapping for the NHS), by my organisation, by myself. That can feel good, exciting, special. But:

(i) If not a hero, I may feel overlooked, left out, even resentful.

(ii) If I can't be a hero (for instance if I need to stay out of things for my own health) I may feel guilty

(iii) No one can be a hero all the time. What happens then? It may feel like we are never allowed to make mistakes, to not know the answers, or not to be firing on all cylinders.

Absorbing the stresses of others. People I am trying to help might be very stressed and struggling to cope. I do my best to help manage their anxiety but then I am left with the anxiety myself, which can take its toll.

Work or home? Home is topsy-turvy because of money, children, people close to me who are vulnerable, or all of these. I can feel split between putting my time and effort into what's needed at home, and what's needed at work. I might feel confused or overwhelmed or feel guilty about having to put one set of needs above the other; or feel guilty about not meeting either set of needs.

The hairline cracks. At work, if relationships have been difficult before the crisis, the extra pressure that everyone is under may make it even harder now. Communication between us might be difficult, or we get locked in argument on bones of contention.

Who is to blame? When things are less than perfect, we may want to find someone to blame. That can feel good but may make others less able to do their jobs well and may not help us when it is our turn for some compassion.

Ideas Worth Trying

What helps to manage these struggles will differ for each of us as people, and differ across our work settings. This is a developing list of general strategies which people we have spoken to have found helpful at times. In Cognitive Analytic Therapy these are known as 'exits'.

- Voicing the struggles, without shame

- Recognise this is a process. Have permission to take one day at a time.

- Normalising - recognise the struggles are universal and normal: we are all human and all in it together, and we can support each other.

- Organise yourselves for connection.
  - o For remote workers – extra check ins, virtual coffee time, WhatsApp groups – but discuss what people find useful and what is too–much.
  - o For present workers – creative ways to do things together–e.g., socially distanced lunches; explicitly ask how each other is doing.

- Create space for yourself and each other, and give permission to use it (e.g., use physical and virtual 'wobble rooms')

- Keep some 'anchors' to your familiar working life (e.g., start and finish work times, team rituals such as regular team meeting times; use 'setting events' for working at home e.g., use a specific chair/ desk)

- Reconnect with things that have meaning and set simple goals.

- Attend to the basics: sleep, food, physical safety.

- Pay attention to boundaries and what feels comfortable; give yourself permission to separate work & home

- Shift your focus – remember the world is bigger than Covid.