The development and evaluation of 'Map and Talk' reflective practice groups

with ward-based staff in an acute adolescent psychiatric inpatient setting

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Abstract:
The author has piloted and established ward-based reflective practice groups in a setting characterised by high expressed emotion, instances of aggression and violence, and multiple demands on front line nursing staff. This paper discusses the development of a regular and flexible Cognitive Analytic Therapy (CAT) approach towards enhancing relational understanding and emotional scaffolding for nursing staff within an adolescent psychiatric inpatient unit, through 'Map and Talk' reflective practice groups. The groups are facilitated within existing resources (no extra funding to cover shifts for nursing staff, specific CAT skills training, or external facilitation), and the paper goes on to present an evaluation that was conducted using a qualitative questionnaire and a thematic analysis. Feedback examples are used to illustrate the main themes that emerged. Overall, staff were appreciative of and positive about the reflective space, and the CAT approach – especially the CAT mapping. All respondents said they would recommend the group to others.

Finally, the paper discusses aspects of organisational mapping and parallel processes to explore relational dynamics, barriers, and potential fracture lines between non ward-based (upstairs) and ward-based (downstairs) staff, as well as those between nursing staff and patients. The layout of a building can unwittingly feed into such potential team divisions, and create unhelpful, and untrue, myths and legends that can be hard to dispel. This paper is likely to be of specific interest to professionals setting up reflective practice groups within their own place of work.

Keywords:
Adolescent Inpatient, Reflective Practice, Map and Talk, CAT

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Introduction

The inpatient setting is a tough place to earn one's living. Taking temporary responsibility for the lives of young people (children) in significant intrapersonal crisis can be exceptionally challenging. The risks are daunting. These environments can place nursing staff in significant moral distress (Musto and Schrieber, 2012). Acutely psychologically unwell young people have high rates of self-harm, suicidal behaviour, and indeed suicide (Hawton *et al* (2012); Griffin *et al* (2018)). When a young person self-injures on a ward, it is damaging for all concerned. The anxiety amongst the staff team is correspondingly high. The chronicity and acuity of cases admitted and rates of violence towards staff on inpatient wards are rising, (British Psychological Society 2012), (Itzhaki *et al*, 2015; Foster, 2018). These assaults are both psychologically and physically damaging to the staff themselves and to the therapeutic relationships between the young person and their treating team, (Burrows *et al,* 2019). Compassion fatigue, secondary traumatic stress, and burnout are seen as occupational hazards for professionals working in these specialised contexts, and specifically for registered mental health nurses (RMNs) and healthcare assistants (HCAs), who spend the most time 'at the coalface' working directly with the young people (Ward, 2013; Matthews and Williamson, 2015; Foster, 2018).

Reflective practice groups are one approach to maintaining the wellbeing, and compassion satisfaction of the staff doing this work (Ray *et al,* 2013; Stamm, 2010; Foster, 2018). This paper is an account of a reflective practice initiative for nursing staff designed to help them better understand the complex presentations of patients and their care systems, the relational stressors of all aspects of the work, and the strong pushes and pulls to reciprocate unhelpful patterns of relating (Ryle and Kerr, 2002, 2020). It is a relational approach which means that it seeks to understand people by looking not solely at disorder in an individual person, but at what is going on **between** people and with the surrounding system. The task of 'understanding' the young people in our care is approached by reflecting on their personal history, and on our responses to them which are usually indicative of their early patterns of relating and of being related to.

Cognitive Analytic Therapy (CAT) and reflective practice groups

CAT has given us some extremely effective tools to help understand complex relational interactions; Reciprocal Roles and Reciprocal Role Procedures (Ryle and Kerr, 2002), Mapping (Potter, 2010, 2014 & 2016), Observing Eye/I (Akande, 2007) – to name but a few. This approach and concept has long been applied to community mental health teams (Kerr *et al*, 2007), (Potter, 2010), and care orientated settings (Shannon *et al,* 2017), and particularly, inpatient teams (Kemp *et al*, 2017).

