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Contents

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.

International Journal
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As well as the three volumes of this journal other CAT books are listed and available.

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Editorial

We are delighted to present the third issue of the *International Journal of Cognitive Analytic Therapy and Relational Mental Health*. We are now moving to an open access, online medium for the journal (though print copies are available for those who would prefer to read a paper copy). All three issues are now online on the International CAT website www.internationalcat.org/journal/

This issue is in line with our wish to create a platform of views which shows the varied applications and developments of CAT. All the contributions highlight an approach which is facing outward across model boundaries, the wider world of psychotherapy and mental health. The journal's commitment is to show the important interplay between the specifics of the therapeutic practice of cognitive analytic therapy and the challenges of seeing mental health from a dynamic, psycho-social, systemic and relational point of view whilst not losing sight of the contribution of temperament and genetics.

The first article on Gender Dysphoria by Anna Laws will hopefully develop and extend a CAT therapeutic and relational perspective on an important debate. It not only offers a provisional relational model on the conflict between self and gender but raises questions more widely about the contribution CAT can make to thinking about the dynamics between personally experienced narratives of self and socially constructed roles and identities. We hope the article brings further contributions in response.

Mikael Leiman's incisive and historically engaging paper on how client self-observation has changed in CAT over several decades takes us to the heart of the story of CAT as a model. It quietly raises deep questions about the choice and timing of engagement in the triangle between therapy tools, client and therapist.

Jason Hepple gives a new and comprehensive theoretical and clinical contribution that shows how CAT may be fine-tuned to work with people living with obsessions and overvalued ideas. The article offers a wide reach beyond diagnostic categories.

In the same open and curious spirit, there are three papers on the wider applications of CAT. Dr Nadine Bearman writes engagingly on small scale research on CAT with functional neurological disorders and puts this in the wider context of physical health and psychotherapy.

A group of authors looks at the changes in understanding resulting from CAT-based case formulation sessions with inpatient staff in a forensic setting (Patrick Doyle, Louise Tansey and Jamie Kirkland). They use a skilfull pre- and post-design based on the repertory grid. This contextual approach chimes well with a commitment to developing relational awareness across the board in mental health provision.

Sarah Craven Staines reports upon and explores a small outcome study on the provision of CAT for mental health staff facing issues of burn-out and challenges to their well-being.

The uniquely international and cross-cultural paper co-written by Ann Treesa Rafi and Ian B. Kerr on issues arising from the development of CAT in India, raises big questions of differences of generation, culture, gender, power and philosophy. Alongside an honest, moving and detailed account of a single therapy, the paper shows the potential of CAT to hold in mind both the macro perspective of the forces that shape mental health in a global context whilst not losing sight of micro, local views and voices. With this paper in mind, the review, by Frank Margison of the book by Julie Lloyd and Rachel Pollard on Cognitive Analytic Therapy and the Politics of Mental Health, is highly relevant.

What all these papers have in common is an interest in the validity, versatility and further development of the model and its use in different contexts.

Thanks are due to our many contributors and to peer reviewers and the editorial team, all of whom give their time freely. Inevitably a journal produced on a shoestring budget is slow in its development and, it is with some regret, but realism, that we have not managed more than an annual issue. However, we hope there is now enough momentum for an annual issue of the journal and welcome offers and suggestions to the editors of future contributions. Meanwhile we look forward to a continuing, creative dialogue both in response to the articles in this issue and those preceding it.

One of the editors, Steve Potter, is standing down after this issue to concentrate on other writing. For him, it has been an honour to work with co-editors and to be in dialogue with the wide range of voices that have made these first three issues possible.

Steve Potter,
Ian Kerr,
Louise McCutcheon (as Chair of ICATA)
December 2019

Gender Dysphoria: A Psychological Model

ANNA LAWS

Abstract

Background: Gender dysphoria is usually defined as the experience of distress or discomfort caused by a sense of the mismatch between a person's gender identity and their sex assigned at birth. This goes some way to explaining the experience of gender dysphoria but misses important aspects. Nor does it explain why medical interventions to change bodily characteristics, to bring them into line with a person's gender identity, do not remove gender dysphoria completely.

Proposal: This article proposes a new model of gender dysphoria which suggests how it might develop, and be maintained, across three different domains of relating. Namely, Self to Self, Self to Other and Community to Culture. The author proposes that this model will bring a clearer understanding of the experience of gender dysphoria and provide a framework from which explorations and dialogue can take place in therapy and other healthcare settings.

Gender is a Cultural Construct

Traditionally, mainstream western cultures have viewed gender identity and biological sex as unified concepts, indistinguishable from one another. An idea, that genitals are the same as gender identity, has become embedded in our culture over many generations and underpinned many societal views on the topic. It has led to a binary cultural construct of gender identity as existing as two categorical possibilities, to match the two perceived types of genitals: male and female. However, there are very few things in nature which are categorical and almost all things lie

Anna Laws, Clinical Psychologist, Northern Region Gender Dysphoria Service (UK). email: Anna.Laws @cntw.nhs.uk

on a spectrum of some kind. (Even genitals and internal sex organs vary to a greater degree than is allowed for in the traditional cultural view, see, for example, Praveen, Desai, Khurana, et al, 2008).

The linking of gender identity to a categorical model of biological sex has allowed the dialogue about gender identity to become one of 'nature vs nurture' to such a degree that variation from the orthodoxy of categorical genitals and their associated gender identity has been pathologized and seen by some as unnatural and somehow an indication of dysfunction or disease (Meyer-Bahlburg, 2019).

It is extremely difficult to estimate the prevalence of diversity of gender identity because gender is defined differently in each culture. Estimates of prevalence have struggled with incomplete data because of a lack of consistent data collection at a national level, and some understandable reticence to share sensitive information (for a summary see ONS, 2009). With this caveat in mind, an estimate of the prevalence of a gender identity that does not match with biological sex has been given as 1:11900–1:4500 in birth assigned males and 1:30400–1:20000 in birth assigned females (WPATH, 2012).

Gender identity is highly subjective and can be defined as an individual's sense of the degree to which they experience gender to include masculinity, femininity, both or neither. It can be stable in a single gender identity or fluid across two or more. This is a definition which recognises the diversity of gender identity as a natural part of human experience, which has universal application, (see for example Halberstam, 2018, Bouman, de Vries, and T'Sjoen 2016, Beek, Cohen-Kettenis and Kreukels, 2016).

Identity is a multifaceted concept, with some parts originating internally, and being core parts of selfhood, (such as gender identity and sexuality), and other parts originating externally, in relation to other people, culture and to society, (such as being a parent, astronaut, or gin drinker).

Identity develops over childhood and adolescence and is usually crystallised during the exploration and disruption of self in puberty and early adulthood (Erikson, 1968).

Like sexuality, awareness of gender identity can be clear from early on. Children can make sense of it for themselves, or it can take many years to crystallise. For some youth, who are gender non-conforming, puberty is a key time when their gender identity, and the direction in

which their biological body is moving into adulthood, are at odds. Often this is when gender dysphoria really comes into focus and exploration can begin in earnest (Ashley, 2019).

Gender Dysphoria

Gender dysphoria is the distress caused to a person when there is a conflict between their gender identity and the way that they, or others, perceive, or relate to, them directly or indirectly (Galupo, Pulice-Farrow and Lindley, (2019), Lobato, Soll, Brandelli, Costa, Saadeh, Gagliotti, FrÈsan, Reed and Robles, (2019)).

Many people find that parts of their body are a source of their gender dysphoria, because they experience them as wrong, not theirs, or that something is missing, or is there when it shouldn't be. This can be the case of any gendering aspect of the body being present or absent (body or facial hair, breasts, hips, body fat distribution, skeletal frame (particularly height and size of hands, feet and shoulders), genitals, voice and facial bone structure) and is usually not as obvious earlier in childhood because children's bodies are more androgynous before pubertal hormones begin to take effect.

Gender dysphoria has a range of impacts on daily life. For example, people may avoid sport or entering sexual encounters because they may find attending to their own body a source of disgust or distress, because they experience it as the 'wrong' gender. Or they feel another's attention to their gendered body is unbearable. Equally they may face a multitude of social restrictions based on real or feared resistance from others (Dowers, White, Kinsley and Swenson, (2019)).

Gender dysphoria can be extremely debilitating for some people and can lead to mental health problems such as anxiety, depression, substance misuse, sexual risk behaviours, self-neglect and self-harm (Morris and Galupo, (2019), Schulman and Erikson-Schroth, (2019), Johns, Lowry, Andrzejewski, Barrios, Demissie, McManus, Raspberry, Robin and Underwood (2019), Testa, Michaels, Bliss et al, (2017), Dhejne, Van Vlerken, Heylens, and Arcelus, 2016, Millet, Longworth, Arcelus, 2016, McNeil, Bailey et al, (2012)). For some people this mental illness may be resolved by social or medical transition to live in ways which are gender affirming (Bouman, Claes, Marshall, Pinner, Longworth et al, 2016). There is increasingly strong evidence that being affirmed and supported, by those people closest to the individual, protects against mental illness in

the presence of gender dysphoria (Pariseau, Chevalier, Long, Clapham, Edwards-Leeper and Tishelman (2019), Puckett, Matsuno, Dyar, Mustanski and Newcomb (2019), Medico and Zufferey, (2018)).

Transition can have unwanted consequences, but regret, which is usually related to loss of family, friends, employment and experiences of transphobia, is reported by only around 2% of people (McNeil, Bailey et al, 2012).

Responses to visible gender variance are diverse and can often come from a position of not understanding the experience of the other, low personal self-esteem, or struggling to accept the difference that the presence of the other brings to mind (Callahan, and Zukowski, (2019), Harrison, and Michelson, (2019), Molofsky, (2019), Anderson, (2018)). When this conflict arises, in society, between individuals, or in the individual, it can create, in gender non-conforming people, a desire to be acceptable to the other, either by appearing to be more cis-heteronormative (i.e. conforming to essentialist views of biological sex matching gender identity and the typically associated gender roles and / or the assumption that most people are, or should be, heterosexual) or to suppress their own needs to appear to be less threatening to society or the individual (Arayasirikul, and Wilson, (2019), Butler, Horenstein, Gitlin, Testa, Kaplan, Swee and Heimberg, (2019), Pham, Inwards-Breland, Crouch, Albertson, Ahrens and Kerman, (2019).

Whilst there is no place, in any therapy, to seek to change a person's gender identity (UKCP, 2014), Cognitive Analytic Therapy (CAT) is well placed amongst other therapies to provide a framework in which people affected by gender dysphoria can explore the impact that it has on their lives and seek to reduce it through therapy alongside medical or social transition. CAT offers a dialogue that is open to individual perspective, rather than a diagnostic framework. Uniquely, it offers a space in which a client can conceptualise their gender dysphoria as a dialogue which happens 'in the space between' parts of themselves, and between themselves and others. The author proposes that gender dysphoria is well suited to being conceptualised in a CAT framework.

CAT Theory of Development of the Self

CAT is a therapy which is grounded in the interpersonal and internal processes of personal development. As infants we experience the world not just through our own senses, but those sensory inputs are mediated

through interactions with our caregivers. The interactions, when repeated with more, or less, consistency over time, become internalised patterns by which we organise our sense of the world, our self and others. These patterns then become the ways in which we mediate our own interactions with the world, self and others throughout life (Ryle, 1975).

The influence of Vygotsky on CAT has been considerable, (see for instance, Leiman, 1994a and b). Integral to Ryle's description of personal development is the inter-related nature of that development. The child does not develop in a vacuum, but rather, in reference to another, and both the child and their 'others' are embedded in social and cultural contexts. Together the child and the caregiver co-construct a meaning out of that context and, with this mediated meaning making, the child comes to know about themselves, the world and the other. It is this repeating relational enactment, which is the means by which the child makes sense of the state of the world and knows about themselves. However, it is largely the *process* by which the repeating relational enactment occurs with the caregiver which forms the basis of their internalised set of self-management and interpersonal resources, or in CAT terms, reciprocal roles (Ryle and Kerr, 2002, Vygotsky, 1978).

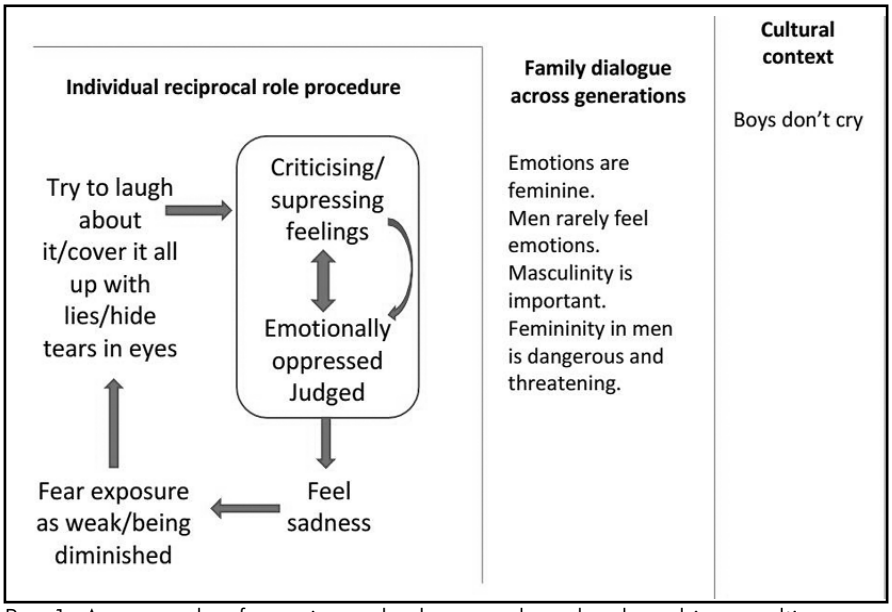
Ryle drew on the work of Bakhtin to develop the notion of the dialogic in CAT. For Bakhtin, the nature of human interactions lies in dialogue. He saw humans as being in constant dialogue with those around them, concretely as well as those who exist in the abstract; our culture, our ancestors, a god or imagined other. Bakhtin described all experience, thought and action as expression, of ourselves in relation to a real, or imagined, other and in dialogue with them (Bakhtin, 1986, 1992).

As a child develops, they are in direct dialogue with their caregiver in verbal, interpersonal and behavioural terms. The caregiver embodies, not only their part of the dialogue, but also that of the dominant current and ancestral cultural voices who give the caregiver legitimacy and transmit that cultural dialogue to the child. All interactions then contain that cultural dialogue and refer back into history as well as forward into an imagined future. Bakhtin proposes, and Ryle expands, that we never act in isolation but always in reference to another and in expectation that the other will respond (Ryle and Kerr, 2002).

As we develop in this context, we learn the whole dialogue, that of culture and caregiver alongside our own voice, and internalise all three. This underpins the development of the two poles of reciprocal roles, acted out between the caregiver and child and then internalised to

become self-to-self relating, offering us two positions from which to respond within that role in seeking or eliciting relationship with others (Ryle, 1991).

Over time we develop a repertoire of reciprocal roles and learn to move between them by way of reciprocal role procedures (RRPs). Ryle described problematic movements between these reciprocal roles as dilemmas, traps and snags in which unconscious processes limit options for positive change and reinforce negative assumptions or beliefs (Ryle, 1979). Leiman, (1997) developed this further to include the concept that these patterns themselves represent a chain of dialogue in progress.



Box 1. An example of a reciprocal role procedure developed in a multi-generation family and cultural contexts

As in the example of box 1 (reading right to left) the cultural context contains ideas, distilled through historical and current dialogues, that men and boys do not display emotions. Family dialogues process and perform these ideas, through history to the present day, in parenting and other enactments, and in embodied responses. These can be seen in what men and boys do when they feel sad or emotional and how family members respond to those emotions (or lack of them). The developing child has repeated relational enactments with their caregiver and the family (in a cultural context which is borne out of dialogues about men and emotions) and internalises them into a reciprocal role

procedure. This then becomes their primary way of managing emotional states as they arise.

Moving from a minority stress model to a CAT approach

Previous attempts to understand the experience of gender dysphoria have centred on a minority stress model, in which an individual faces exposure to distal stressors such as discrimination, lack of representation, rejection and violence by virtue of their gender identity. These may then prompt proximal stressors such as concealing aspects of one's identity, anxiety, and rejection of their identity. Over time these combined stressors become a pattern of chronic stress that makes individuals susceptible to poor health including poor mental health (Meyer, 2003, Hendricks and Testa, 2012).

This model recognises the importance of the attributions made to trauma experienced by people in their cultural and societal contexts, as a result of their gender identity, in forming internalised transphobia and in prompting the proximal stressors such as repressing, or hiding, their gender identity. However, the author suggests that it lacks complexity and detail. It is limited in being able to describe the development of gender dysphoria, or how, and when, it is maintained, or resolved. Whilst the minority stress model does recommend that people with gender dysphoria compare themselves to those within the group with which they identify (rather than those who do not share the same gender identity), it does not offer more specific assistance in resolving gender dysphoria than to make social connections and 'receive skills and support'. For many people this is not a sufficient level of detail to afford understanding or make changes in their life.

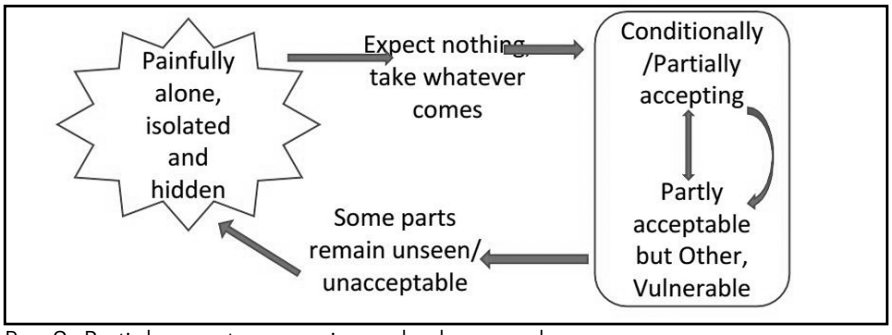
A Psychological Model of Gender Dysphoria

The author proposes a new, CAT informed, psychological understanding of gender dysphoria as an experience that arises out of the culture in which the person is embedded. It uses Bakhtin's description of inherited cultural dialogue which offers a perspective that encompasses the views of the individual and the history of all the views of gender which have come before them, as well as those of the future. This CAT model describes the development and maintenance of gender dysphoria by proposing an overarching model with space for each individual to respond with their unique set of strengths and resiliencies.

The model is described in three parts and considered from the perspective of the individual relating to themselves (self to self), to those who populate their world now, and in the past, (self to other) and from that of the gender diverse community to the wider culture in which it exists (community to culture). Each section is illustrated with the words of Amy, Ben, Claire and David, who generously offered their personal experiences of gender dysphoria and the model. Their names have been changed to protect their anonymity.

The following are three layers of patterns of interaction using the concepts of CAT reciprocal role procedures and dialogical sequence to explore the multiple interactions of self-management, interpersonal and culture coping procedures. They are from the point of view of the person dealing with gender dysphoria. Detailed below are three reciprocal role procedures, each broken down into perspectives which represent the different dialogues and the ways in which they build up a context in which Gender dysphoria is created and maintained.

Part 1. Partial acceptance reciprocal role procedure (RRP)



Box 2. Partial acceptance reciprocal role procedure

The following are three layers.