Within this specific type of practice, perhaps a gold standard approach would be a whole unit philosophy – to have external facilitators who train the whole team in CAT skills, develop a common language for understanding relational behaviour, and provide ongoing reflective practice groups thereafter. A silver standard would be a specific department philosophy – with external CAT facilitators providing a planned and consistent staff reflective group format and schedule. A bronze standard would be to establish a consistent meeting opportunity, within usual resources (no additional costs/external facilitators) but ensuring that there is a contained therapeutic space with a CAT frame, philosophy and approach, where staff can explore the relational dynamics of the inpatient setting, and the impact this has on them and their work.

This paper talks about a 'bronze' standard approach, 'cutting your coat according to your contextual cloth' (Mulhall, 2015), within the zone of proximal development of that environment (Vygotsky, 1978). Whilst outlining the context and possible limitations of this situation, it is not to detract from the potential value and benefits from harnessing the expertise within, rather than outsourcing to external experts – who could be perceived as outsiders who know nothing about this specific environment and work, for example.

The Centre and context

The Centre comprises two wards, a 15-bedded generic ward, and a 10-bedded psychiatric intensive care unit (PICU). Although the wards are different in terms of their acceptance threshold criteria, and in terms of how they are managed, the map and talk work is ostensibly the same.

How the group(s) evolved

I have been a CAT Psychotherapist at the adolescent inpatient unit for approaching nine years now. A long-standing, psycho-dynamically and

externally facilitated staff group, open to all staff had been stopped – it was poorly attended, and associated costs were an unjustifiable expense. However, it had left the unit with a significant hole in the provision of staff support/reflective space. In particular, the nursing staff had few opportunities to sit down and think about the complexities of the work and its impact on them. With the approval of my manager, and under my initiative, I looked at the possibility of myself bringing a CAT approach to supporting staff in their work through reflective practice.

CAT Theoretical influences

I had begun reading about the 'Four Ps' (Pause, Pull, Pattern, Professional Response) work and model of Annesley & Jones (2010 & 2011), and how this could be used as a tool for thinking and reflection on one's own interactions with patients. The original group was set up on these, and general CAT principles, about six years ago.

As time went by, I was inspired to develop this initial thinking and practice after attending the International CAT Conference in Greece in 2015. There I listened to Mark Ramm and Jamie Kirkland, as well as Nicola Kemp, Alison Bickerdike, and Clare Bingham talking about their CAT approaches to reflective practice – building on the work of Steve Potter (2010) and others previously mentioned. The term 'Map and Talk' was used, which I instantly liked, and thought was an excellent description of what CAT in action looks like in this context.

With initial experience of facilitating staff support at the unit under my belt, together with an increased knowledge base, enhanced enthusiasm, and support from my own supervisors and manager, I relaunched the staff support initiative as a reflective practice space. I used enticing slogans such as; 'We are in it together, so let's try and understand it together' (Kirkland & Ramm, 2015), 'Shared thinking time to assist and build reflective capacity', 'to map situations and difficult moments', 'to build the ability to zoom in and out of situations, and recognise patterns of relating', 'not necessarily a space to find solutions – though it is hoped that they might occur', to build enthusiasm to make the groups happen, consistently.

The group was open to all staff, and attendance was not compulsory. In its infancy, attendance was mixed and erratic. Over time it became apparent that those who seemed most in need of it, and more likely to attend, were the nursing staff. The groups have continued to evolve, and for the last three years, they have been known as 'Map and Talk' reflective

practice meetings. After several years of trying various midweek arrangements, the unit has arrived at the fact that it can achieve the most consistent attendance for nursing staff if they are facilitated at the weekend. This is a time that is not so highly structured with clinical meetings and other demands on staff. There may also be more leave and visits for patients, which can free up nursing staff time. Therefore, the current, and most consistently attended structure so far, is that 'Map and Talk' groups are facilitated (by me) on each ward, separately, for an hour every Sunday.

At these meetings we attempt to explore the convergence of four main areas: the patient and their history, the patient's family or care system, the service with its demands and constraints, and staff members individually and collectively.

Evaluation

After six years of facilitating reflective practice groups in the unit, a more formal and current evaluation was indicated as part of usual good clinical practice. Data collection needed to be simple and easy. The most pragmatic way of doing this was with a questionnaire. In terms of devising the questions themselves, I was mindful of trying to keep it brief and straightforward, and to elicit more qualitative than quantitative responses.

Sample

As is usual in these types of environments there is a high turnover of staff (Foster, 2018), and therefore of group attendees. On each ward there is approximately a whole time equivalent of 15 RMNs and HCAs which is overall in the region of 25 regular staff providing the care and support for 25 patients across both wards. There is also the addition of regular and irregular bank staff, and agency staff when observation levels are high. Some staff are also regularly on nights.

There has been quite a difference between how many groups staff have attended, depending on their length of service, availability on a Sunday, and being able to be freed up from ward duties to attend. So, some members of staff have attended over 20 sessions, and others (newer or irregular members of staff) only twice. It was decided to send the questionnaire to all current nursing and health care staff who had attended the group more than twice.

Questionnaires

25 questionnaires were distributed, 17 were returned, giving a return percentage of 67%. This included six HCAs, and 11 nurses comprising three Associate Practitioners, five Staff Nurses, two Charge Nurses, and one Ward Manager. This represented nine responses from the Generic ward, and eight from the PICU. Respondents were invited to return their questionnaires anonymously, virtually all did not. All respondents consented to the author using their questionnaires for the purpose of service evaluation, and this paper.

When devising the questions themselves, I wanted to try and capture how helpful the Cognitive Analytic Therapy aspects of the group were, but I didn't want to use CAT technical terms (such as reciprocal roles, reciprocal role procedures, enactments, etc.) as I thought it would put people off responding.

The first three questions centred on how helpful Map and Talk was in helping staff in their patient interactions/understandings, the fourth was in relation to useful tools, the fifth was in relation to anything unhelpful, the sixth (in keeping with the UK NHS staff survey questionnaire) in relation to recommending the Map and Talk approach to friends or family, and the seventh in relation to anything else they might have to say about the initiative.

Analysis and responses

A Thematic Analysis (Braun & Clarke, 2006) of the returned questionnaires was carried out by a Clinical Psychologist colleague with no involvement in the groups. From this thematic analysis, five broad themes emerged (**bold**), which are reported below. Examples of responses (evidence in relation to the five broad themes) appear in *italics*.

1) A valued forum for self-expression; a safe space to share, containing, supportive/caring, professional, time to 'step back'.

> *It gives me a forum to 'offload' any worries or queries I have regarding a patient/staff/building issue. But not just that, it gives me a person who can answer back in a professional way, and he can then point me in a good direction, and possibly give me a different perspective on something that has been bothering me.*

> *It's good to express my views and hear those of others.*

Just the space to vent and explore how our difficult patient group care gets inside of us.

Yes, it's very helpful and supportive, and also puts me in a good frame of mind for the day.

I would like to say thank you. I find it very useful, and I like coming into the group to give me a different headspace to think. It is not that often in the week I have time to sit and think and discuss, and I think that this should very much continue to be a protected time.

2) 'Why we see what we see' (increasing understanding); breaking it down, seeing the bigger picture, benefits of broad learning tools (seeing the pattern), sharing views, reading more widely.

It helps to get a better understanding of what is going on for a particular patient. It also helps staff to become self-aware about our own attitudes and behaviour towards patients, and how we can support them.

When a patient has been let down in the past, they can put up huge defensive walls, and to protect themselves, sabotage (in verbal, physical or emotive attacks towards staff or others around them) any form of care of compassion towards them, as they see it being fake, false or untrustworthy.

Highlighting when discussing a situation that hits a personal experience, and realising you've been drawn in, and how I can be better prepared through this awareness.

I like the use of 'mapping'.

3) Personal and professional growth; building empathy, better self-awareness, feeling empowered and valued, improved self-efficacy, reduced/managed anxieties.

It adds a psychological aspect to my work. It allows me to stop and think about the situation in a controlled and encouraging environment.

It helps me to take a step back and look at things more clearly. It also helps me to understand people's behaviour.