Self to other: Whether or not they grow up in a family which is wholly accepting of their gender identity, the response – to a person expressing their gender identity when it does not fit the cultural norms for their birth assigned sex and gender – is most often rejection. It is the indication that their gender expression is not acceptable to the other. Over childhood and adolescence and into adulthood, this is reinforced, whilst other aspects of the person's identity are given a different reception. This leads to a

sense that the person is only partly, or conditionally acceptable (subject to them not expressing gender identity outside of the cultural norm).

Self to self: As individuals we learn to reject those parts of ourselves that others view as less acceptable and, be less accepting of them ourselves. We develop an 'if only I' identity, that wishes away aspects of a gender identity which we see as unwanted or difficult. We learn to hide our 'Otherness' from ourselves and others, for fear of judgement, aggression and comparison. This results in avoiding relationships and not thriving. When we do make connections, we fear being discovered as 'other' and this leaves us vulnerable to making relationships on the basis that 'something is better than nothing'. This gives permission to those to whom we relate, to only accept those parts of us that feel valid to them. This makes us vulnerable to suffering abuses at the hands of others.

Community to culture: We live in a society that is in the early stages of equality and acceptance of diversity in gender identities, but still fears, erroneously, that gender diversity is, at its heart, a psychopathology and a matter more superficially of a sexual preference. Western society tolerates expressions of gender diversity as entertainment but struggles to allow conversations about mundane personal experience, except though a media lens of 'otherness'. Fearing a backlash against individuals, or against the gender diverse community as-a-whole, much of those in the community stay hidden and quiet about the reality of living in this society. It is a reality of accepting representation and the beginning of national 'conversations' whilst continuing to face systematic and institutional discrimination.

Lived experience of the partial acceptance reciprocal role procedure

Amy, 27 years old
At 16-18 years old I tried to suppress it. I became depressed and tried to be normal. I didn't want to be, seen as, a freak. I was worried about losing friends and family, of being bullied and disowned. I felt down, and there was a dissociation between myself and the person in the mirror. I was in lots of pain, but I put on a smiling face to everyone else. I felt trapped in who I was. I met my ex-girlfriend aged 18. I suppressed things more and tried

to live up to the boyfriend ideal. I tried to just really focus on the needs of others. I hated myself but if she could love me, then it was worthwhile, if someone saw some good in me. I saw no good in myself. I broke up with my ex because she was abusive but someone who loved me, and I couldn't love myself. I try and hide my being trans so that people don't find it unacceptable. I still lean towards trying to isolate myself.

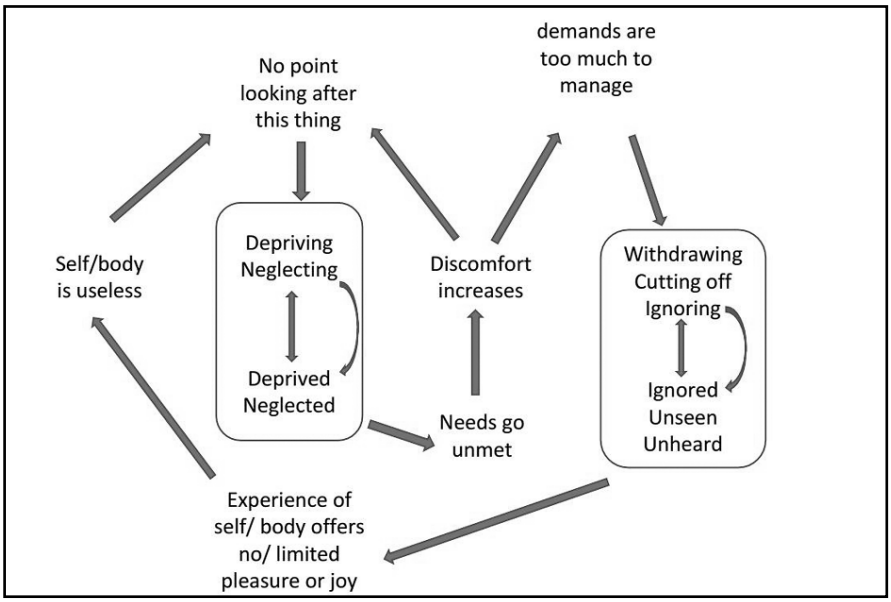
Ben, 36 years old
It's how my family was when I came out. It was a case of I was ok when I was a lesbian but not when I was a male. I was still hiding parts of who I was. I used to have to hide all of me and that led to self-harm and suicide(attempts).

In my late teens and early twenties, I was depressed and suicidal but deep inside I wanted to be a man. I brought it up with my family when I was younger, but I was disregarded. They told me to think about the effect on the family and brushed it under the carpet. It was always there in the back of my mind though, and I still don't speak to my family now. I have a little brother who is 15 years younger than me and he was small in school. They told me to think of the effect on my brother at school, he could be bullied because of me. It felt like they were ashamed and didn't think about the impact that all of this was having on me. It was all about how it was for them.

Claire, 47 years old
Growing up in the 70s and having a female aspect that I kept hidden, like it was 'just fun' and didn't mean anything. My father accepts me now, but it's far from comfortable. He and his wife still misgender me regularly. It's difficult for us to have a relationship because I refuse to hide myself anymore. I'm the only openly trans person in [my workplace]. This [partial acceptance RRP] hit home. I still worry about parts of myself that remain unseen. It took a long time to work out that I'm not really a cross dresser.

David, 45 years old
The meeting didn't go down well with the family. They told me that I had always been different and pleaded with me not to have the surgery. We lost contact for almost 18 months. For 30 years, all I had thought about was them and they couldn't see what life was like for me. For a while I lived a double life [in a large town]. I got my first flat and changed my name and moved in as David. I still had to go to the bank with my birth name and my girlfriend and I had to hide from people we saw from back home on the streets. After 8 years, I wasn't prepared to live in secret anymore, but my girlfriend got cold feet and couldn't go forward with the plan to tell people and be together. We split up and I moved back in with my parents.

Part 2. Withdrawing and depriving reciprocal role procedure



Box 3. Withdrawing and depriving reciprocal role procedure

Self to self: Holding parts of our self away from sight and awareness, means that we are limited in how we go through life. Our body feels wrong and useless and can be unavailable for use, or enjoyment. We see others having a different experience and come to feel that our body, and even our whole self, is useless to us. We neglect and deprive our body, and our self, struggling to seek medical care, or see the point in working hard to achieve. Our physical and social needs go unmet and we are further dismayed with ourselves. At times the demands on us become overwhelming and we withdraw and cut off from our bodies, wholly or in part, leaving parts of our physical and emotional selves ignored and avoided.

Self to other: Fearing rejection and an upsurge of distress, people hide their bodies from sight. Diverse bodies/identities go unseen and when they do come into view they are often labelled as 'not real'. When people approach medical or other services for help, they are often seen as somehow dysfunctional and denied the help because attention is erroneously diverted to their gender identity. They experience chronic neglect as a result. If they continue to raise issues of unmet need, they are seen as

demanding, and support is withdrawn. People learn that their needs and their bodies are unacceptable and not valued.

Community to culture: Our society places a high value on specific versions of masculinity and femininity and less value on diversity from those norms. Communities who are not perceived as complying with these norms are marginalised and devalued and go unrepresented. Expressing gender diversity openly in this society becomes increasingly difficult and unsafe until it is too unmanageable, and communities move underground again for their own protection and relief.

Lived experience of the withdrawing and neglecting reciprocal role procedure

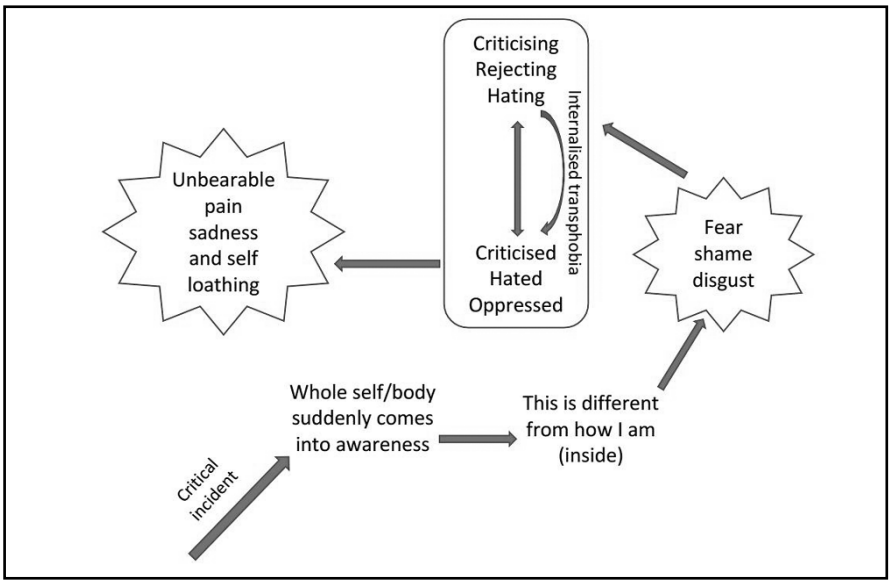
Amy
I had periods of not eating or not washing but when I got into a relationship I looked after myself. I found work and got into a routine. I forgot about it and survived that way. In the past I struggled daily and only working helped. I accepted my dysphoria, but I couldn't have worn a suit. I kept my hair long and wore black and didn't think about what I was wearing or doing.

Ben
I blocked puberty out. I knew it was happening, but I blocked it out. Periods were the worst part. I wasn't coping, I was self-harming and suicidal. I went to the GP and they were good. They didn't know what to do but they wanted to help and said they would find out and get back to me.

I cut off from myself and from society and it happens over and again, so you don't expect different outcomes. You end up just ignoring it and not doing anything about it. It's hard sometimes with professionals who don't understand and refuse care, or have to be educated. In my old GP surgery, I saw a locum who didn't understand what gender dysphoria was and just refused to give me treatment. I kept on seeing locums there and eventually I just left.

Claire
I often thought that if my marriage broke down, I would live full time as a woman, but I didn't think about a medical transition, [gender dysphoria] was just [at] a very low level [of distress] for a long time. Once I told my wife the floodgates opened. I had permission to feel it. The unhappiness and dissatisfaction and disconnect with my body started coming in.

Part 3. Rejecting and Criticising reciprocal role procedure



Box 4. Rejecting and criticising reciprocal role procedure

Self to self: An incident occurs in which we suddenly see our whole self (physically in the mirror/shower or emotionally). Parts of us, that we have been ignoring, are seen and we are abruptly met with the incongruence between our gender identity and our whole self – which contains congruent and incongruent parts. We are distressed and respond negatively, criticising and rejecting our whole self for having parts which are difficult to bear, and feeling that our experience of ourselves makes us somehow lesser (internalised transphobia). In terrible pain we push away parts of us that are unbearable and cut off from them again (see box 5 for clarification).

Self to other: As we move through the world, others label our sex and gender unreflectively and act on these labels. When the labelling is incongruent with our identity (misgendering) we suddenly see ourselves through the other person's lens, bringing parts of our experience that were held at arm's length into our awareness. Both we and others may suddenly become aware of our perceived 'otherness' and react negatively. The otherness is pushed away forcefully with rejection, criticism and hatred leaving a feeling of being criticised, hated and oppressed.

Community to Culture: When gender diversity is only represented as sensationalised, oppressed or in crisis, the ordinariness of real people's lives is lost from the narrative. Stereotypes are formed because ordinary people feel too frightened to disclose their gender identity and so go unseen.

When the community profile is raised within the society it is in the context of unrepresentative incidents or issues and the society does not easily connect with the humanity of individuals. Fearing that the community is somehow different, society pathologizes, rejects or sensationalises them, oppressing the community and reinforcing the negative stereotypes of gender diversity.

The whole model is shown in box 5 with the interconnecting reciprocal role procedures.

Lived experience of the rejecting and criticising reciprocal role procedure

Amy

The anxiety is still there that people will think that I am a trans freak. I don't hate those people; they're not educated or accepting about others. I only hate myself more when I hate them. I blame myself for being visible as trans and not being cis.

When I look in the mirror it's triggering, it's my face. I don't like getting my hair cut, I see myself as I was, when they wash my hair and pull it back from my face, it's my hair line. I hate it and feel angry. My biggest fear is being judged as how I was, not how I am.

Ben

In the past misgendering was a massive problem for me. It's the looks you get when people are trying to work out what gender you are. I was anxious using the male toilet in case someone said something. My voice gave me away, so I avoided speaking.

I see my self-harm as a coping mechanism. I could wake up and be having a great day and all it takes is to walk past a mirror and see parts that match and don't match and that sets you off. I don't get changed in front of my partner. I know I'm male, but I've still got these female parts and it can ruin your day.

Claire

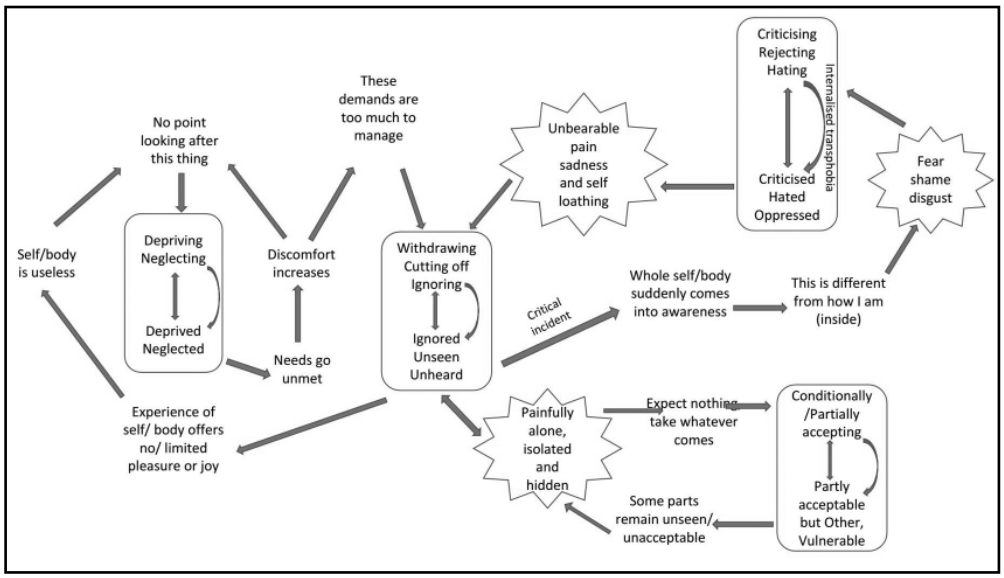
There's a societal aspect to it as well. The knowledge that people would see me as a man in a dress. It's less so now but the worry and anxiety that it causes with how other people see you is part of

it. Thinking 'is today the day that someone will say or do something'. It adds to it all; factors that amplify your feelings and imagination. It's a feeling of failure. I'm doing this wrong and there's nothing I can do to fix it. Discomfort and distress are at the core but there's more, it's a negative loop and everything makes you feel more and more 'I'm wrong'.

David
I told my GP in [isolated rural area] and he was just a rural GP and he looked at me like I was an alien. It was 2004! I needed time off work so the GP wrote a sick note that said that I was 'mentally disordered' because that was what he thought I was after hearing about my gender identity. I wasn't going to hand that in at work!

I didn't use to talk about it. You can't ever trust anyone. My partner told people at the beginning and some weren't supportive, they called me a freak. I hated the label of being trans and was angry when I visited the GIC.

The bit about internalised transphobia, I am still critical about myself that I've not achieved [something more]. I'm critical of myself a lot, a huge amount, internally and privately. I'm angry. I'm waiting to start my life and I feel like it's so late and I'm having to play catch up. I can't go forward because I'm still waiting for things to be sorted out with my dysphoria.



Box 5. The psychological model of gender dysphoria

Application of the psychological model of gender dysphoria

This is the first comprehensive model of gender dysphoria (GD) and, as such, seeks to create a description of the development and maintenance of GD in Western culture. In proposing this model the author seeks to offer a framework in which people who experience GD may be able to understand their experiences more fully and seek to remedy those parts of their distress which have been brought about by parts of our culture which are pathologising of gender diversity. The intention is not that psychotherapy based on this model should replace necessary and life-saving medical transition for those who need that intervention. However, it may be that finding greater self-acceptance and being able to see one's bodily characteristics and gender identity as being of equal value, regardless of their adherence to the norms of cis-heteronormativity, may mean that some people feel that they can live with less GD and as a result need fewer medical interventions to be content and affirmed.

In addition, it provokes the question of what cultural, societal and systemic changes we should seek as a health service, as practitioners and as members of society to shift our attitudes and practices to understand and accept that all gender identities are normal and natural parts of human experience. This would in turn, reduce the prevalence of the idea that some expressions of gender identity, or differences of bodily characteristics and gender identity were somehow less acceptable or valuable.

In practice the model can be used to educate health professionals to allow a greater understanding and increase confidence in working with people presenting with GD. It offers a means by which to develop a non-judgemental dialogue with clients about their experiences that does not focus solely on their experience of their body in isolation, which is a narrowing of dialogue which can understandably occur if a professional has no lived experience of GD themselves.

As a CAT model it allows for the formation of changed patterns or exits; new procedures and reciprocal roles that can bring about changes to the ways that we relate to ourselves, to others and to the wider society. It is evident from speaking with people who experience GD that these exits have been found by some and that many could benefit from being supported in finding similar patterns. Future work should identify these and seek to operationalise them, so that the widest possible group of people can benefit from the relief that this could bring. □

REFERENCES

Anderson, V.N. (2018). Cisgender men and trans prejudice: Relationships with sexual orientation and gender self-esteem. *Psychology of men and masculinity*, 19(**3**) 373-384.

Arayasirikul, S. and Wilson, E.C. (2019). Spilling the T on trans-misogyny and microagressions: an intersectional oppression and social process among trans women. *Journal of Homosexuality*, 66(**10**), 1415-1438.

Ashley, F. (2019) Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth. *Clinical child psychology and psychiatry*, 24 (**2**), 223-236.

Bakhtin, M.M. (1986). Speech Genres and Other Late Essays. In C. Emerson and M. Holquist (Eds.). Trans. V.W. McGee. University of Texas Press: Austin, TX.

Bakhtin, M.M. (1992).'The Dialogic Imagination: Four Essays.' University of Texas Press: Austin, TX.

Bearse, M.L. (2012). Becoming who we are meant to be: Native Americans with Two-spirit, LGBT and/or related tribal identities. In J.M. Poirier, G.M. Blau and S.K. Fisher (Eds.) Improving emotional and behavioural outcomes for LGBT youth: A guide for professionals. PP 87-110. Brookes: Baltimore.

Beek, T.F., Cohen-Kettenis, P.T. and Kreukels, B.P. (2016). Gender incongruence/gender dysphoria and its classification history. *International Review of Psychiatry*, 28(**1**)**,** 5-12

Bouman, W.P., Claes, L., Marshall, E., Pinner, G.T., Longworth, J., Maddox, V., Witcomb, G., Jimenez-Murcia, S., Fernandez-Aranda, F. and Arcelus, J. (2016). Sociodemographic variables, clinical features, and the role of preassessment cross-sex hormones in older trans people. *Journal of Sexual Medicine*, 13(**4**), 711-719.

Bouman, W.P., de Vries, A., and T'Sjoen, G. (2016). Gender dysphoria and Gender Incongruence: an evolving inter-disciplinary field. *International Review of Psychiatry*, 28(**1**)**,** 1-4.