Support when feeling overwhelmed by the job, and unsure and anxious. Being able to talk about this and share concerns with colleagues.

It's sometimes difficult on the ward to free staff up to attend on the dates set aside and sometimes you may be unable to attend groups for several weeks due to shift patterns and staff availability, despite wanting to come to the groups to help with processing. When we are able to go, it's fantastic and staff feel more energised and focused back on the ward with the team.

It can sometimes be a helpful break from the ward environment. Reassuring, self-affirming and teambuilding.

4) Noticing the pushes and pulls; impact of negativity, struggle to keep boundaries (team and self), dynamics of attachment/care seeking (seeking attachment, understanding defences, self-sabotage).

Too many pushes and pulls to mention!

When patients invite you to feel something and having the experience to know to go with it, or deflect it positively.

Negative staff pulling me into a negative mood, due to high stress and them feeling uncontained.

There have been situations whereby a young person has managed to engage me in a childish back and forward argument about something they had requested.

5) Service improvement; identify new path's, implementing change.

It is helpful to think in a little depth about a particular patient and has been insightful to hear the views of colleagues. It is helpful to look holistically at situations and sharing staff experiences to gain more understanding in order to develop skills to achieve improved outcomes.

I find that the sessions provide an opportunity to reflect on our practice, to unpick the young people we have at the time, and what their care looks like, and how we might improve it. But also provides a safe and supportive environment to tackle (sometimes personal) issues that can be impacting our roles on the ward.

We are able to look at roles of the young person and why they might be behaving in a certain way. Discuss interventions that may not have been tried yet.

I think it's a godsend. I feel all staff should be given the opportunity to attend.

Observations

The five broad themes that emerged from the thematic analysis are encouraging and can bring helpful buffers to the terrain of this difficult setting. From a professional, patient, family, and managerial perspective, we would want staff in units like this, doing this challenging work, to have access and exposure to a valued forum for self-expression, increased understanding into 'why we see what we see' on the wards, a place for staff personal and professional growth, a method for developing our own capacity to notice 'pushes and pulls', invitations to join unhelpful dances (Potter 2014), and on the ground reflection about service improvement. This can only lead to better service delivery, and therefore better outcomes and patient experience. As a cautionary thought the qualitative data is drawn from a limited number of respondents but those who know the team and the work see it resonating with overall perceptions of the Map and Talk work.

Perhaps most striking were the replies to Question six. All 17 respondents (100%) said they would recommend it. . . '*yes, definitely, most certainly, absolutely, without a doubt'*.

One respondent made the interesting additional observation to this question. . . '*Yes, . . . however, you need all the staff to participate fully to get more benefit*.'

I take that to mean either that there needs to be more of the (whole?) staff (shift) team in it, or, that participants need to allow themselves to interact more when in it – to get more benefit. The unit continues to think about how it can enhance attendance, but solutions are challenging given the limits of staff resourcing and as, ultimately, the patients on the wards require high levels of nursing.

At the Centre we have acknowledged the presence and effects of both primary and secondary trauma on the staff team, and have developed and implemented additional forms of staff support, in the form of the Group Traumatic Experiences Protocol (GTEP) which is openly accessible

to all staff in the building (Shapiro and Moench, 2017).

> *I don't think anything is unhelpful, but sometimes it may bring back some memories at times, I guess sometimes with the culture we have on the ward, it can feel like we are escaping the work that we need to do. Or we feel negatively/defensively about taking the time to attend the session (on a short-term basis), rather than focus on the positive impact that attending the group has in the long term.*

When reflective practice initiatives are facilitated solely within existing resources (no extra cover), in an environment where demands can be relentless, this can easily fuel **ignoring** and **self-denying** procedures in relation to **depriving, neglecting and overlooking** one's own needs, and even guilt – probably at the time you might need to take the reflective space the most.

Facilitation

Ideally one would not choose to have a sole (internal) facilitator for this type of work. The additional support, energy, and observations that another facilitator might see could be enriching for all. However, a sole facilitator is the reality of the situation. There have been many times along the road that the groups have looked like they could come to a halt. Many a good initiative has 'run out of steam' through loss of patience or interest in these often furiously busy and demanding environments. Despite their obvious value, keeping these groups going, perhaps surprisingly to outsiders, requires a significant amount of facilitator persistence and flexibility – which can of course lead to its own enactments when feeling **isolated**, or not feeling **valued**. One has to not take it (non-prioritisation of the group on any one given day) too personally (**rejecting** to **rejected**), which is not always easy to do. Solid regular supervision is essential.

The wider picture

Whilst developing deeper relational understanding of the patient and staff dyad is extremely important, and has also been extensively reported above, one also has to try and understand patterns and enactments through the lens of the service demands and constraints and the wider multidisciplinary team. An example of organisational orientated mapping, with particular relevance to themes two, three and four above *(2. 'Why*

we see what we see', 3. Personal and professional growth, 4. Noticing the pushes and pulls) is discussed below.

Generic maps

Over the years, many specific maps have been co-constructed within the groups, exploring a wide range of issues from critical, over involved and intimidating parents, perceived ineffective/absent management, use of ineffective (agency or bank) staff, patient violence, patient challenging behaviour, patient distress, and serious risk related behaviour. It is both incredible and enlightening to see the links and patterns that emerge between all these seemingly different things. From this work, a generic organisational map has emerged and it would have been difficult to think that the pure design logistics of a building would make such a significant contribution to a potential fracture line in the whole unit multidisciplinary team. By this, I mean that it costs less to construct a taller building than a wider single-storey one, and this is reflected in the design of the Centre where the upstairs part is used as the bases for doctors, therapists and administration, and young people are not allowed there due to the window/height risk – an upstairs and downstairs is physically created.

Within inpatient work, it is not unusual for there to be (conscious and subconscious) tensions between those at the coalface, and those not in continual contact with the whole patient group (on shift). This also reflects possible issues with professional standing, and perceived privilege. This fracture line can become magnified by the internalisation of an 'upstairs–downstairs' metaphor, and then reinforced by the actual geography, which can then permeate subsequent interactions, see figure 1 [overleaf].

This map has been useful to hold in mind in terms of understanding how staff members can find themselves in difficult and **exposed** positions when they feel **unsupported**, **unacknowledged, overruled** or **undermined**. The danger is that this can lead to a **scapegoated** or **neutered** position, or a **distanced subgroup** position. None of these are particularly helpful for any service. Bringing this map out alongside the current issue being discussed has proved helpful.