Butler, R.M., Horenstein, A., Gitlin, M., Testa, R.J., Kaplan, S.C., Swee, M.B. and Heimberg, R.G. (2019). Social anxiety among transgender and gender non-conforming individuals: The role of gender-affirming medical interventions. *Journal of Abnormal Psychology*, 128(**1**), 25-31.

Callahan, M.P. and Zukowski, K.T. (2019). Reactions to transgender women and men in public restrooms: Correlates and gender differences. *Journal of Homosexuality*, 66(**1**), 117-138.

Chessick, R. (2015) Kernberg and the modern object relations theory. International Psychotherapy Institute: USA.

Dhejne C, Van Vlerken R, Heylens G, Arcelus J (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, 28(**1**), 44-57.

Dowers, E., White, C., Kinsley, J. and Swenson, R. (2019). Transgender experiences of occupation and the environment: A scoping review. *Journal of occupational science*, 26(**4**), 496-510.

Erikson, E.H. (1968). *Identity: Youth and crisis.* New York: Norton.

Galupo, M.P., Pulice-Farrow, L. and Lindley, L. (2019). 'Every time I get gendered male, I feel a pain in my chest': Understanding the social context for gender dysphoria. *Stigma and Health*, Advance online publication Sept 2019. https://psycnet.apa.org/record/2019-56084-001.

Halberstam, J. (2018). Trans: A quick and quirky account of gender variability. University of California Press: Oakland, CA.

Harrison, B.F. and Michelson, M.R. (2019). Gender, masculinity threat and support for transgender rights: An experimental study. *Sex roles: A journal of research*, 80(**1-2**), 63-75.

Hendricks, M.L. and Testa, R.J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, 43(**5**), 460-467.

Johns, M.M., Lowry, R., Andrzejewski, J., Barrios, L.C., Demissie, Z., McManus, T., Raspberry, C.N., Robin, L. and Underwood, J.M. (2019). Transgender identity and experiences of violence, victimisation, substance use, suicide risk and sexual risk behaviours among high school students – 19 states and large urban school districts. Morbidity and Mortality Weekly report, 68(**3**), 67-71.

Leiman, M. (1994a). Projective identification as early joint action sequences: A Vygotskian addendum to the procedural sequence object relations model. *British Journal of Medical Psychology*, 67(**2**), 97-106.

Leiman, M. (1994b). Integrating the Vygotskian theory of sign mediated activity and the British Object Relations theory. *University of Joensuu Publications in Social Sciences*, Number 20. Joensuu: University of Joensuu.

Leiman, M. (1997). Procedures as dialogical sequences: A revised version of the fundamental concept in cognitive analytic therapy. *British Journal of Medical Psychology*, 70(**2**), 193-207.

Lobato, M.I., Soll, B.M., Brandelli Costa, A., Saadeh, A., Gagliotti, D.A.M., FrÈsan, A., Reed, G. and Robles, R. (2019) Psychological distress among transgender people in Brazil: Frequency, intensity and social causation- An ICD-11 field study. *Brazilian Journal of Psychiatry*, 41(**4**), 310-315.

McNeil, J, Bailey, L, Ellis, S., Morton, J. and Regan, M. (2012). Trans Mental Health Study 2012. Scottish Transgender alliance: September 2012 https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf.

Medico, D. and Zufferey, A, (2018). Giving future to transgender youth. . . What do we currently know of their needs, what are the best practices? *Revue Medicale Suisse*, 14 (**621**), 1765-1769.

Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin,* 129(**5**)**,** 674-697.

Meyer-Bahlberg, H.F.L. (2019). 'Diagnosing' Gender? Categorising gender-identity variants in the Anthropocene. *Archives of Sexual Behaviour*, 48(**7**), 2027-2035

Millet N, Longworth J, Arcelus, J. (2016). Prevalence of anxiety symptoms and disorders in the transgender population: A systematic review of the literature. *International Journal of Transgenderism*, 18(**1**), 27-38.

Molofsky, M. (2019). Co-opting the Body of the Identified Other: The hysterization of otherness in relation to self. *The Psychoanalytic review*, 106(**1**), 49-71.

Morris, E.R. and Galupo, M.P. (2019). 'Attempting to dull the dysphoria': Non-suicidal self-injury among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, 6(**3**), 296-307.

O'Neill, A. (2017). *Hate Crime, England and Wales, 2016/17*. Home Office statistical Bulletin 17/17: United Kingdom Government https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/652136/hate-crime-1617-hosb1717.pdf.

Office for National Statistics (ONS) (2009). Trans data position paper. http://www.ons.gov.uk/ons/guide-method/measuring-equality/equality/equality-data-review/trans-data-position-paper.pdf.

Pariseau, E.M., Chevalier, L., Long, K.A., Clapham, R., Edwards-Leeper, L. and Tishelman, A.C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Paediatric Psychology*, 7(**3**) 267-277.

Pham, A., Kerman, H., Inwards-Breland, D., Crouch, J., Albertson, K., and Ahrens, K. (2019). How are transgender youth affected by the news? A qualitative study. *Journal of adolescent Health*, 64(**2**), supplement, S105.

Praveen, E.P., Desai, A.K., Khurana, M.L., Philip, J., Eunice, M., Khadgawat, R., Kulshreshtha, B., Kucheria, K., Gupta, D.K., Seith, A., and Ammini, A.C. (2008). Gender identity of children and young adults with 5alpha-reductase deficiency. *Journal of Paediatric Endocrinology and Metabolism*. 21(**2**), 173–179.

Puckett, J.A., Matsuno, E., Dyar, C., Mustanski, B. and Newcomb, M.E. (2019). Mental health and resilience in transgender individuals: What type of support makes a difference? *Journal of Family Psychology*, Jul 18. Advance online publication.

Ryle, A. (1975). Self-to-self, self-to-other: The world's shortest account of object relations theory. *New Psychiatry*, April **24**, 12-13.

Ryle, A. (1979). The focus in brief interpretive psychotherapy: Dilemmas, traps and snags as target problems. *British Journal of Psychiatry*, **134**, 46-54.

Ryle, A. (1985). Cognitive theory, object relations and the self. *British Journal of Medical Psychology*, 58(**1**), 1-7.

Ryle, A. (1991). Object relations theory and activity theory: A proposed link by way of the procedural sequence model. *British Journal of Medical Psychology*, 64(**4**), 307-316.

Schulman, J.K. and Erikson-Schroth, L. (2019). Mental health in Sexual Minority and Transgender Women. *The Medical Clinics of North America*,103(**4**), 723-733.

Testa, R.J., Michaels, M.S., Bliss, W., Rogers, M.L., Balsam, K.F. and Joiner, T. (2017). Suicidal Ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology*, 126 (**1**), 125-136.

UKCP (2014) Conversion Therapy Consensus Statement. United Kingdom Council for Psychotherapy: June 2014 https://www.psychotherapy.org.uk/wp-content/uploads/2016/08/ukcp-conversion-therapy.pdf.

Vygotsky, L.S. (1978). *Mind in society: The development of higher psychological processes.* Harvard University Press: Cambridge, MA.

WPATH (2012). World Professional Association of Transgender Health, Standards of Care version 7. https://www.wpath.org/publications/soc.

How assisting client self-observation has changed in CAT

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Abstract:
Assisting client self-observation is the fundamental task of therapists in any model of psychotherapy. In what follows, I will summarise my understanding on how this task is conceptualised in CAT at various stages of its development. The key issue is, should we understand self-observation as an ability, or is it a jointly generated activity that is, primarily, dependent on the therapists' ways of timing and addressing the focal themes of therapy?

1. Early understanding

Looking back, in the pre-CAT period of traps, dilemmas and snags, client self-observation seemed unproblematic. It was assumed that clients recognised their problematic procedures when provided with portable and accurate tools for self-reflection.

This straightforward assumption worked quite well. A lot was accomplished only in 10-12 sessions. The reason for the success was in the accuracy of reformulation, which required that it was accessible to the client.

Traps described self-fulfilling anticipation. By monitoring their traps, clients quickly recognised the assumptions by which they predicted the consequences of their actions. Generalised assumptions were described as either-or or if-then dilemmas. The cleverness of dilemma formulations is hidden in the negative pole. 'Either I keep feelings bottled up or make a mess' describes the preferred, protective alternative and the implied risk, if the precaution fails. 'If then' dilemmas, in turn, describe risky situations that will lead to an intolerable position, if the risk materialises: 'If close, then smothered'.

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Dilemma formulations were effective, because they targeted the outer border of the client's conscious self observation and because their wording was emblematic. 'Smothered' contains a collection of referential routes, which allow clients to explore further the undesirable or feared alternative.

The elegance of these brief formulations lies in their dynamic power as tools that expand the client's zone of proximal development. Their use agreed with the classical psychoanalytic view on starting the therapeutic work from defences. Traps, dilemmas, and snags nicely captured the rich variety of ways by which we try to manage anxiety, helplessness, and forbidden wishes.

2. Development of complex reformulations

The way of assisting client self observation changed quite radically by the end of the 1980s, when the simple, portable tools were replaced by reformulation letters and diagrams. Letters were mainly a way of helping the as yet inexperienced psychotherapists to organise the client's complex clinical material in some coherent way and help them infer the salient trap, dilemma, and snag formulations, or the TPPs on the basis of this material. True, a lot of clinical experience is required to identify the client's recurring action patterns in a free dialogue during the first session and to generate accurate mini-formulations that begin to guide client self observation.

Diagrams were inspired by Mardi Horowitz's configuration analysis that, originally, was mainly used for research purposes. Tony Ryle's innovative idea was to extend their use to help dissociative clients perceive and remember their disruptive ways of dealing with helplessness or difficult interpersonal situations. The early visualisations resembled the SSSDs, or Self State Sequential Diagrams, that evolved in the mid 1990s. They named alternating emotional states and identified risky situations that provoked state shifts.

Such visualisations began to grow more complex, and by the turn of the decade some of them resembled roadmaps of Birmingham as Tony Ryle noted. At that stage, CAT theory stepped in to discipline the anarchistic variety of maps. Reciprocal roles were summarised in the core of the diagram and the client's various ways of dealing with unmanageable roles were depicted by loops around the core. While the description organised the maps, the dissociated states and shifts between

them were lost in this diagrammatic format. After some years, this shortcoming was amended by the SSSDs.

As tools for self observation, diagrams were difficult, because they suffered from the same problem that had stimulated the development of reformulation letters. Instead of simple and portable tools that evolve in the course of joint reflection of client problems, writing a letter or constructing a diagram during the first sessions became an arduous task for the therapist and their sharing with the clients a ceremonial process.

A lot of clinical experience is required to stay within the limits of what the client can access. During my years of CAT trainer and supervisor, I rarely saw diagrams to which I did not have any reservations. Their main advantage was that they demonstrated the therapist's developmental level on understanding reciprocal roles and their relationship to coping procedures. I was often concerned about how the therapist's construction might look to the client and whether it actually helped in focusing the therapy on salient issues.

3. The dynamic space

Freud's early experience with hysterical patients showed him the presence of powerful forces that affected patient self-observation. Dissociation banished the memories of traumatic experiences from consciousness either completely, or allowed pale, affectless memory traces to enter as objects of self-observation (Freud, 1894). He found a way of approaching such objects indirectly by free association. The patient was instructed to let her mind wander freely, observing what was going on, and describing it to the analyst. The self-observing part of this practice is almost identical with current mindfulness methods. The difference is in the request to tell about what is going on.

Freud soon found out that the presence of the analyst introduced distractions in the flow of tracing the semantic networks of internal objects. At times, the patient's associations stopped completely. This phenomenon led Freud to postulate transference, which he, initially, understood as a hinder to the analytic process. Only later he realized that patients show, in the interaction, what they cannot yet make a target of deliberate self-observation. Thus, transference became an important object of joint observation that helped patients address disavowed aspects of themselves and dissociated past experiences (Freud, 1914).

The dynamic nature of self-observation became very clear to Wilfred

Bion, when he tried to work psychoanalytically with fragile and nearly psychotic clients. The general contemporary belief was that helping clients access the unconscious by accurate interpretations was mutative. Bion (1954) noticed that, for psychotic clients, interpretations provoked fragmentation and confused mental states. This finding led him to develop the idea of containment. The noxious internal objects, or unmanageable memories of past experiences, which the client could not encounter without risks of deterioration, needed to stay with their full emotional force within the therapist's consciousness for some time. This altered the power balance between the client and the 'unthinkable object' and it could become a target of joint observation. Eventually, clients were able to tolerate the emotional impact of the object and modify their way of relating to it.

4. Self-observation as an ability

In current psychotherapies of personality disorders, Freud's dynamic understanding has tacitly been replaced by the idea of self-observation as a developing capacity. This is true of the more cognitively oriented therapies like dialectical-behavioural therapy, emotion-focused therapy, and schema-focused therapy. However, it is also shared by the more psychodynamically oriented models, e.g., mentalization-based therapy and CAT.

History tends to repeat itself here. Dissociation posed a puzzling problem for Janet and Freud, who wanted to develop psychological treatments for mentally ill patients. Their ways departed early, as Janet continued to use hypnosis as one of his treatment techniques. It was an effective method to transcend the blocs in self-observation, but one problem was that hypnotic trance could not be induced for all patients. Free association became Freud's technique of approaching dissociated mental contents, which had an additional advantage. It showed that shifting mental states are object-dependent.

A hundred years after Janet and Freud, dissociation was again tackled by the above-mentioned models. The problem was identical, but the explanatory principles were now obtained from attachment theory and cognitive script or schema models. Self-observation was understood as a mental capacity that could be impaired by maladaptive early development and relationship schemas. This view is strongly endorsed in all current psychotherapeutic approaches that attempt to treat borderline, personality disordered clients.

Harri Valkonen (2018) examined the three initial assessment interviews of three clients with BPD diagnosis. The study yielded two main results. First, the clients' self-observation was strongly object-dependent. Their ability to reflect on their memories, experiences, and actions was fully appropriate in 'conflict free' domains. They could even describe their state shifts and dissociated self-states, but the problem was that their self-observation was partly state dependent. Dissociation was a problematic way of coping with dangerous memories and unmanageable experiences. It blocked further exploration during the interview and it also seemed to wipe away, before the next session, what had been jointly achieved.

Secondly, the quality of clients' self-observation did not only depend on the objects of observation. The psychotherapist's way of conducting the interview and addressing sensitive issues had a decisive impact on the clients' responses. Reading the transcribed excerpts from the sessions is quite startling. The power of what we address, or do not address is much bigger than we tend to think.

The therapeutic relationship is indeed indispensable for self-observation. Clients may gradually access unmanageable themes when trust and safety develop in the relationship. This happens when they have repeated experiences of a containing and non-collusive therapist who is not afraid of what may emerge and who does not judge. The microanalysis of the assessment interviews showed how difficult it is to implement this general principle in practice.

5. It is all about timing

The development of self-understanding is a dynamic process, depending on the client's growing trust in the therapist's capacity to tolerate the client's emotionally unmanageable experiences. Trust helps in accessing and expressing mental contents that the client has not been able to manage alone.

Fredrik Falkenström's account of Ms B in his paper on the levels of self-observation (Falkenström, 2007) illustrates the joint power of trusting and the right moment for the development of client insight. Ms B had a history of drug addiction but had been clear for six years. She sought help because renewed craving for drugs and fears of relapsing. She had had both institutional treatment and psychotherapy, which had helped her to get off drugs. In her third therapy session, Ms B spoke in an agitated

manner and switched between topics as if being afraid of touching anything in more detail. She did not leave any room for the therapist's comments. Something that troubled her was becoming closer to conscious perception.

At one point the therapist said: 'Wait a minute – could you, just for a moment, try to sense – how do you feel, right now, sitting in this chair?' (Falkenström, 2004, p. 569). Focusing on the here-and-now was quite a bold intervention, because the therapist could not know what might appear.

Ms B stared at the therapist, settled back in her chair, and tears welled up in her eyes. She said, 'I feel empty', looking fearful. She added a metaphoric description, as if having a black hole inside.

In terms of classical CAT dilemma formulations, Ms B had only two options. 'Either keep on running or falling into a black hole'. She showed the defensive alternative, but the therapist's direct request to stop helped her get hold on the feared alternative.

Falkenström describes in the paper how this momentary insight into her agitated emotional state opened a path to an understanding of the role of emptiness as a protective device against painful feelings of guilt that she had unconsciously assumed to be uncontainable by anybody.

To me, Falkenström's account illustrates how many layers may exist in our internal world. What at first appears as the feared problem, which the client attempts to manage by hypomanic action, turns out to be a protective response to even more painful and dangerous feelings.

Initially, we only see some fragments of the ways by which clients try to cope with their lives. Their protective actions form hierarchical chains. Each layer is well guarded like Ms B's hypomanic attempts to avoid getting in touch with the sense of emptiness. But although feared, feeling empty was not the bottom layer. It had developed early as a way of dealing with overwhelming guilt.

The therapist's intervention struck the right chord at the right moment. One of the most difficult tasks in any therapy is to decide, when the time is ripe to help clients confront something they fear, are ashamed of, or feel guilty about. We must perturb the client, if we want to get over the stalemate that staying within the safety area tends to generate. However, we should not intervene prematurely, because it only forces the client to react, defensively, and our good intention has backfired.

Assisting client self-observation is not, primarily, an issue of what kind of tools we should use. Mini formulations, mapping, diagrams, and reformulation letters present quite an impressive array of techniques that CAT therapists have generated over the years. None of them can tell the therapist the moment at which they afford clients to approach and address experiences that they have warded off for different reasons. A reformulation letter may act as a premature interpretation, if it contains themes correctly anticipated by the therapist but not yet accessible to the client. Maps may clarify repetitive action patterns, but they too may contain too much information from the client's viewpoint.

Every tool is permissible, when the time is ripe. *Kairos,* or the opportune time, is the most important tool for any psychotherapist. □

REFERENCES

Bion, W. R. (1954). Notes on the Theory of Schizophrenia. *International Journal of Psycho-Analysis*, 35: 113-118.

Falkenström, F. (2007). The psychodynamics of self-observation. *Psychoanalytic Dialogues*, 551-574.

Freud, S. (1894). The neuro-psychoses of defence. *Standard Edition*, 3: 41-61.

Freud, S. (1914). Remembering, Repeating and Working Through (Further Recommendations in the Technique of Psychoanalysis II) *Standard Edition*, 12:145 -156.

Valkonen, H. (2018). The dynamics of self-observation in patients with borderline personality disorder (BPD) diagnosis. Dissertations in Education, Humanities, and Theology No 125. *Publications of the University of Eastern Finland*, Joensuu.

Cognitive Analytic Therapy and Functional Neurological Disorders

NADINE BEARMAN

Abstract:
Around one-third of neurology outpatients have symptoms that neurologists conclude as either not at all, or only partially, explained by organic causes. Around twenty percent of patients brought into hospital for epileptic seizures receive a diagnosis of non-epileptic (dissociative) attacks (Stone, 2011). Within neuropsychiatry, the focus of psychological treatments for functional neurological disorders has been cognitive behavioural therapy (CBT) (Williams et al, 2011; Goldstein et al, 2004, 2010). There is also a growing interest in using other approaches such as Acceptance and Commitment Therapy (Graham, O'Hara and Kemp, 2018), EMDR (van rood et al, 2009; Cope et al, 2008), psychotherapy (Reuber et al, 2007; Howlett and Reuber, 2009), Dynamic Interpersonal Therapy (Luyton, et al 2013) and Cognitive Analytic Therapy (Jenaway, 2011; Jenaway et al, 2018). This article is a brief 'review of using a cognitive analytic approach with people with functional neurological disorders (FND) with case examples and some initial outcomes from pre- and post- self-report measures. Included in this review, are clients who experience non-epileptic attack disorder (NEAD), functional motor disturbances, functional stroke and other functional neurological symptoms including memory loss and speech difficulties.