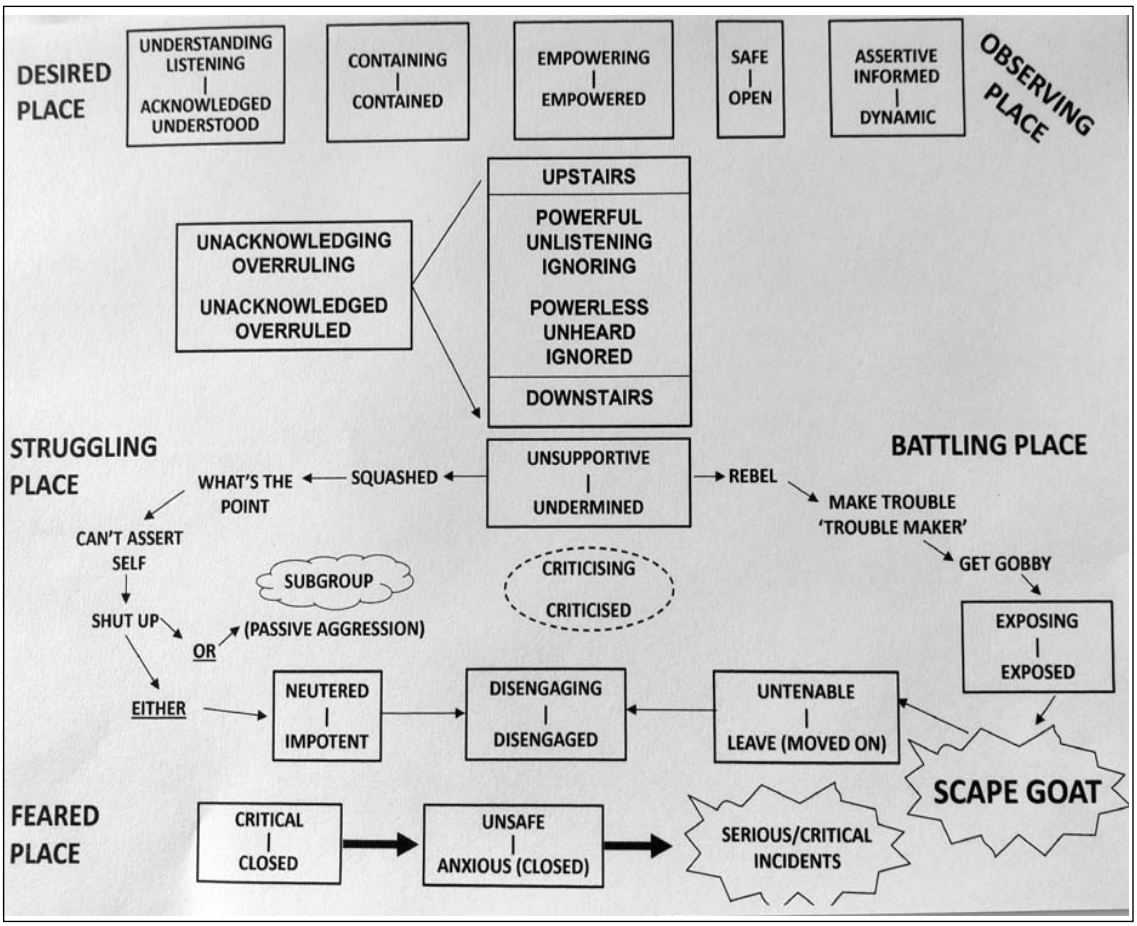

Figure 1

Integration

As stated previously, the target group for map and talk sessions is ward-based nursing staff. When one thinks of the whole clinical and management team, again, ideally, the thinking that happens in map and talk could be increased in value if it had the opportunity to be more integrated into the workings of the whole Centre. However, it also has to be acknowledged that it is just one of a number of initiatives and models of reflection present within different parts of the unit, and some people in the building, for many reasons, may never be too aware of its content or function. For example, some of the multidisciplinary team and ward managers are required to be part of a regular DBT Consult group as the Centre heads towards accreditation in this treatment model. In this situation attendees can meet consistently and regularly, and keep

themes going as they are in control of their own diaries, unlike nursing staff. It is also an organisational goal to attain this accreditation, and there are multiple people linked to this goal, so there is more organisational drive and specific focus behind it. Many wider team senior professionals may also be saturated by supervision demands also.

During its existence Map and Talk has perhaps assumed a low overall profile. The facilitator has chipped away at the many prevailing dynamics and addressed potential fracture lines in the best way they could. Now that Map and Talk has developed a more solid platform and clear identity, the facilitator has attempted to raise its profile. Undertaking this evaluation is part of that process. There is evidence to suggest that the collective efforts of the whole multidisciplinary team are making some helpful inroads (exits) into dispelling the upstairs–downstairs myth and legend, by developing a (more) **attuned**, **available**, and **responsive to**, **listened to**, **understood** and **connected** role. For example, I was heartened to receive an email very recently from a nursing colleague who became pregnant and had to carry out her duties away from the risks on the ward (upstairs). She gave her full consent for me to share her departing observations as follows:

> *I just wanted to say thank you to everyone who has supported/ responded to my questions/emails over the past few months.*
>
> *I enjoyed my time sitting upstairs with everyone before I left. It was a real eye opener to be able to see all the hard work that goes into each young person's case on the ward, I think being within the ward and especially doing a lot of nights I was hidden away from all the other work that goes on past the ward doors. I think as part of the nursing team you get so caught up in firefighting and managing that you forget about all the other work that goes on.*
>
> *Each one of you do an amazing job and being able to sit at home and read everyone's notes from therapy/CPAs/social care and to be involved in the million email trails that go on for each young person has given me a great insight into what each person does for the unit and the dedicated work of all the team 'upstairs'.*

Perhaps the Centre is often more integrated than the myths would have you believe. Although perhaps there are still echoes of the legend in some of the language?