Key words:
functional neurological, cognitive analytic, somatic, conversion.

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Introduction

Functional neurological disorder (FND) is a syndrome of neurological symptoms arising without organic cause. Other terms for FND include conversion disorder or psychogenic disorder. The term 'medically unexplained symptoms' is also often used, although FND requires a

positive diagnosis, meaning that it needs to be clear that the symptoms cannot be due to organic causes. Medically unexplained symptoms on the other hand, describe an 'open verdict' as to what the causes may be. Neurological symptoms can include visual or auditory defects, motor symptoms, co-ordination or gait disorders, paresis, loss of speech, amnesia or non-epileptic seizures (Stone et al, 2005). Non-epileptic attack disorder (NEAD) has also been known as psychogenic seizures, pseudo-seizures or dissociative seizures.

The questions of *how* and *why* functional neurological disorders develop has been subject to extensive theorising and research. In terms of *how* FND develops, the neural correlates and mechanisms underpinning such disorders are not yet well understood. The role of dissociation in the development of functional neurological symptoms and non-epileptic attack disorder is of increasing interest. Research suggests that brain areas in the lateral and medial frontal cortex, as well as the supplementary motor area and basal ganglia, are involved, and are similar neural processes to those seen during hypnosis (see Bell et al, 2011). Research and theory into the cognitive system also provide some insight, particularly the role of different attentional mechanisms and their impact on, shaping the content of consciousness, and controlling thought and action (Brown, 2004). In practice, it is important for patients to understand *how* FND develops from a neurological and cognitive perspective such as the role of dissociation and attention. Rather than explaining FND as a 'psychological reaction' or 'symptoms due to stress', adverse life events are presented as a risk factor or trigger, along with past stressors and recent illnesses. A widely used analogy is that the basic wiring of the nervous system is intact, but the messages are not being sent and received as they should and that this is 'like a software problem, rather than a hardware problem' (see Cock and Edwards, 2018).

In terms of 'why' functional neurological disorders develop, this has been theorised within psychiatry since the late 1800s and the focus has largely been around the experience of trauma. For example, Janet's (1889) early dissociation theory provides an explanation involving attentional narrowing, where the exposure to traumatic events limits the number of sensory channels that can be attended to. The individual may focus on some sensory channels at the expense of others, leading to the loss of deliberate attentional control over neglected channels. According to Breuer and Freud (1893-1895/1955), the brain often attempts to regulate the conscious experience of distress by unconsciously suppressing (or repressing) the conscious recall of memories, without which there is a

state of tension, or conflict, that is too painful to acknowledge. By removing these memories or conflicts from a conscious level of mental life and driving them into the unconscious, the individual's needs to preserve the energetic balance of the brain are met. The distress is essentially 'converted' into a neurological symptom.

The most prolific cases of FND as a result of severe trauma can be found by studying accounts of shell shock during and after the first and second world wars. Jenaway (2011) describes the usefulness of using the knowledge we have about shell shock to explain a client's symptoms. Many clients can feel dismissed or disbelieved when given a FND diagnosis. Often the initial stages of intervention include psychoeducation for the client and their family and carers. Often clients cannot attribute their physical symptoms to a past trauma and so we draw on cognitive and attentional explanations. For example, the individual may have experienced a physical illness (such as a minor injury, flu-like symptoms or migraine) which triggers or precipitates the development of FND (Stone, Carson and Aditya et al 2008). There may be underlying anxiety or emotional difficulties that are not acknowledged, and anxiety and excessive focus on the physical experience, maintaining the problem over time. Being given possible diagnoses by different physicians during, often extensive and repeated, physical examinations and evaluations can leave an individual feeling more concerned that something is 'wrong', and perpetuates the focus and attention on the symptom.

Research suggests that physiological markers of anxiety are often reported at the onset of FND symptoms or persistently throughout the illness, but patients only rarely report a concurrent emotional state of anxiety (Kranick et al, 2011). There is also a body of research that explores the link between alexithymia (difficulties identifying and describing emotions in oneself and in others) and the development of FND (Demartini et al, 2014).

Treatment for FND

Within neuropsychiatry, the focus of psychological treatments for FND and NEAD has been cognitive behavioural therapy (CBT) (Williams et al, 2011; Goldstein et al, 2004, 2010). There is also a growing interest in using Acceptance and Commitment Therapy (ACT) (Graham, O'Hara and Kemp, 2018). However, there is a developing understanding that a significant number of people diagnosed with FND have also experienced early trauma (Karatzias, 2017; Ludwig et al, 2018). The use of trauma

focussed therapies such as EMDR (eye movement desensitisation and reprocessing) has been identified as a potential treatment for FND, although research in this area is at the early stages (Van Rood et al, 2009; Cope et al, 2008). In other cases, rather than requiring trauma processing, the individual may benefit from a more collaborative understanding of the way in which emotional distress is as a result of disordered attachment, interpersonal difficulties and/or unresolved emotional conflicts, such as those pertaining to early abuse or other childhood traumas. In such cases, psychodynamically oriented therapy has been identified as an appropriate treatment option (Brown, 2004). For example, Reuber et al, (2007) and Howlett and Reuber (2009) have evaluated the effectiveness of a brief psychodynamic interpersonal therapy, augmented with elements of cognitive-behavioral therapy, somatic trauma therapy, and the involvement of caregivers and family members. More recently, Luyten and colleagues have provided an account of how Dynamic Interpersonal Therapy (DIT) can be used with clients with functional somatic symptoms (Luyton et al, 2013). This approach is based on theories of attachment, mentalization and stress regulation.

The neurobiology of the attachment system is well understood. A secure attachment activates the dopaminergic 'reward' system (Insel and Young, 2001) and downregulates the neuroendocrine regulation systems (the hypothalamic-pituitary-adrenal axis and sympathetic nervous system) (Beatson and Taryan, 2003). There is emerging evidence of structural differences in these systems in people with insecure attachment, poor coping skills and functional neurological disorders (Williams et al, 2018) and that insecure attachments in early life are a predisposing risk factor for functional neurological disorder. For example, Williams et al (2019) found that fearful attachment style was associated with self-reported adverse life event burden, alexithymia, dissociation, depression, anxiety, impaired stress coping skills and functional neurological symptom severity.

CAT and Functional Neurological Disorders

Within CAT, the focus of treatment is on collaboratively developing an understanding of how early attachment relationships have impacted on the individual's unconscious and subconscious interpersonal and inter-relational expectations, responses and behaviour. Understanding these early relationships and maladaptive responses (problem procedures) and then developing adaptive strategies (exits) to change stuck patterns of

relating and behaving, could potentially have an impact on FND symptoms.

Accounts and evaluations of using CAT with people with functional neurological symptoms are emerging within the literature. For example, Jenaway (2011) and Jenaway et al (2018) have reported outcomes of CAT treatment for small samples of patients with functional neurological disorders. Although described as medically unexplained symptoms, Jenaway describes functional neurological symptoms such as non-epileptic attack disorder and functional paralysis and spasms, and presents promising initial outcomes using CAT with this client group. Jenaway discusses using the CAT model to understand how early attachment relationships impact on the way an individual relates to themselves, with their body and their physical symptoms. For example, where an individual may have internalised a critical-criticised/demanding-not good enough reciprocal role pattern, they may be pushing the body and ignoring signals to rest, and struggle to respond to their physical needs with kindness and compassion.

Some clients whom I have met in the neuropsychiatry clinic, have experienced early abuse and emotional neglect. This often leads to a coping strategy throughout life of being the 'caring' other and putting one's own needs aside. It often feels as though the individual is exhausted from a lifetime of caring and may have not had an opportunity or have developed an internal 'self to self' relationship to consider and attempt to meet their own needs. When the FND symptoms begin, often triggered by illness or injury, and perhaps alongside a loss of the role in caring for others, the individual may feel dismissed again by professionals who are unable to provide a clear medical diagnosis for their symptoms. Within their personal relationships, they may find that their loved ones find a way to provide care and support by making demands on the professionals instead. Sometimes the demands for the affected individual to provide care cease, and they can give themselves permission to rest and be cared for.

This is a generalised example of the way a reformulation may develop. The reality is that with this client group the functional neurological symptoms, the causes, course and treatment responses vary significantly from person to person. CAT enables the clinician to explore many aspects of the individual's experience, including early life and their relationships with others, themselves, their symptoms, their body and their experience of the medical professionals (including the therapist). The reformulation is developed collaboratively, creating a dynamic person-centred approach

that has the openness, curiosity and flexibility to explore and learn.

What follow are two cases to describe in more detail the use of CAT with clients with functional neurological disorders. Both cases are anonymised, and the clients have kindly given their permission to be included in this paper.

Case example 1:

Suzy was referred to the neuropsychiatry service with a diagnosis of functional neurological disorder (FND) after many years of physical investigations that were inconclusive. Suzy reported experiencing pain in her back which was as the result of a previous injury, along with acute functional stroke-like symptoms such as slurred speech, facial drooping and weakness on her left side. When I met with Suzy for her initial assessment, she expressed frustration that an organic cause had not been found for her stroke-like symptoms and she insisted that some tests had not yet been performed. In order to progress forward with the therapy, we agreed to keep an open mind about the cause of her physical symptoms and during the initial 3-4 sessions, Suzy continued to meet with the consultant neuropsychiatrist to discuss her concerns.

We talked about how growing up, Suzy's parents were not very affectionate, but she was initially very reluctant to share more about her family. As an adult, Suzy had entered abusive relationships where she experienced her needs being completely disregarded, and she would assume the role of caring for others without support or care in return. She injured her back and then experienced a traumatic incident. The stoke symptoms started at this time and she spent the next year searching for the cause or a diagnosis. Suzy seemed preoccupied with feeling powerless in relation to dismissive and uncaring professionals whom she perceived were withholding important examinations from her and letting her down. In our relationship, I identified with the frustration, feeling that important information about her past was being withheld from our discussions. We talked about how her experiences and responses to the health professionals were reminiscent of her experience of her ex-partner, with whom she also seemed to remain very angry. We also talked about feeling powerless in relation to her pain, and having to accept a lifestyle that didn't fit with her expectations of herself.

We talked about the way that she related to her physical symptoms. She seemed to respond to her back pain with criticism and demanding

that she push herself to do more and more until she would be exhausted and collapse in intense pain, spending many days in bed recovering. She would then punish and criticise herself for letting herself and her daughter down, leading to an increase in physical activity when she was well enough to compensate. Thus, the cycle continued.

During these initial stages of therapy, Suzy seemed increasingly interested in the formulation and contributed to the development of her diagram. She identified a snag fairly early on in the therapy of – 'If I accept that my symptoms have a functional cause, rather than a physical one, I will have put my family through years of stress for nothing – if it's in my head, I could have stopped it ages ago'.

When I drafted the reformulation letter there was a sense that I had limited information as Suzy still held on strongly to the belief that her stroke-like symptoms had a physical cause that had not yet been discovered, and she was reluctant to share information about her early life. The reformulation letter was short and full of questions, but upon reading it to Suzy she started to open up more about other aspects of her life that have been difficult, including how she has, throughout her life, felt blamed and criticised by her parents and siblings for 'failing' in her relationships, and for the way she parented her daughter.

We explored the possibility that Suzy was fighting with the medical professionals in a way that perhaps she felt she couldn't with her family and ex-partner. We talked through her relationship with herself, her pain, her family and medical professionals. The exits from her stuck patterns included learning to acknowledge and accept her emotional pain, developing her ability to protect herself and assert her needs with her family, and accept a 'good enough' life for her and her family, rather than expect the 'perfect' life. Understanding the way that functional symptoms develop, and contacting local FND charities, became important to help Suzy develop a more accepting and understanding relationship with her symptoms.

At the end of therapy, Suzy reported that she experienced the stroke-like symptoms less frequently and she had ceased the search for a 'medical diagnosis'. She reported an increase in confidence as a parent and was able to think about what she wanted to do, rather than give in to her family's demands on her. She reported having more self-compassion, treating her body with more loving kindness and care, which led to an improvement in her experience of pain.

Case example 2:

Mary was referred to the service with non-epileptic attack disorder. She had four grown up children living locally whom she saw on a regular basis, and she lived with her husband. She had eight grandchildren, one who was sadly killed at the age of four, knocked down by a car which Mary had witnessed. Mary and her husband were understandably very frightened by the non-epileptic attacks which happened daily. Mary had stopped cooking and did not go out on her own, fearing she would be injured or be vulnerable if she had an attack.

Mary had not had any talking treatments before. She identified herself as a mother, who always put her children first. We talked about her early life and she described physical abuse at the hands of her father and witnessing domestic violence, seeing her mother not being able to control what was happening, or protect her and her siblings. Being the eldest and with her mother being in bed with depression often, she became the carer for her siblings. Mary left home as soon as she could and devoted her life to her husband and children. The non-epileptic attacks started after a period of significant stress when her husband had difficulties at work, her daughter had some serious health conditions and her grandson had been killed two years before. Mary's mother, who lived some distance away, was increasingly frail and unwell and Mary was very worried about her. She had been struggling to visit her though, stating that she was unable to tolerate her mother crying when they parted.

Mary was open and curious about the therapy, but found it hard to speak about some things, especially her grandson's death. We talked about how she had seen her mother appearing weak and unable to protect her, which was terrifying. She recognised how she had vowed not to be weak and vulnerable and so had always been strong and pushed any feelings of vulnerability away. When we explored this, Mary could see how this had affected her. We included on her sequential diagrammatic reformulation (SDR) or map, a 'protective-protected' reciprocal role along with a 'vulnerable/weak-vulnerable/terrified' reciprocal role. We explored the idea that her strategy of pushing her feelings away to protect herself and avoid the terror of being vulnerable had perhaps predisposed her to developing the non-epileptic attacks, and then the recent series of traumatic events and family difficulties left her feeling as though she was powerless to protect her family. This may have precipitated the development of the non-epileptic attacks. Mary talked about how the non-epileptic attacks had taken control of her life and had become the new terror, and that now she was the one being

cared for and protected by her family. This led to further feelings of vulnerability and anxiety, further exacerbating the frequency and intensity of the non-epileptic attacks.

In our work, we explored how Mary could both allow herself to be vulnerable safely and allow her mother to be vulnerable but without experiencing the terror. We also explored how she could let go of the caring role in relation to her mother and accept that her siblings could take more responsibility for supporting her, as they lived nearby. Mary visited her mother and was pleased to report that she coped with her mother's tears and her feelings of responsibility when they said goodbye. Mary also started to allow herself to be vulnerable in the therapy, talking about her grandson and her early relationships with her parents and her siblings. We gradually worked on her allowing herself to be vulnerable with her husband. This involved telling him how she was really feeling, and allowing herself to cry in front of him. This was the stage when the non-epileptic attacks reduced significantly. The final piece of work was supporting Mary to re-build her confidence with cooking and going out on her own. This required some negotiation and psychoeducation with her family, but by the end of the therapy she was more independent, going on public transport to the town to meet friends and cooking meals for her family. Mary continued to accept her family's need to provide her with care and protection.

Initial Outcomes

Six clients completed sessions of CAT and two dropped out at sessions 2 and 6. Due to difficulties with demand and resources, we aim to provide treatment within 12 sessions. Clients are usually offered 6 or 12 sessions initially depending on their needs and we extend therapy, as appropriate, up to 16 sessions in some cases. Of these six clients, three attended a total of 16 sessions, one client had 14 sessions, another 12 sessions and the final client had 8 sessions in total. Sessions are offered on a fortnightly basis and the final two sessions are offered monthly to prepare the client for discharge. Fortnightly sessions are offered due to our service covering a wide geographical area and so clients often travel long distances to the clinic. All clients were given psychoeducation, about how and why FND symptoms or NEAD develops, within the context of the reformulation.

All six clients were women, four diagnosed with FND and two with NEAD. The duration of their FND/NEAD ranged between 15 months and 14 years with a mean duration of $4^1/_2$ years. The ages of the clients ranged

from 20 years to 60 years with a mean age of 45. Three measures were administered before and after treatment. These were the Hospital Anxiety and Depression Scale (HADS), the CORE (Clinical Outcomes Routine Evaluation) and the Work and Social Adjustment Scale (WASA).

The HADS is a 14 item self-assessment scale that measures levels of anxiety and depression over the previous week (Snaith, 2003). There are cut-off points for grouping scores into 'normal, mild, moderate and severe' levels. The outcomes summarised in Table 1 show that there was a significant difference in HADS scores for anxiety and depression post CAT therapy, with a more significant difference in levels of depression. Four of the six clients reported 'moderate' levels of anxiety post-treatment, one 'mild' and one 'normal' level. Only one of the six clients reported 'moderate' levels of depression post-treatment, with one client reporting a 'mild' level of depression, and four reporting 'normal' levels of depression.

	Pre-CAT		Post-CAT		95% confidence interval of the difference		*df*	*t*	*p*
	M	SD	M	SD	Lower	Upper			
GAD-7	11.19	5.54	3.06	2.71	4.76	10.84	14	5.5	.000
PHQ-9	13.18	8.68	3.31	2.75	4.98	14.48	14	4.3	.000
WSAS	19.12	12.31	4.18	3.41	8.21	21.79	14	4.7	.000

Table 1. Break down of significant pre and post measures using T-tests

The CORE is a 34 item self-report questionnaire that rates how the individual has been feeling over the past week (Evans, Mellor-Clark et al, 2000). The measure covers four dimensions: subjective wellbeing, problems/symptoms, functioning and risk/harm. Overall scores can be grouped from 'healthy' to 'severe' levels. Table 1 shows that there has

been a significant decrease in scores on the CORE. Three of the six clients remained in the 'severe' level. Two client's scores reduced from 'moderate' to 'mild' levels and one client's score reduced from 'severe' to 'healthy' levels.

The Work and Social Adjustment Scale (WASA) is a measure of impairment in functioning (Mundt et al, 2002). Clients are asked to rate on scale of 0-8 to what extent their difficulties affect various aspects of their functioning from working to taking care of their home and socialising. Table 1 shows that there was a significant decrease in scores on this measure post-CAT treatment. Three of the six clients' scores remained in the 'severe' level. Two reduced from the 'severe' to 'moderate' level of impairment and one client's score reduced from 'severe' to 'subclinical' levels.

Whilst these initial results are positive, they do not inform how the use of CAT has impacted on the client's experience of FND. This will need to be considered in future evaluations of treatment approaches with this client group (e.g. seizure frequency for those with NEAD). All the clients in this evaluation reported a reduction in their neurological symptoms and a better understanding of their neurological symptoms (such as the cause, triggers and strategies to manage them). Those with NEAD reported a reduction in the frequency and intensity of their seizures. All the clients reported that they felt more independent and confident, and so most were going out of the house alone for the first time in several years and one took up a volunteering post.

Conclusions

The outcome from this small sample of clients suggests that cognitive analytic therapy has the potential to be an effective treatment model for clients presenting with functional neurological disorders. Further studies are required with much larger samples, appropriate controls and evaluation at follow up. The impact over the longer term could also be evaluated as FND symptoms may continue to improve post-treatment.

One of the key challenges in evaluating treatment outcomes for functional neurological disorders is the absence of specific measures, and this is in part due to the heterogeneity of symptoms experienced by individuals with this diagnosis. Measures of anxiety and depression are used within our service routinely, but do not always capture positive outcomes. This is because many clients attend initially without recognising any emotional difficulties and attribute their problems to

their FND symptoms. Their scores are sometimes higher post-treatment as they are then able to recognise their underlying emotional experiences, and qualitatively, clients report improvement in their overall wellbeing. Quality of life measures such as the WASA can be more indicative of change. However, some clients report no improvement in the way the problem impacts their life in practical terms, but they feel more able to cope. Again, this isn't always captured adequately on many quality of life measures, such as the WASA. The CORE, covering wellbeing, problems and functioning and being more of a generic measure is useful and with 34 questions is more detailed than many other measures. Seizure frequency for clients with NEAD could be considered in future evaluations, and potentially qualitative studies to explore in more detail the client's experience of CAT and the way this therapeutic approach impacts on their experience of FND.

It is also difficult to compare outcomes with other studies as functional neurological disorders fall within a wider spectrum of other difficulties such as medically unexplained symptoms, chronic fatigue, fibromyalgia and functional somatic syndromes. When reading the literature, the mechanisms underlying the development of these conditions overlap, but there is also heterogeneity in presentation within them and numerous terminologies to describe the same condition. It is positive nevertheless that the interest and research in this field has increased in recent years and with that, clearer definitions of the various conditions and their underlying aetiology continue to develop.

Reflections

Clients often attend the neuropsychiatry clinic in the role of a medical patient. It can be difficult to engage in therapy after months or years of medical tests and being discharged from neurology clinics with an FND diagnosis. Many clients feel frustrated and dismissed, and I frequently hear the phrase 'apparently it's all in my head'. The collaborative nature of CAT, where the therapist models openness and curiosity, listening and being alongside the client can provide a different experience or relationship from one that was perhaps expected. For individuals who have felt out of control, as if their body has been hijacked and taken over by their frightening symptoms, being involved in their treatment and learning about themselves and FND can help them regain a sense of control. As can be seen from the second case example, working with families and loved ones can also be an important part of the work.

Many clients with FND have not had any talking treatments previously and have not acknowledged emotional or interpersonal difficulties. The process of developing a shared dialogue about thoughts and emotions that have not been verbalised or sometimes even identified and acknowledged seems to have a positive impact on both the individual's emotional and physical wellbeing. It can feel as though a weight is lifted or some confusing or hidden aspect of their experience is made conscious. The reformulation and SDR become important tools and as can be seen in the first case example, the reformulation letter seemed to trigger a more open dialogue. With clients who are reluctant to engage, these tools give a message that you are listening, acknowledging and trying to understand. The identification of exits from stuck patterns can enable the individual to develop the tools needed to manage situations and relationships differently and improve their capacity to cope with stress and distress. It could potentially be this, along with increased self-awareness and self-care, that leads to the improvement of functional neurological symptoms. □

REFERENCES

Beatson, J. and Taryan, S. (2003) Predisposition to depression: The role of attachment. *Australian and New Zealand Journal of Psychiatry, Vol. 37(2),* pp. 1440-1614.

Bell, V., Oakley, D. A., Halligan, P.W., & Deeley, Q. (2011). Dissociation in hysteria and hypnosis evidence from cognitive neuroscience. *Journal of Neurology, Neurosurgery and Psychiatry*, 82, 332–339.

Breuer, J., & Freud, S. (1893–1895/1955). Studies on hysteria. In J. Strachey, & A. Strachey (Eds.), *The standard edition of the complete psychological works of Sigmund Freud*. Vol.II. (2011) London: Hogarth Press and the Institute of Psycho-Analysis.

Brown, R. J. (2004). Psychological mechanisms of medically unexplained symptoms: An integrative conceptual model. *Psychological Bulletin,* 130, 793–812.

Cock, H.R. and Edwards, M.J. (2018) Functional neurological disorders: acute presentations and management. *Clinical Medicine,* Vol. 18(5), pp. 414-417.

Cope, S.R., Mountford, L., Smith, J.G., Agrawal, N. (2018) EMDR to Treat Functional Neurological Disorder: A Review.*Journal of EMDR Practice and Research*, 12 (3). pp. 118-132.

Demartini, B., Batla, A., Petrochilos, P., Fisher, L., Edwards, M.J, et al. (2014). Multidisciplinary treatment for functional neurological symptoms: a prospective study. *Journal of Neurology*, Vol. 261(12): 2370-2377.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., McGrath, G. (2000) CORE: Clinical Outcomes in Routine Evaluation. *Journal of Mental Health,* Vol. 9, pp. 247-255.

Graham CD, O'Hara DJ, Kemp S. (2018) A case series of Acceptance and Commitment Therapy (ACT) for reducing symptom interference in functional neurological disorders. *Clinical Psychology and Psychotherapy*. Vol. 25 (3):489-496.

Goldstein, L. H., Deale, A. C., Mitchell-O'Malley, S. J., Toone, B. K., & Mellers, J. D. C. (2004). An evaluation of cognitive behavioral therapy as a treatment for dissociative seizures: A pilot study. *Cognitive & Behavioral Neurology*, 17(1), 41–49.

Goldstein LH, Chalder T, Chigwedere C et al. (2010) Cognitive-behavioral therapy for psychogenic non-epileptic seizures: a pilot RCT. *Neurology*; 74:1986–94.

Howlett, S., Reuber, M. (2009) An augmented model of brief psychodynamic interpersonal therapy for patients with nonepileptic seizures. *Psychotherapy: Theory, Research, Practice, Training* Vol. 46, Iss. 1: 125-138.

Insel, T. and Young, L. (2001) Nature Reviews.

Janet, P. (1889). L'automatisme psychologique [Psychological automatisms]. Paris: Alcan.

Jenaway, A. (2011) Using cognitive analytic therapy for medically unexplained symptoms: some theory and initial outcomes. *Reformulation*, Winter, pp. 53-55.

Jenaway, A., Gregory, C., Damaris, K. &Bristow, K. (2018) Service evaluation of cognitive analytic therapy for patients with complex medically unexplained symptoms referred to a liaison psychiatry department. *International Journal of Cognitive Analytic Therapy and Relational Mental Health*, Vol. 2.

Karatzias, T., Howard, R., Power, K., Socherel, F., Heath, C., et al. (2017): Organic vs. Functional neurological disorders: The role of childhood psychological trauma. *Child Abuse & Neglect* Vol. 631-6.

Kranick, S.M., Gorrindo, T., Hallett, M. (2011) Psychogenic movement disorders and motor conversion: A roadmap for collaboration between neurology and psychiatry. *Psychosomatics: Journal of Consultation and Liaison Psychiatry* Vol. 52(2): 109-116.

Luyten, P., Van Houdenhve, B., Lemma, A., Target, M. Fonagy, P. (2013) Vulnerability for functional somatic disorders: A contemporary psychodynamic approach. *Journal of Psychotherapy Integration, Vol. 23(3)* pp. 250-262.

Ludwig, L., Pasman, J.A., Nicholson, T., Aybek, S., David, A.S. et al. (2018) Stressful life events and maltreatment in conversion (functional neurological) disorder: Systematic review and meta-analysis of case-control studies. *The Lancet Psychiatry*, Vol. 5(4): 307-320.

Mundt, J.C., Marks, I.M., Shear, M.K., Greist, J.H. (2002) The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *British Journal of Psychiatry,* Vol. 180, pp.461-464.

Reuber, M., Burness, C., Howlett, S., Brazier, J., Grünewald, R., et al (2007): Tailored psychotherapy for patients with functional neurological symptoms: a pilot study. *Journal of psychosomatic research* Vol. 63, Iss. 6, (625-632.

Snaith, R.P. (2003) The Hospital Anxiety and Depression Scale. *Health and Quality of Life Outcomes,* Article Number 29.

Stone J., Smyth R., Carson A. et al. (2005) Systematic review of the misdiagnosis of conversion symptoms and 'hysteria'. *British Medical Journal*, 331:989–91.

Stone, J., Carson, A., Aditya, H., Prescott, R., Zaubi, M., Warlow, C., & Sharpe, M. (2008). The role of physical illness injury in motor and sensory conversion symptoms: A systematic and narrative review. *Journal of Psychosomatic Research*, 66, 383–390.

Stone, J. (2011) Functional Neurological Symptoms. *Journal of Royal College of Physicians* Edinburgh, 41: 38-42.

van Rood, Y.R., de Roos, C. et al (2009) EMDR in the Treatment of Medically Unexplained Symptoms: A Systematic Review. *Journal of EMDR Practice and Research*, suppl. Special Issue on the 20th Anniversary of EMDR; New York Vol. 3, Iss. 4.

Williams, C. (2011) *Overcoming Functional Neurological Symptoms: A Five Areas Approach*. Routledge.

Williams, B., Ospina, J.B., Jalilianhasanpour, R., Martin, M., Fricchione, G.L., Sepulcre, J. (2018) Individual differences in corticolimbic structural profiles linked to insecure attachment and coping styles in motor functional neurological disorders. *Journal of Psychiatric Research, Vol. 102,* pp. 230-237.

Williams, B., Ospina, J.B., Jalilianhasanpour, R., Fricchione, G.L. and Perez, D.L. (2019) Fearful attachment linked to childhood abuse, alexithymia and depression in motor functional neurological disorders. *The Journal of Clinical Neuropsychiatry and Clinical Neurosciences, Vol. 31(1),* pp. 65-69.

Cognitive Analytic Therapy (CAT), Obsessions and Overvalued Ideas: Developing a Model and a Method

JASON HEPPLE

Abstract:
Psychological therapies, including CAT, can have limited efficacy when working with more complex people, with disorders that feature overvalued ideas and obsessions, such as Obsessive Compulsive Disorder and Anorexia Nervosa. This paper develops the CAT model and method for working with these problems. Theoretical exploration is grounded in clinical practice and a series of workshops in the UK and Greece. Ideas are drawn from CAT theory, cognitive theory, trauma theory, psychoanalysis and literature, to present a 'third' CAT guide map for working with obsessionality. It offers detailed suggestions as to adaptations to the method presented under the headings of the C-CAT adherence tool.

Key Words:
Cognitive Analytic Therapy (CAT), Obsessive Compulsive Disorder (OCD), Anorexia Nervosa, Overvalued ideas, Treatment method, Trauma

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Overvalued ideas and obsessions

My starting point comes from psychiatric phenomenology and the concepts of 'obsession' and 'overvalued idea'. Andrew Sims (1988 p.92) explains the latter: 'An overvalued idea is an acceptable, comprehensible idea pursued by the client beyond the bounds of reason.' The idea falls short of being a delusion (and thus not a psychotic idea) because there is some sense of rationality; if only the idea could be held in balance and

not go on to dominate the person's life. So for example, it is good to consider hand hygiene, but to be trapped in the bathroom all day by obsessional doubt is excessive. Similarly, obesity is a new epidemic in the developed world and some restriction on eating and on avoidance of unhealthy food types is good for health, but not when the person's Body Mass Index (BMI) falls to dangerous levels. It is the dominance of the overvalued, or obsessional idea, whether it be about weight, body shape or contamination, and the affective grip it has on the person, that connects OCD and Anorexia and some rarer disorders such as Body Dysmorphic Syndrome and some forms of Hypochondriasis, Hoarding Disorder and Morbid Jealousy. I am using the term 'obsessionality' to describe this commonality that I see as behind *some* presentations of OCD, Anorexia and the other rarer conditions I have mentioned above.

Clinicians working with people in these areas will be aware of how difficult it can be to engage the person in challenging the core idea that drives the disabling behaviours. It is as if the main relationship for the person is with an internal idea rather than with people in the outside world like the therapist. The driving idea is out of dialogue and non-negotiable. This, as we will see later, has profound *interpersonal* effects.

Obsessionality, CAT and CBT

Ryle and Kerr (2002 p.138) give a case example of a client with OCD, which is a description of how CAT is often applied to obsessionality. They draw attention to the safety of ritualization in cultural settings (for example, religious and military rituals) and emphasise the need to gain control in order to manage anxiety. The dilemmas 'absolute order or dangerous chaos' and 'absolute success or shameful failure' are used in formulations. At the heart of the map is the reciprocal role controlling to controlled. Procedures map the effects of these patterns on the self and others. There is encouragement of the expression of feelings and the sharing of responsibility for managing anxiety. They note that in more severe cases, when the behaviours are very disabling, a behavioural approach, like response prevention, or medication may be needed.

Protogerou et al (2008) present a brief report of the outcome of using CAT to treat 64 patients with obsessive-compulsive personality disorder. They showed significant improvement in depression scores and anhedonia. Boogar et al (2013) have published a controlled outcome study of a 16 session group CAT intervention for patients with OCD showing significant improvement in symptom severity. Kimber-Rogal

(2008) has described using CAT with an obsessional client and emphasizes the interpersonal aspects of treatment.

Cognitive Behaviour Therapy (CBT) has a clear formulation of obsessionality as being driven by intrusive thoughts that cause doubt and an emotional response involving anxiety. This is followed by some form of behavioural or mental activity that causes temporary relief but then the resurgence of doubt, with the acknowledgement that the more the doubts are acted upon the worse the problem becomes over time (for a review see: Foa, 2010). Emphasis in treatment is on response prevention and challenging the rationality of the thoughts that trigger the whole cycle. The 'CBT cycle' is a very helpful description of the thoughts, feelings and behaviours that are the apparent problem or symptom and, in my view, should be present on any CAT map.

My reservation with both the standard CAT and CBT models is that there is a lack of emphasis on underlying causes and the question 'why?' CBT is explicitly symptom focussed and in CAT, the therapist is often drawn into mapping symptoms and their effects in the present while perhaps neglecting links to the past. The client may never have been invited to go beyond a discussion of their symptoms before, so making it difficult to make the sorts of connections that a CAT therapist would normally draw attention to in a reformulation letter (for example, early loss or an anxious/controlling parent).The therapeutic dialogue can end up as a circular monologue about symptoms and their devastating effect.

How can CAT be adapted to make it possible for the client to link the present to the past in the normal CAT way? How can obsessionality be formulated as a complex protective system against a real but possibly disavowed core pain? This attempt is in no way intended to dismiss biological, genetic and possibly epigenetic factors that are well documented in these conditions, but is an attempt to offer a CAT relational angle that may benefit some clients, especially when medication and other treatments have not been successful.

In 2014, Tony Ryle wrote in the paper celebrating CAT at thirty (Ryle et al, 2014 p.260):

> 'Symptoms and symptom complexes such as eating disorder or OCD are seen to originate in the need to replace or avoid forbidden or feared reactions to unmanageable experiences. The role of many symptoms is illustrated by a story – I think a Buddhist one – of a drowning man who was saved when a raft drifted by. In recognition of his gratitude he strapped the raft to his back and

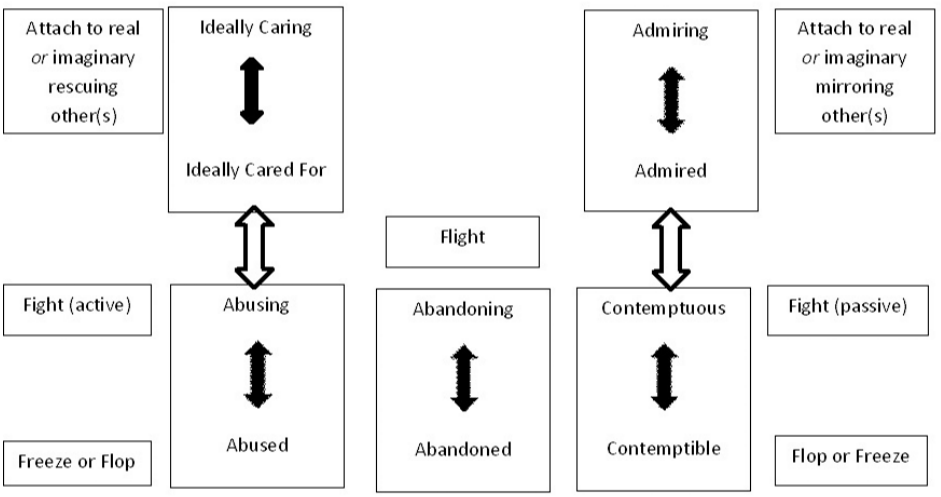
carried it for the rest of his life. Many symptoms can be relieved by the recognition and modification of the avoided procedure.'

This timely metaphor not only linked OCD and eating disorders, but started me on a journey of trying to think 'outside the box' when it comes to obsessionality.

Trauma, Submission and Sacrifice

If you look up 'responses to trauma' on the internet (see for example Reisinger, 2017) you get a growing list of possible survival strategies. In addition to the traditional fight and flight responses there are now freeze, flop, attach and submit (sometimes called 'fawn'). It is interesting to think about these in terms of the existing CAT borderline and narcissistic guide maps (see Fig 1). It is easy enough to see where fight and flight may fit in (with the narcissistic fight taking a more passive form without direct physical aggression but with more subtle forms of contemptuous attack). Freeze and flop are bottom role protective positions. The attachment strategy can be seen as initiating a state shift to the idealised self state; either seemingly finding a rescuer (even if this is at other times the abuser) or in the narcissistic case, seeking escape through the admiration of mirroring others (which may be in the real world or sometimes only in an imaginary future world).

Fig 1: Borderline and Narcissistic CAT Guide Maps and Trauma responses



When it comes to obsessionalty, I was immediately drawn to the trauma response 'submit'. The word 'obsession' comes from the Latin *obsessus* – the perfect passive participle of *obsideo*; meaning 'to have been possessed'. People with OCD often talk about their OCD as a tyrant; indeed there is a statue of the 'OCD bully' by Steve Caplin commissioned by the South London and Maudsley Trust. The figure resembles a devil. The Tarot card of the devil often shows a man and a woman chained in misery at its feet; having made a pact with the devil, they are enslaved for all eternity. Submit is a way of surviving overwhelming threat and certain death. To lie prostrate and swear undying and unconditional allegiance to a powerful, annihilating other gives you a chance of survival. My hypothesis for obsessionality is that some people when faced with such a seemingly overwhelming threat use obsessional mechanisms to turn to an *internal* protector/tyrant that they can serve. They have signed a contract without having had a chance to read it. They have no idea how long the slavery will last or what they have to do to fulfil their obligations. As time goes on the demands of the tyrant get more and more draining and exhausting.

My hypothesis is that this can be due to an early environment of uncontainment and neglect as opposed to explicit abuse or narcissistic contempt and conditional admiration. In my experience there are some attachment patterns that come up again and again. For example, a mother with OCD; an anxious self-absorbed parent combined maybe with early loss of a parent or sibling; an uncontained family break-up in early adolescence. The fundamental strategy seems to be to try to solve an overwhelming problem on your own *for the sake of everyone else.* In J. D. Salinger's *Catcher in The Rye* (1951), the title of the book alludes to the fact that the main character, in an attempt to compensate for the tragic loss of his younger brother, imagines a sacrificial role for himself running out of a field of rye to catch children as they are about to fall over a cliff to their deaths.

Ideas from Psychoanalysis

Psychoanalytic theories relating to obsessionality also make connections to themes of threat, dread and striving to protect the self and others. Freud (1955a) described a short analysis of a man with obsessional neurosis, often known as the case of 'Rat Man', who used rumination to protect himself from the fear of his girlfriend and mother undergoing horrific torture. In 'Inhibitions, Symptoms and Anxiety', Freud (1955b)

describes two main obsessional defences: 'undoing' (sometimes called 'magic undoing') and 'isolation'. In undoing, some action or behaviour is attempting magically to reverse or ward off some feared happening. In isolation there is an attempt to isolate or disconnect unmanageable fears from more manageable day-to-day worries. It is safer to worry about having dirty hands, for example, than to consider the death of a loved one.