Parallel processes

There can also be a powerful parallel process in relation to the organisational dynamic which can be enacted between patients and nursing staff on the ward itself **(revisit figure 1)**. It can often feel to patients that nurses and health care assistants are in a position of holding **power** and **control** over them (which is true insofar as they hold the keys to the doors and can say yes or no to requests for leave) and can be **ignoring** of their self-perceived needs and wants, especially when they are busy in the ward office. In response to this, patients can often feel **ignored** (not properly cared for), and **powerless**, leading them to feeling **overlooked**. This can then escalate risk behaviours as they seek more care and attention, usually through behaviour that demands action and intervention. Although this is a common pattern for such establishments, ultimately this can then lead to some young people being **scapegoated** and experienced as an impossible patient who either needs to be moved to a higher level of care than can be currently provided, or abruptly discharged. Sometimes this is an accurate assessment, and at others it can be because there is something within the patient and their system that is hard to connect positively with.

Some patients can go through an opposite type of pattern of giving up on the unit, and they then move towards **disengagement** and impulsive self-discharge from the inpatient service, without addressing something important, and their cycle of being **unheard** or o**verlooked**, or **alienated** may well continue and lead to subsequent multiple unsatisfactory admissions. There can also be a strong pull for them to be conscripted into joining a **subgroup (**anti-group, Nitsun 1996**)** of 'nothing to lose' (rebellious) patients who really do up the anti with the ward team. It can be hard for the nursing and multidisciplinary team to recognise or acknowledge their role in these patterns for many reasons, so any opportunity to reflect on this is extremely important.

Concluding remarks

As previously mentioned, retainment of nursing staff is often challenging within inpatient units, as compassion fatigue, primary and secondary trauma, and subsequent burnout can run high (Ray *et al,* 2013; Stamm, 2010; Foster, 2018). Naming the possible systemic enactments and entrapments that can feed into this, as well as the (often disturbing) aspects of the job can be really helpful in terms of staff finding a middle ground that they can more healthily inhabit for longer periods of time.

Ultimately, exploring this can help ward-based professionals achieve more compassion satisfaction within their work, and then make more conscious (less reactive) decisions about their careers.

The feedback itself seems to indicate that, with the support of consistent map and talk sessions, ward-based professional staff are developing increased recognition of the concept of being pushed or pulled into potentially unhelpful encounters, enactments and entrapments with patients, and their care systems and how potentially damaging reciprocations might be avoided.

Delivering staff supportive measures of value, which may contribute towards retainment and therefore consistency, without extra resources, can be extremely challenging – but it is needed and is appreciated, despite often relentless and overwhelming competing demands.

Overall, Map and Talk' enhances professional and personal understanding and is recognisable as an approach specific to CAT.

The last words – are left with the ward-based professionals engaging in this process:

> *'Mapping is very important to our kind of job. It helps to understand the patients better and also enhances staff awareness.'*

> *'To have a visual representation of what we are discussing, and seeing this mapped out as we go, assists me to break this down and see it much clearer [sic] in my mind. Having the space to discuss things and view other colleagues' ideas, to obtain a much more rounded way to approach a situation and/or patient is sometimes lost in the day-to-day running of the ward. But the session provides a good basis to do this and enables us to learn more from each other and take account of each other's strengths and weaknesses, which can sometimes impact on the ward.'* □

ACKNOWLEDGEMENTS

I want to say thank you to everyone who has supported/responded to my questions/emails over the past few months.

I would like to express my sincere gratitude to; Conrad Barnard, Hilary Brown, Claire Wheeler, Louise Cook, Francoise Hentges, Leanne Hunt, and Geoff Barford for their editorial support and ideas in compiling this article. I would also like to thank the nursing staff group at the St Aubyn Centre for their feedback, and preparedness to think about challenging material within the groups themselves.

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