There is also something greedy about the obsessional protector/tyrant in that its demands are '. . . exceeding what the subject needs and what the object can or wishes to give' (Klein, 1957 p.181). Hanna Segal expands: '. . . the destruction (of the object) is incidental to the ruthless acquirement' (Segal, 1988 p.40). The internal obsessional tyrant demands more and more over time. It can never be satiated and leaves the person controlled, drained and exhausted, and feeling guilty for the effects their obsessionality can have on others as they have no intention to cause harm to those close to them.

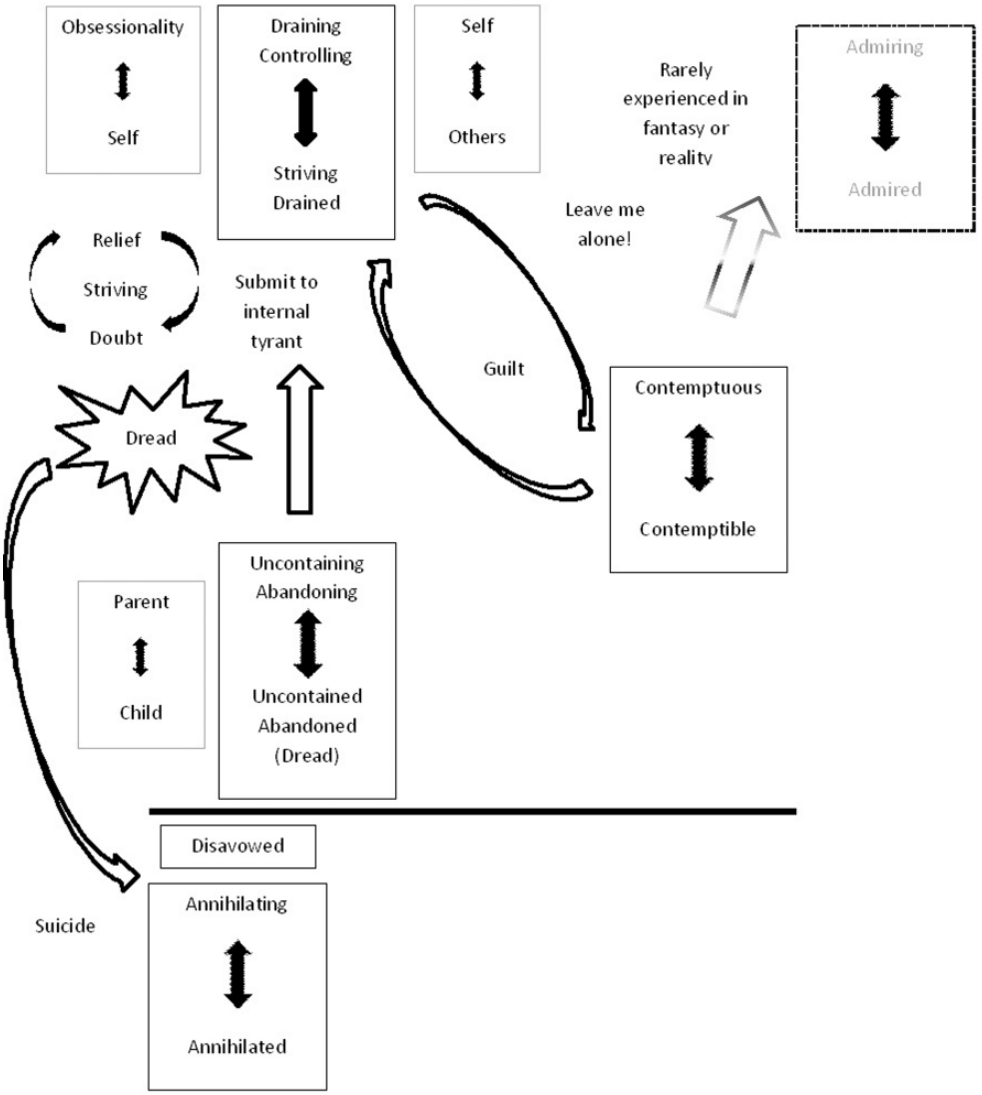
For example, a person feels worried about having left the cooker on when on the way to a holiday. They are overwhelmed with dread and know that they will not be able to relax on their holiday until they have gone back to check. Others try to reassure but this has no effect. The person becomes distressed and eventually critical: 'You have no idea what I am going through. Someone needs to take risk seriously!' The whole family have to go back due to the needs of the obsessional doubt. The person ends up feeling ashamed and guilty. The family feel drained and as if their needs have not been understood or met.

There are also links to be made with Fairbairn's (1952) description of a schizoid personality as being characterised by omnipotence, detachment and preoccupation with fantasy and inner reality. Ralph Klein draws attention to the master/slave aspect of the internal relationship: 'The basic attachment unit of the schizoid patient is the master/slave unit, the basic nonattachment is the sadistic object/self-in-exile unit' (Klein, 1995 p.52).

The 'third' CAT Guide Map

In the template map below (Fig.2) I have pulled together the themes discussed.

Fig 2: CAT Guide Map for Obsessionality and Overvalued ideas



annihilating to annihilated

At the bottom of the map is the disavowed role, annihilating to annihilated, with its associated emotion 'dread'. To me, dread is the worst of all fears as it is not even clear what you are afraid of. The worst thing. The Bogey Man. Many obsessional procedures, I think, can be linked to an attempt to protect others from annihilation in some magical way. The

annihilating pole concerns fears about the destructiveness of the self (towards self and others); at some level perhaps feeling responsible for a death, illness or catastrophe. At the core of a client's obsessional cleanliness, for example, was the overvalued idea that her body fluids were as dangerous as anthrax to other people. The top role annihilating can also be enacted when, often after many years of striving and exhaustion, the person sadly contemplates taking their own life.

uncontaining to uncontained

The key formative reciprocal role can be summarised as uncontaining/abandoning to uncontained/abandoned. There are many different variants on this in terms of the parent-derived pole; an anxious and self-absorbed mother, a parent unavailable due to intoxication or severe depression or psychosis, an abandoning parent due to death of incarceration. Often there is a life event like the loss of a sibling combined with a family's inability to grieve or contain this loss. The core unmanageable feeling is dread and the lack of a containing relationship to help the child feel that they can survive. At some point the child decides to take matters into their own hands and do something they can do, as this is better than nothing; to submit to, and seek protection from, an internal tyrant who makes it clear what needs to be done (washing, not eating, seeking to change the shape of a part of the body, hoarding, ruminating).

It may not be possible to directly link dread to an event. It seems to me that dread is a normal part of growing up and is regularly experienced throughout life. It is having the resilience and self-containment to survive dread (through previous containing relationships) that prevents it becoming all-consuming. There are likely to be temperamental differences in how likely a child is to use obsessional procedures like this. Another child, maybe with access to more narcissistic procedures, would survive uncontainment by soothing itself with real or imaginary admirers or a future when success and recognition would be attained.

draining/controlling to striving/drained

This is the 'master to slave' relationship; the submission to an internal protector/tyrant. This describes the relationship of the client to the obsessional idea. The CBT cycle of doubt, striving and relief is a procedure coming from and returning to the bottom pole of this reciprocal role. This reciprocal role also describes the harder-to-see enactment between the person with obsessionality and others in their life (remember the

family returning from their holiday to check that the gas was turned off). Carers of people with OCD often end up getting involved in the compulsions and rituals and find they are also serving the 'OCD tyrant'. This indirect enactment between the obsessional person and others is harder to name or think about as the natural reaction to someone with severe obsessionality is concern and empathy for the distress and exhaustion they experience. It is as if the internal tyrant draws in new slaves by showing them a struggling victim; once the 'good Samaritan' has started to help with the obsessional tasks in hand, they can also be drawn in and find it hard extricate themselves.

This enactment, of course, can also be part of the relationship between client and therapist. Often from a position of empathic counter transference (perhaps with some element of admiring to admired), the therapist commits much emotional energy to trying to find a new way of working to relieve such distress. Over time the therapy may seem to get stuck. The client can seem to demand more and more time in the session, to off-load how much they are suffering at home with the obsessionality, and express despair that the therapist cannot really help or understand. Links with the past can be acknowledged as 'obviously true but so what?' and the client may say that they cannot engage in any homework or behavioural experiments as this will make the distress worse. They will get 'pay back' later for even talking about this in the session. The therapist can become drained and exhausted and perhaps turn the tables by feeling critical and demanding of more collaboration from the client to show that they have a therapeutic alliance. Fundamentally, there is a draining dynamic at work and a lack of the exit reciprocal role: *freely giving to gratefully receiving.*

admiring to admired; contemptuous to contemptible

This represents on the diagram the narcissistic 'side-arm' of the obsessional map. It can often be mistaken for the core of the problem when the uncontainment and dread is disavowed by client and therapist. This is a modified narcissistic pattern. Basically, the client gets frustrated and hurt by the demands of the therapist to engage in homework or the joint activity of co-creating CAT tools and can become contemptuously dismissive. They are saying 'leave me alone, you just don't understand that you are making things harder for me', and this can push the therapist into another attempt at striving to make progress or into an unconditional empathic position; where they started in the first place. The client often feels guilty and bad for the contemptuous attack and will have to make

up for this at home with more obsessional striving. The therapist can become burnt out and rejecting of the client and contemptuous of the purpose of continuing therapy.

The admiring to admired self-state is rarely fully enacted. Just occasionally in specialist treatment centres one client can become special; the lowest in weight or the most burdened by OCD and looked up to or in competition with other clients. There can be a splitting between the admired and desired specialist treatment centre and the contemptuously dismissed, local treatment on offer, like CAT. Having severe obsessional problems like Anorexia or OCD, does not attract admiration as onlookers can easily see the distress and disability of the client.

Working with obsessionality in CAT

So, how do we make progress in CAT in the face of these powerful enactments and times when it seems as if there is a limited therapeutic alliance? I will finish with some suggestions and illustrations in the broad domains of the C-CAT tool (Bennett and Parry, 2004).

1. phase specific therapeutic tasks

Some of the conditions that I have grouped under the heading 'obsessionality' can have a range of causes linked to functional and organic mental illness (particularly Morbid Jealousy, Hoarding Syndrome and Hypochondriasis), and a prior psychiatric assessment is advised. If the problems seem amenable to psychological treatment and particularly for CAT, may be 'refomulatable', I think that it is important at the outset to give the client information about the sort of therapy CAT is; that it is concerned with the past and finding relational patterns or survival strategies that may link to current problems and distress (even if these links may initially be hard to see or disavowed). This is basically informed consent for the process of reformulation. It is important to acknowledge that CAT does not have a strong evidence base for obsessionality and is not a first-line treatment in NICE guidelines, but that it may be helpful when medication or CBT has already been tried and the client is interested in thinking more relationally, with an acknowledgement that the process of reformulation may exacerbate obsessional symptoms. At the same time the therapist will be attentive to arousal and distress in the client and will monitor these and the client's views on the therapy in order to negotiate the pace of therapy or even agree an early ending or referral for other treatments.

Negotiation of the client's Target Problems (TPS) will need to allow for the agreed possibility of a relational procedural understanding that underlies them. For example, a belief that 'I am too fat' without objective truth or preparedness to link this to the past will be difficult to make progress with. A preparedness to link the onset of hand-washing to the loss of a sibling, for example, even in a tentative way, would show joint agreement for reformulation.

2. theory practice links

The theory underpinning CAT with obsessionality is fundamentally CAT, but the therapist will need to have awareness of the 'third' guide map model, with the emphasis on making connections between the present and the past and powerful disavowed emotions related to uncontainment and dread, and have appropriately informed supervision. Care is needed in terms of managing the Zone of Proximal Development (ZPD) in the therapy relationship and in managing client arousal and distress (see 3. and 7. below).

3. CAT specific tools and techniques

Reformulating procedures: Below are illustrations of procedures for OCD and Anorexia. They show how obsessional symptoms and behaviours can be linked to anxiety generated by past events and also to current intrapersonal and interpersonal relationships.

> Target Problem: My life is dominated by my need to wash my hands.
> Target Problem Procedure: Because of my anxiety about the safety of my family following the loss of my brother and my mother's breakdown after this tragic event, I started washing my hands more and more frequently. It is as if this 'obsession' has promised me a way to feel less anxious, look after everyone and to get in control of a situation I felt helpless and alone in. Unfortunately, the more I wash my hands the more I have needed to until the point when it is dominating my whole life. Other people are exhausted with trying to help me and then try to bully me into 'being normal', which makes my anxiety worse. I feel totally alone and as if no one understands.

> Target Problem: I feel overweight and restrict my eating to lose weight, which is badly affecting my health.
> Target Problem Procedure: Because of the way I felt helpless and out of control when I was thirteen when my parents announced they were going to split up, I started to restrict my food intake and lose weight. This made me feel more in control and seemed to

help keep my parents together as they had me to worry about rather than their own disagreements. As time has gone on I feel more and more need to lose weight to the point when I have collapsed and other people feel that I look very thin, although I can't see it myself. It is as if restricting food is protecting me from my deepest fears about being alone and abandoned. Unfortunately, I have ended up in hospital where I feel very alone and my parents seem more and more frustrated with me for not getting better. Again, I feel out of control and don't know what to do for the best.

Mapping: Fig 2 illustrates positioning some form of uncontainment as the central 'core-pain' with its disavowed unmanageable feelings of dread and fear of annihilation. The internal relationship to the obsessionality is mapped as: draining/controlling to striving/drained, with clear links to the possible interpersonal consequences of enacting this role with family and in the therapy relationship. The narcissistic extension may or may not be present.

In Fig 3, I have added some example exits. In the therapy relationship the therapist can overcome a feeling of uncontainment by being attentive but not collusive and proceeding carefully within the ZPD of the client and with an eye to managing arousal and backing off, or even agreeing to end therapy when necessary. This zone (ZPD) may be very restricted at the beginning due to the client's fear that talking about hidden feelings and fears can make the obsessionality worse. Therapy cannot go forward without some reciprocation; *freely giving to gratefully receiving* in the therapy relationship. If the client is unable to complete the tools like the Psychotherapy File or other homework tasks, then maybe slow down and try to engage in some joint activity in the session. Maybe the client can bring a dream to talk about, just read something suggested by the therapist and have an opinion on it. It may be that, for the client, giving will seem less dangerous than receiving at first. They will probably not be able to receive the reformulation letter until there is some history of giving and receiving in the relationship.

Later on in the therapy, the focus will be on moving forward into a more engaged and creative life with the chance of mutually respectful and caring relationships. As I heard Tony Ryle say about working with OCD: 'Just talk about their life.' It is a nice metaphor to suggest that the client may need 'give up guilt' and 'take the obsessionality with you'. It is good to acknowledge that there is no way to defeat or eradicate this protector/tyrant entirely and at times of stress it will again loom large. But, if the client is able to move on into a life with other people as the priority, the obsessionality will begin to shrink and its voice become less powerful and easier to ignore.

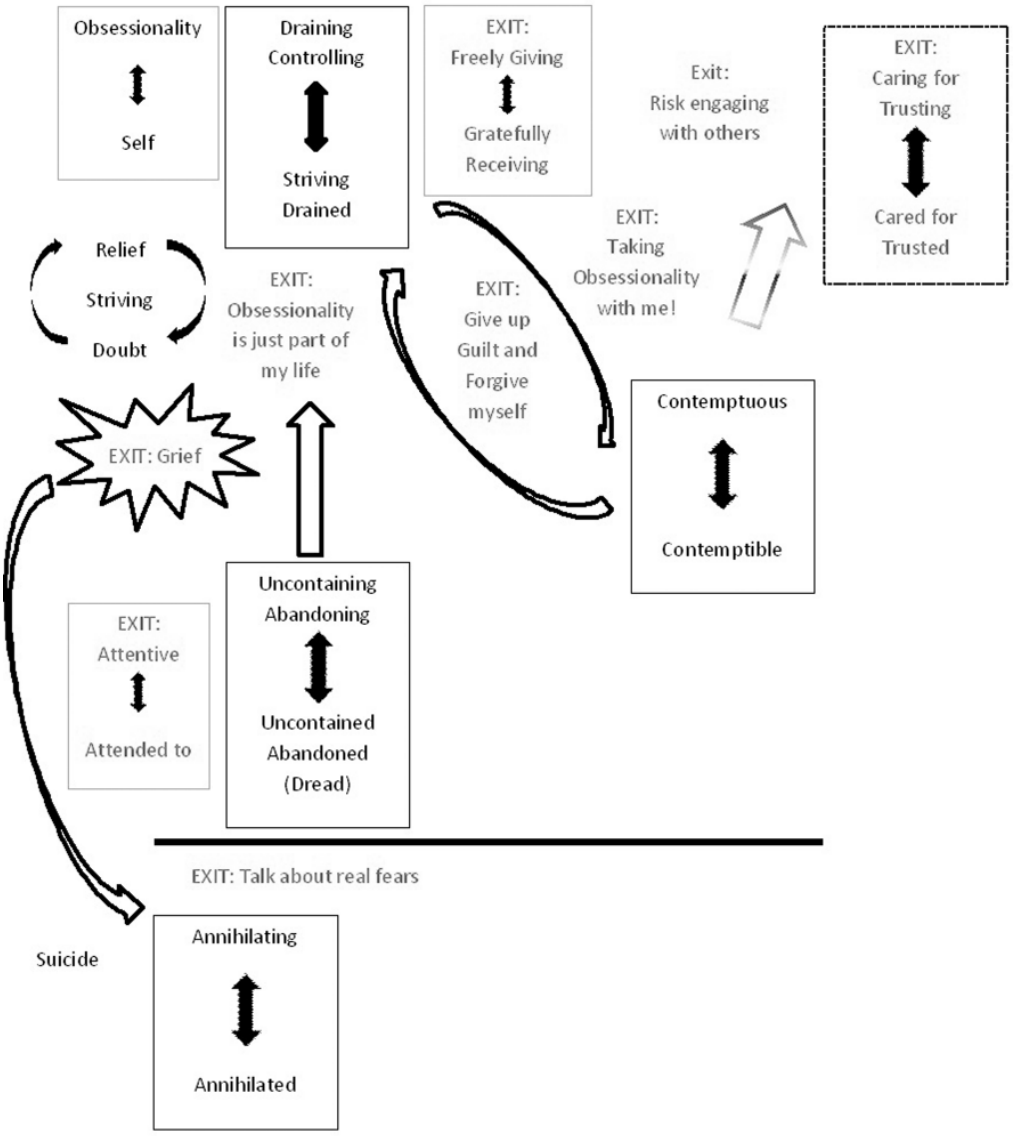


Fig 3: Guide Map with Exits

4. establishing and maintaining external framework

Clients with obsessional problems can find it difficult to get to sessions on time, or at all, as the fear of exposure causes a sabotaging rise in obsessional behaviour. One new client with OCD spent the first three sessions stuck at home in her shower and arrived at the fourth session 40 minutes late. It was important to acknowledge this as a success and not to criticise the client or be too rigid with the local 'DNA policy'. Negotiation of a shared agenda for each session may allow some time for the client to discuss symptoms and distress, with the therapist able

to spend time making links and using CAT tools. Obsessional clients may benefit from extended follow-up sessions as change in the real world can be slow and often limited by opportunity (possibility of relocation or meeting new people).

5. common factors: basic supportive good practice

The therapist's position is attentive and hopeful but not overly striving or unrealistic in terms of the extent of the change achievable within the duration of the therapy. Small changes need to be recognised as significant. For example, a client said that he had been able to reflect on the therapy at home and had re-read the reformulation letter which he had previously just 'filed away'. Breaks in therapy and the end of the therapy may cause strong disavowed feelings of dread and abandonment that need to be anticipated and acknowledged. Conversely, grief and sadness for the end of the therapy could be seen as an exit and can be shared as a mark of the connection made in the therapy relationship.

6. respect, collaboration and mutuality

Respect is modelled in the therapy relationship as the therapist empathically identifying with the client's suffering but not being subsumed by it or recruited in to it. Attention to the ZPD and acknowledgement of the reality of the sometimes small scale of progress being made allows the client to feel tolerated and contained and able to forgive themselves for being stuck for so long and to counter the shame they feel comparing themselves to others who have gone on to seemingly achieve more in their lives.

7. assimilation of warded-off, problematic states and emotions

Disavowed feelings are at the heart of the CAT formulation of obsessionality. It may be that the therapist feels some of the dread and/or grief for the client initially when hearing about some past events like a sudden bereavement. The client may seem to feel little but the therapist can bring the empathic counter-transference into the dialogue and attend to this in the reformulation letter and process. It is good to notice when there is a hint of sadness or a tear that marks out grief from the frozen grimace of dread.

It has been my experience that clients will gradually bring more emotional content to sessions as trust builds up and they may want to

go back to a CAT tool or discussion weeks later, as they have been thinking about it. Therapy or no-send letters, particularly to people who have been lost, may be a great opportunity, but may be very difficult for some clients. Grief is a major exit here; grief for people who have been lost; grief for all the wasted time the obsessionality has soaked up over the years and disavowed grief for the loss of the therapist at the end of the therapy.

Fears about the destructiveness of the self (annihilating role) can sometimes be present. In some ways the bereaved child may have blamed themselves for the loss of a parent or sibling and the obsessionality is a form of sacrifice in order to make amends.

The Burden:
I have written a narrative tool for use in obsessionality that visits these emotions. It is called: 'The Burden'. It is available on the ICATA website as an appendix to this paper. It is a story about a child who loses a sibling and an encounter with an angel. It has some elements of a reformulation and is extremely sad. I will leave the reader to read it. The task is to write a new ending to the story. I have used it with clients later on in therapy when I have wanted to bring more emotion into the room. It is important to think about the ZPD of the client and the timing of this tool as it is very powerful and not for everyone. It is free for the reader to use. I have versions so far with a male, female and de-gendered protagonist and translations into Greek, Spanish and Polish.
www.internationalcat.org/journal.burden

8. making links and hypotheses between therapy and client's past and client's other relationships so facilitating awareness of procedures that are operating

In the recognition phase of CAT therapy, it may be important to try to extend the awareness of the distressing effect of the reciprocal role: draining/controlling to striving/drained beyond the suffering relationship of the client to the internal obsessional protector/tyrant. This will be by looking at the effects of the obsessionality on those close to the client, for example: 'I wonder how your mother felt after she was up all night with you checking the bins again?', and also to its presence in the therapy relationship. This reflection risks intense feelings of guilt and fear of abandonment in the client. Sometimes it is safer to look back on an example in an earlier session. For example: 'Do you remember that session when you were so stressed that I couldn't get a word in edgeways?'

9. identifying and managing 'threats' to the therapeutic alliance
Frequently negotiated engagement may help maintain a therapeutic alliance. The therapist's ability to tolerate the client abandoning them due to the demands of the obsessionality (both in the room if they are distracted/ruminating and in the external world when they are unable to come at all) may allow the client to use the sessions to partly shed some of their exhaustion and frustration but also to allow the therapist to offer 'surplus of vision' and new ideas and perspectives. I have found it useful to say frequently that I am not dismissing how hard it is for the client but I will still try to take the opportunity to 'do some CAT' when I think it is safe.

Abandonment and lack of response to communications is the most likely kind of therapeutic rupture, where the client has just decided that coming to sessions stirs things up too much and it is safer to stay in the internal world at home. It may be good to try to re-engage the client over a period of time: 'If you would like to come to talk about re-starting therapy I would be very pleased to give you another appointment.' The therapist may feel contemptuously dismissed in these circumstances, and may be tempted to dismiss the client from their caseload prematurely. It may be helpful to re-identify with the client in their silent world of obsessionality and realise this is about the client's need and is not attack on the therapist.

10. therapist's awareness and management of own reactions and emotions
Strong emotions can be disavowed in obsessionality and are replaced by non-specific anxiety and dread, that the therapist may experience in a disconnected way, that is not easy to link to a specific client. More healthy and healing emotions like sadness and humour are likely to enter the room through the therapist first and can usually be introduced directly into the therapy dialogue. For example: 'I felt really sad when you told me about your dad just then'. The most likely feeling that a therapist will need help with in supervision is exhaustion. It is perhaps a golden rule in CAT that when you are striving and exhausted, the best thing, and sometimes the only thing to do, is to stop striving. □

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REFERENCES

Bennett, D. & Parry, G. (2004). A measure of psychotherapeutic competence derived from Cognitive Analytic Therapy. *Psychotherapy Research*, 14, 176-192.

Boogar, R. I., Rezael, A. M. and Yosefi, A. (2013). The effectiveness of Cognitive Analytic Therapy on the severity of symptoms in Patients with obsessive-compulsive disorder. *Journal of Practice in Clinical Psychiatry*, 1(4), 197-204.

Fairbairn, R. (1952). Schizoid factors in the personality. In: R. W. D. Fairbairn, *Psychoanalytic studies of the personality*. (3-27), London: Routledge.

Foa, E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. *Dialogues in Clinical Neuroscience*, 12(2), 199–207.

Fontini, K. et al (2008). The efficacy of Cognitive-Analytic Therapy (CAT) on anhedonia in patients with Obsessive-Compulsive Personality Disorder. *Annals of General Psychiatry*, 7 (Suppl 1), S158.

Freud, S. (1955a). Bemerkungen über einen Fall von Zwangsneurose (Der 'Rattenmann'). In: J. Strachey (Ed.) *The standard edition of the complete psychological works of Sigmund Freud*. 10, 158-251. London: Hogarth Press.

Freud, S. (1955b). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.) *The standard edition of the complete psychological works of Sigmund Freud*. 20. London: Hogarth Press.

Kimber-Rogal, N., (2008). My Life in Pictures - OCD and CAT. *Reformulation*, 312, 7-13.

Klein, M. (1957). *Envy and Gratitude. A Study of Unconscious Sources*. New York: Basic Books, Inc.

Klein, R. (1995). Intrapsychic structures. In J. Masterson and R. Klein (Eds.) *Disorders of the self: New therapeutic horizons. The Masterson approach* (45-68). New York: Brunner Mazel.

Protogerou, C. et al (2008). Evaluation of Cognitive-Analytic Therapy (CAT) outcome in patients with Obsessive-Compulsive Personality Disorder. *Annals of General Psychiatry*. 7, S1-S109.

Reisinger, C. (2017). Six responses to stress. Reported by: http://www.dailymail.co.uk/sciencetech/article-4690778/Researchers-reveal-SIX-responses-stress.html (accessed 23rd August 2018).

Ryle, A., Kellett, S., Hepple, J. and Calvert, R. (2014). Cognitive Analytic Therapy (CAT) at Thirty. *Advances in Psychiatric Treatment*. 20, 258-268.

Salinger, J. D. (1951). *The catcher in the rye*. London: Penguin.

Segal, H. (1988). *Introduction to the Work of Melanie Klein*. London: Karnac books.

Sims, A. (1988). *Symptoms in the mind. An introduction to descriptive psychopathology*. London: Balliere Tindall.

A repertory grid study of CAT group formulation in a forensic setting

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Abstract:
The study sought to examine the effect of Cognitive Analytic Therapy (CAT) group reformulation sessions on staff perceptions of a patient in a forensic mental health setting. The study evaluated ongoing practice of team based formulation using a pre-post design, with analysis through a range of repertory grid assessment techniques. The study used both individual and group level analysis of repertory grid data. There was no control sample. A repertory grid with common elements and constructs was developed through discussion with trained CAT therapists. This grid was completed by staff members, in a medium secure inpatient unit, before and after a CAT reformulation session. The outcomes were analysed using IDIOGRID. Individual level outcomes were validated through discussion between researcher and participants.

Seven staff members took part in the study. The results are interpreted as demonstrating some shift in constructs associated with the subject of the CAT sessions. The outcomes also indicated increased cohesion between staff members following the CAT session as evidenced by reduced differences between grids. Individual grids were analysed to explore the shifts seen in the group level analysis.

Repertory grid methods can provide meaningful individual and group level analysis to explore the effect of CAT formulation sessions. CAT reformulation sessions appeared to demonstrate positive effects, though the study's methodological weaknesses make it difficult to draw firm conclusions.

Keywords: consultation, team reformulation, forensic, repertory grid, cognitive analytic therapy

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Introduction

Forensic Settings and Relational Problems

Forensic mental health settings have high levels of violence and interpersonal threat (Papadopoulos et al., 2012). Patients in forensic settings can present with complex needs, particularly relational difficulties (Moore, 2012; Royal College of Psychiatrists, 2012). Psychological formulation may be a useful approach to providing a means to understanding patient needs and presentation in forensic settings, though there is currently limited evidence of efficacy (Davies, Black, Bentley, & Nagi, 2013; Moore & Drennan, 2013). Formulations developed within Cognitive Analytic Therapy (CAT; Ryle, 1991; Ryle, Poynton, & Brockman, 1990), an integrative from of psychotherapy, have been identified as a potentially useful approach for teams working with complex patients (Caruso et al., 2013; Davies et al., 2013). Team formulations may provide a means to targeting intervention, maintaining focus on treatment goals and reduce reactive responses to crises that may be successful in the short term, but inhibitory towards integrated treatment in the longer run (Moore & Drennan, 2013)

Cognitive Analytic Therapy

CAT is a psychotherapeutic approach, with a primary focus on relational difficulties (Ryle et al., 1990). An integrative therapy (Leiman, 1994; Roth & Fonagy, 2006), CAT draws on several theoretical models including Personal Construct Psychology (PCP; Kelly, 1955), object relations theory (Ryle, 1985), cognitive psychology and developmental psychology (Ryle & Kerr, 2002). CAT takes as its basis, that individuals develop internalised representations of the self and others termed 'reciprocal roles', which influence how we engage with the world (Ryle & Kerr, 2002). Based on these representations people engage in patterns of interpersonal interaction that can become problematic or inflexible (Calvert & Kellett, 2014). These problematic patterns, or target problem procedures, are described as 'snags, traps and dilemmas' in CAT (Ryle & Kerr, 2002). A shared understanding of reciprocal roles and the problematic patterns is developed through the process of reformulation; in individual therapy through a letter from the therapist to the patient and through a diagrammatic representation of the patterns, known as a sequential diagrammatic reformulation (SDR) (Ryle et al., 1990).

Though designed as an individual psychotherapy, CAT has also been used at a contextual level with teams. A CAT informed approach in teams can provide a shared language and be the basis for consistent approach

between therapist and patient (Kirkland & Baron, 2015). Training in CAT has been shown to increase team cohesion and clinical confidence among staff working with difficult patients (Caruso et al., 2013; Thompson et al., 2008). Team training in CAT has been suggested as a means to provide a 'common language' for staff teams, as well as providing a relational focus which may be effective in working with patients who present with interpersonal difficulties (Kerr, Dent-Brown, & Parry, 2007). In common with many studies of interventions with teams (Buljac-Samardzic, Dekker-van Doorn, van Wijngaarden, & van Wijk, 2010), the quantitative research evidence for CAT staff training reports positive outcomes. Thompson et al. (2008), in a qualitative study evaluating the impact of CAT training, found that staff reported increased confidence in their therapeutic skills and a perception that the training fostered team cohesion. Caruso et al. (2013) found changes at one month, post a CAT training intervention, though found no immediate difference following the intervention. As they did not have a control group it is difficult to attribute changes seen at one month post intervention to the CAT training.

A CAT consultation approach has also been suggested as a means to develop a shared relational understanding of the interaction between staff teams and patients and provide a psychological perspective on patient management (Carradice, 2013; Kellett, Wilbram, Davis, & Hardy, 2014; Kirkland & Baron, 2015). However, to date, there is limited evidence of the efficacy of this approach.

Carradice (2013) describes a CAT consultancy approach for work with people with a personality disorder diagnosis who may not be suitable for individual therapy. The model involves working with the patient and a staff member for five sessions with the aim of developing a shared SDR (map) between the patient, staff member and consultant. An unpublished case study based on this approach described this approach as acceptable and valued by the patient and care coordinator (Styring, in Carradice, 2013).

Kellett et al. (2014) completed a small, randomized, control trial to evaluate CAT consultancy in an assertive outreach team, using the consultancy model described by Carradice (2013). The intervention, cognitive analytic consultancy (CAC), involved team training, case consultation and CAT based team supervision (Kellett et al., 2014). The training focused on development of the SDR, while the consultation involved development of an SDR with the care coordinator and support workers that mapped the key reciprocal roles of staff and the patient. In

contrast to Carradice (2013), the model described did not involve joint sessions with the patient and care coordinator. The authors found no differences between CAC and treatment as usual on patient outcomes. However, the introduction of CAC had a significant effect on staff outcomes, as measured by team climate. In particular there was an increase in feelings of psychological safety and support, support for innovation and task orientation within the overall assertive outreach team (Kellett et al., 2014). A positive staff impact of consultation is consistent with qualitative research indicating that staff value psychological consultation (Murphy, Osborne, & Smith, 2013).

CAT training, consultation and supervision has been practised in the Orchard Clinic, a medium secure forensic mental health facility for several years. The consultancy and supervision components are provided through CAT reformulation sessions which seek to develop a relational understanding of the dynamics of staff interaction with patients. Kirkland and Baron (2015) presented a case report demonstrating the use of CAT to share a complex formulation across multiple agencies. The sessions are valued by staff but their efficacy is difficult to test. It might be hypothesized that CAT formulation promotes a 'shared language' across teams which leads to a more consistent treatment approach and protects against 'splitting and fragmentation' (Mitzman, 2010). In contrast to the approach adopted by Kellett et al. (2014), the current study seeks to explore how efficacy of CAT formulation based interventions can be measured by developing an understanding of the process through which the consultancy sessions influence team members' understanding of patients.

Repertory grids and attitudes

There is no clearly established method for examining the efficacy of formulation-based interventions (Davies et al., 2013). This is a difficult area to assess as individual understanding of a group formulation is an internal phenomenon. Repertory grid methods may provide a useful approach as they can provide a measure of the extent to which a formulation is 'shared' amongst participants. Sharing of psychological formulations in staff teams may reduce blaming and increase optimism about treatment (Berry, Barrowclough & Wearden, 2009). Repertory grids were developed from a PCP framework (Kelly, 1955). PCP suggests that each individual builds a representation of the world based on dichotomous constructs. The repertory grid has been widely used in

psychology research to measure attitudes and relationships (e.g. Fransella, Bell, & Bannister, 2004; Saúl et al., 2012), though often it has been used without reference to PCP (Bell, 2009). The repertory grid can be seen as an exploratory technique, drawing out a person's understanding of the world (Bell, 2009).

Repertory grids have historically been used in individual CAT psychotherapy. The similarity between reciprocal roles and the dichotomous constructs of the repertory grid, suggest that the repertory grid can be usefully applied in CAT. Ryle developed a relationships grid to examine interpersonal relationship dyads in CAT (Ryle & Lunghi, 1970). A repertory grid methodology has also been used to examine relationships between self-states in CAT (Golynkina & Ryle, 1999; Ryle & Marlowe, 1995). In forensic settings, repertory grids have been used to develop understanding of construal (internal representations) of offenders and examine the utility of CAT (Pollock, 1996; Pollock & Kear-Colwell, 1994). The repertory grid has also been used in a pre-post design to evaluate the efficacy of psychological therapy (Winter, 2003).

Repertory grids have been used within mental health research to explore patients' perception of the world or themselves (e.g. Castiglioni, Faccio, Veronese, & Bell, 2012; Castiglioni, Veronese, Pepe, & Villegas, 2014; Paget & Ellett, 2014; Randal, Bucci, Morera, Barrett, & Pratt, 2016). In recent years the repertory grid methodology has been used to examine staff perceptions of patient groups (Blundell, Wittkowski, Wieck, & Hare, 2012; Hare, Durand, Hendy, & Wittkowski, 2012; Ralley, Allott, Hare, & Wittkowski, 2009; Woodrow, Fox, & Hare, 2012). These staff based studies have employed a common methodology described by Ralley et al. (2009). This involves supplying a list of role titles relevant to the patient group of interest, termed elements, for example *ideal client*. Using the 'triadic opposite' method (Caputi & Reddy, 1999), the elements are used to elicit bipolar constructs from each individual participant (Fransella et al., 2004). Each element is then rated on each construct to provide the repertory gird.

One of the advantages of a repertory grid methodology is that it provides a rich range of potential summary indices (Caputi, Bell, & Hennessy, 2011). Relevant measures when assessing staff members' construal of patients include complexity (Bell, 2004) and identifying the constructs that each staff member associates with patients. The analysis of meaning requires some interpretation and can be understood as a qualitative approach.

A consistent finding across studies is that lower levels of cognitive complexity is associated with greater differentiation between staff and patient roles (Blundell et al., 2012; Hare et al., 2012). Cognitive complexity refers to the flexibility of an individual's construal, the ability to hold multiple perspectives (Caputi et al., 2011) and make fine distinctions between different elements (Hare et al., 2012). An increase in this cognitive flexibility, may be seen as an important outcome of CAT based reformulation with staff members as it would provide a basis for developing more nuanced perspectives of the patient.

Aims

The study aims to examine at the impact of Cognitive Analytic Therapy (CAT) reformulation sessions held for groups of staff in a medium secure forensic mental health setting. These sessions, informally termed 'CAT chats', are routinely provided at the clinic at the request of staff members. The study aims to measure if a CAT reformulation session leads to the participants (staff members) viewing the patient in a more consistent way.

Method

The study was an evaluation of current practice and the patient that was the subject of the CAT chat was typical of the patient group in the unit. To maintain confidentiality and anonymity no identifying details about the patient are presented in this report. The patient had a history of offending behaviour, a diagnosis of schizophrenia and was detained under the Mental Health (Care & Treatment) Scotland Act 2003. Permission was sought and granted from the patient's Responsible Medical Officer. The study received ethical approval from the School of Health in Social Science of the University of Edinburgh.

The study used a pre post design. The study used both individual and group level analysis of repertory grid data. There was no control sample. Prior to the CAT reformulation session those who consented to participate in the study completed the repertory grid. All pre-session grids were completed on the day of the reformulation session. Participants also completed a brief sheet rating their experience of CAT and the amount of contact they have with the patient being reviewed. Immediately following the CAT reformulation session, participants again completed the repertory grid.

Description of CAT reformulation session

CAT reformulation sessions last one hour and focus on developing a CAT based reformulation of the relationship between the patient and the staff team. The sessions are not limited to any one professional staff

group and any person working with the patient may attend. Two group reformulation sessions were held to increase the number of study participants, one preceding a Care Programme Approach (CPA) meeting and one during nursing staff handover. Both CAT sessions were facilitated by an accredited CAT therapist (JK), who had limited knowledge of the patient and had not previously been involved with the patient in a clinical role.

The CAT reformulation sessions were developed in line with the writings of Potter (2010). He describes how his approach to 'mapping' can teach all the staff of a team a 'relationally enhanced' approach to care and treatment. Essentially he describes three approaches to the mapping process, each more complex. Briefly these are 'sketches', 'life-maps' and 'therapy maps'. The most complex, a therapy map, is more akin to the traditional SDR used in CAT therapy. Of less complexity, he describes life-maps as trying to capture the 'bigger picture and key positions of someone's life experience as a whole'. These are built upon from a series of 'sketches'. 'Sketches' are described as early and impromptu sketches of patterns of interaction that can be drawn from the patient's initial accounts of interacting with the self, the others and the world.

One approach utilising these ideas for terms in forensic settings has been written about by Kemp, Bickerdike & Bingham (2017). They describe using a specific 'map and talk template' comprising a 'striving or battling place' a 'stuck' place, a 'hiding' place, a 'hoped for' place and a 'feared' place. Each position contains a reciprocal role or set of roles that are enacted.

The research described here took a slightly different approach, as described in Kirkland & Baron (2015) and similar to Potter's (2010) description of 'sketches'. Briefly, the team was asked to suggest words, descriptions, emotions and thoughts that came to mind in relation to the patient discussed. The approach sought to describe a reciprocal role or roles of the team in relation to the patient. It also sought to consider any procedures (traps, dilemmas and snags). The result was a diagram describing a simple procedural sequence.

Participants

Participants were Health or Social Work staff based in a medium secure unit. They were drawn from both the patients' treating clinical team and ward based staff. All participants had experience of working with the patient that was the subject of the CAT chat.

Eleven staff members took part in the two CAT chats about the same patient. The first chat, held prior to a CPA meeting had eight participants. The second CAT chat was ward based and had three participants. In all eight participants consented to take part in the study, with seven completing both pre and post study measures. The seven study participants included 4 Nurses, 1 Clinical Psychologist, 1 Social Worker, and 1 Forensic Psychiatrist.

Design of the Repertory Grid

There are two key differences in the methodology employed in the current study compared to the approached described by Ralley et al. (2009). Firstly, the current study used a standard grid rather than having participants elicit constructs. Using a standard grid allows for all participants to be compared to each other, and for changes to be measured before and after the reformulation session (Paget & Ellett, 2014). Supplying constructs assumes a commonality of understanding across participants and also assumes that the selected dimensions are the most relevant for the individual. The use of supplied constructs is not typical in repertory grid research though can be valid if the constructs are meaningful and similar to those that may have been produced spontaneously (Easterby-Smith, 1980; Fransella et al., 2004). Secondly, the current study adopts a pre-post design, with the grid being completed prior to and following the CAT session (Randal et al., 2016). This allowed for exploration of any individual or group level shifts following engaging in the contextual reformulation session.

As the focus of the grid was on measuring changes in staff perceptions of one patient, the selected constructs were based on discussion with the patient's individual therapist. The grid was also developed through consultation with CAT therapists to ensure that the constructs selected were meaningful and consistent with CAT. The grid was designed to access staff perceptions of patient roles, staff roles and self-roles. The measure was piloted on staff to test for acceptability and usability. Initial iterations of the grid used standard reciprocal role formats such as 'controlling – controlled' and 'rejecting – rejected'. On piloting, the 'ideal' elements were rated at a middle point on these constructs. This is consistent with the CAT model, which seeks to find the middle ground, however it represents difficulties for repertory grid methods, which suggest that there is a preferred pole in line with Kelly's personal construct theory (Fransella et al., 2004). For this reason, the constructs were reviewed to develop a more clearly 'preferred – not preferred' format (e.g. heard – ignored). The final grid developed contained ten elements and fifteen

bipolar constructs (Table 1). Elements were in the form of role titles, and included self-roles (*ideal self*), patient roles (*A typical restricted patient*), and colleague roles (*An admired colleague*). The role titles included both positive and negative roles. The roles were rated across 15 constructs on a 7 point Likert Scale.

Elements	**Constructs**		
Myself at work	Empathic	-	Cold
An admired colleague	Engaged	-	Dismissing
A colleague you dislike	Ignored	-	Heard
Myself outside of work	Moving Forward	-	Stuck
Patient X	Powerful	-	Powerless
Myself when working with	Competent	-	Incompetent
Patient X	Calm	-	Frazzled
A really difficult patient to work with	Respectful of Others	-	Disrespectful of Others
A typical Life sentence prisoner	Understood	-	A mystery
A patient you worked well with	Sticks to their guns	-	Easily influenced
A typical restricted patient	Pleases Others	-	Prioritises own needs
	Needs Reassurance	-	Self-confident
	Draws out parental feelings	-	Seems self-sufficient
	Caring	-	Cared for
	Containing of others	-	Not containing of others

Table 1: List of Elements and Bipolar Constructs

Analysis

To examine similarities of participants, Procrustes statistics were calculated and these values were used to compute a Principal Components Analysis Biplot for both pre and post treatment grids. This graphs all of the participants in a single space, demonstrating relative similarity to each other (Grice & Assad, 2009).

Group level analysis were conducted on pre and post grids using Generalized Proscrustes Analysis (GPA; Gower, 1975). This analysis was completed in IDIOGRID (Grice, 2006) using the methods described by Grice (Grice, 2007; Grice & Assad, 2009). A consensus grid combining all the grids at each timepoint was first created and then used to compute a principal components analysis. A further Multiple Groups Component Analysis, a form of extension analysis (Grice, 2007), was computed to demonstrate the relationship between elements and constructs for the

pre-intervention and post intervention grids. This plot would allow for interrogation of any relationships between elements' groupings, in particular to identify if there was differentiation of patient and non-patient roles.

To test for cognitive complexity the principal components were extracted for each participant's pre and post grids. The number of factors that accounted for 80% of variance was extracted from these results and analysed using Bell's (2004) descriptions of no principal components as fragmented, one principal component as monolithic and two or more as complex. To test relationships between pre and post grids for each participant the correlation between grids was calculated using Slater's analysis through IDIOGRID.

Results

Similarity among participants

Seven participants completed all the study measures. Six participants had prior experience of CAT, including attending a 5-day CAT skills training course. Similarity among participants is analysed using the Procrustes statistic where higher values indicate that grids are dissimilar to each other. Using these values, Principal Components Analysis (PCA) was completed to examine similarity between participants. At pre-treatment a two dimensional bi-plot (Figure 1) explained 74.34% of variance. The bi-plot demonstrates some similarities between participants. The raw Procrustes statistics range from 0.41 to 1.21 (Table 2) and as demonstrated in the graph, both P4 and P8 held significantly different views to the other participants. The remainder of the participants differed from each other in a relatively narrow range (0.41 to 0.72).

	P1	P2	P3	P4	P6	P7	P8
P1	0.00						
P2	0.54	0.00					
P3	0.51	0.72	0.00				
P4	0.99	1.12	0.92	0.00			
P6	0.41	0.71	0.63	0.93	0.00		
P7	0.53	0.68	0.71	0.92	0.47	0.00	
P8	0.93	0.82	1.11	1.21	1.06	1.06	0.00

Table 2: Procrustes statistics for pre intervention participants

	P1	P2	P3	P4	P6	P7	P8
P1	0.00						
P2	0.82	0.00					
P3	0.55	0.61	0.00				
P4	1.23	1.22	0.98	0.00			
P6	0.89	0.62	0.69	1.08	0.00		
P7	0.86	0.93	0.53	0.75	0.56	0.00	
P8	0.73	0.69	0.75	1.67	0.73	1.01	0.00

Table 3: Procrustes statistics for post intervention participants

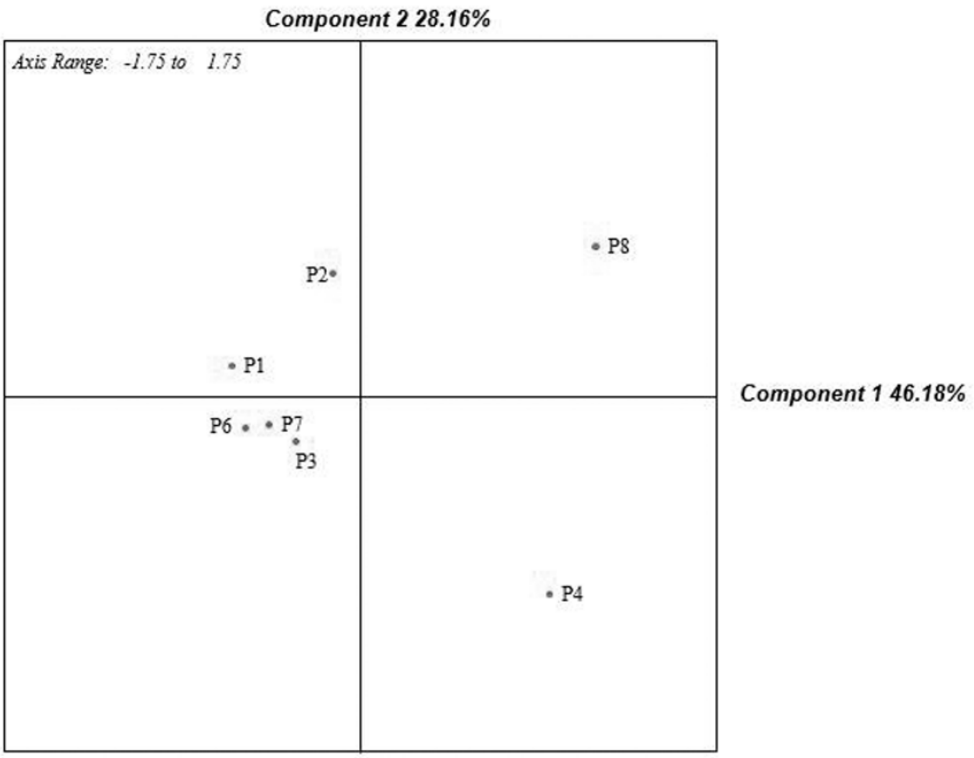


Figure 1: Biplot of Procrustes Statistics – pre intervention

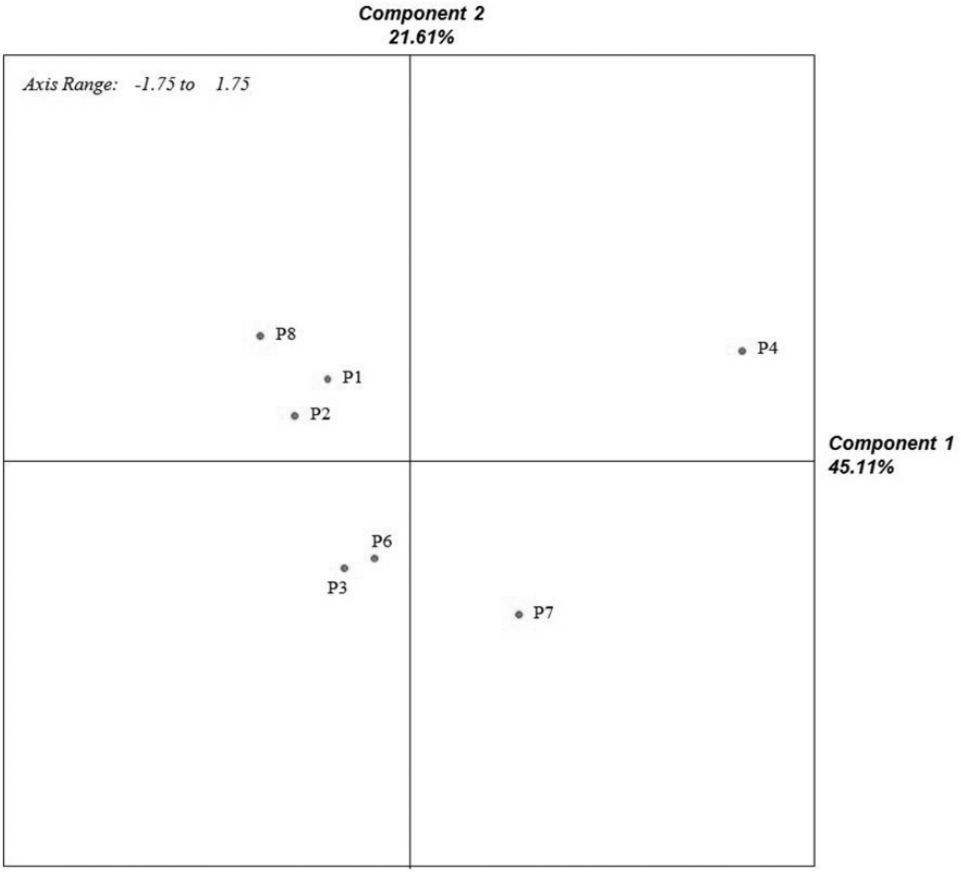


Figure 2: Biplot of Procrustes Statistics – post intervention

Following the intervention a two dimensional bi-plot (Figure 2) explained 66.72% of variance. The raw Procrustes statistics range from 0.53 to 1.67 (Table 3). The majority of participants appear to form two clusters (P1, P2, P8 and P3, P6, P7), with only P4 maintaining a markedly different perspective (Figure 2). However, within the 6 'grouped' participants only P7 and P8 have a Procrustes statistic greater than 1 (1.01). The relative placements of the participants in space may be due to this difference (e.g. though they appear to have different relationships P3 is as similar to P1 (0.55) as P7 (0.53)). Compared to the pre-intervention grids, P8 has demonstrated the most shift, moving from a relative outlier to being similar to other grids.

Combined perspective on constructs and elements

The level of consensus was statistically significant for both pre and post treatment grids (Consensus pre = 0.83, $p < 0.01$; Consensus post = 0.82; $p < 0.01$). This is further evidence that the participants had a relatively similar construal system. The relatively higher residuals for P4

and P8 at pre intervention and P4 at post intervention is consistent with the findings of the Procrustes statistic (Table 4). The elements: *An admired colleague, A colleague you dislike* and *A really difficult patient to work with* demonstrated the greatest variance across participants at both pre and post intervention (Table 5). This is likely due to these elements being specific to each individual participant, for example, each participant would likely choose a different disliked colleague and attribute particular qualities to them.

Participant	Pre Intervention		Post Intervention	
	Residual	Total	Residual	Total
P1	1.48	15.40	2.52	14.05
P2	2.16	14.56	2.34	14.56
P3	2.17	14.71	1.55	15.88
P4	3.66	12.38	4.37	11.41
P6	1.78	15.35	2.01	15.21
P7	1.94	15.22	2.08	15.12
P8	3.76	12.39	3.02	13.77
Total	16.95	100.00	17.89	100.00
Consensus		0.83		0.82

Table 4: Residuals for Pre and Post treatment grids

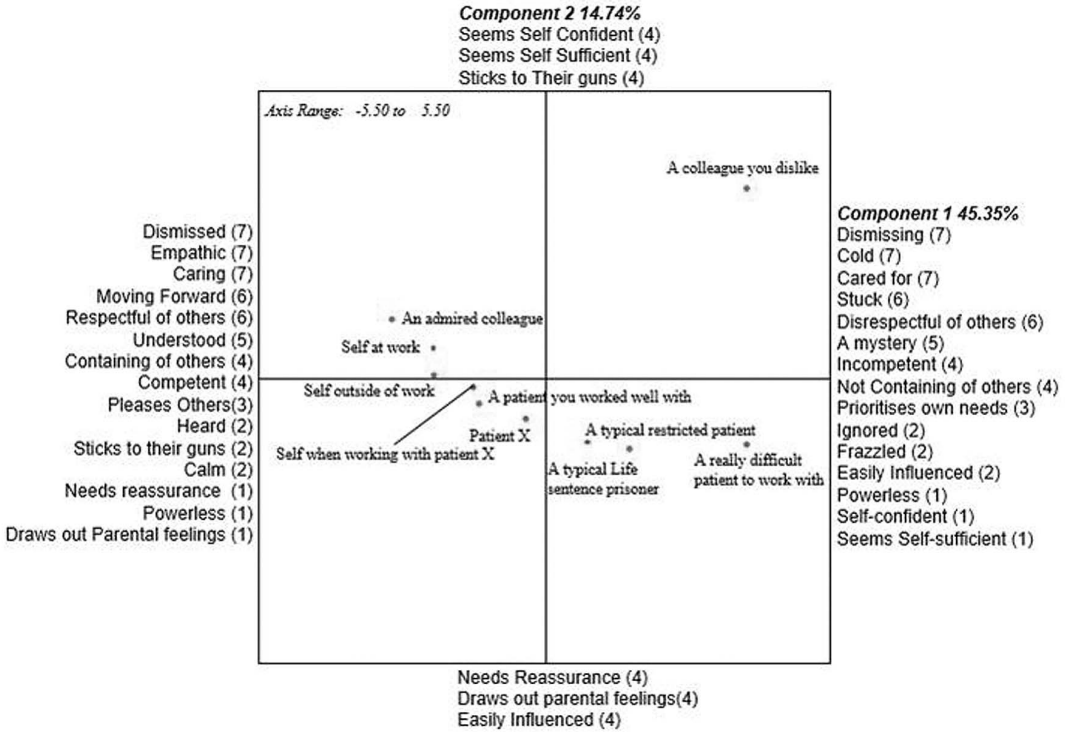
Table 5: ANOVA Residuals for rated elements

Element	Pre Intervention		Post Intervention	
	Residual	Total	Residual	Total
Myself at work	1.12	7.04	1.36	7.70
An admired colleague	1.25	12.28	1.03	11.32
A colleague you dislike	1.96	23.07	3.65	21.51
Myself outside of work	1.91	7.76	1.50	7.00
Patient X	1.82	8.82	2.02	8.43
Myself when working with Patient X	1.42	4.87	1.19	4.90
A really difficult patient to work with	2.51	19.90	2.30	24.05
A typical Life sentence prisoner	2.09	6.66	1.85	6.16
A patient you worked well with	1.72	5.64	1.68	5.07
A typical restricted patient	1.15	3.67	1.31	3.86
Total	16.95	100.00	17.89	100.00

loadings???

A consensus grid was calculated through GPA at each time-point and from this an extension analysis was used to generate a PCA (Figure 3, 4) (Grice & Assad, 2009). Constructs associated with each dimension (those with higher than 0.70 factor ladings) and the number of times they appeared are reported in the figures (Grice, 2007). The PCA of pre-intervention grids (Figure 3) explained 60.09% of the variance. The first component accounted for 45.35% of variance and highlights a dimension of negatively attributed construct poles (dismissing, cold, stuck, disrespectful of others) being associated with negative elements (A colleague you dislike, A really difficult patient to work with). Self and admired elements were more closely associated with positive poles of the constructs whilst patient roles were more closely associated with negative poles. This dimension appeared to differentiate patient and non-patient roles. Component two, which was associated with 14.74% of variance related to items around self-sufficiency and self-confidence. This dimension also differentiated patient and non-patient elements, though there was no differentiation between patient elements on this dimension. The construct poles, *needs reassurance, draws out parental feelings* and *easily influenced* were those identified as relevant for Patient X during the development of the repertory grid.

Figure 3: Biplot of Consensus Matrix for Pre Intervention Grids



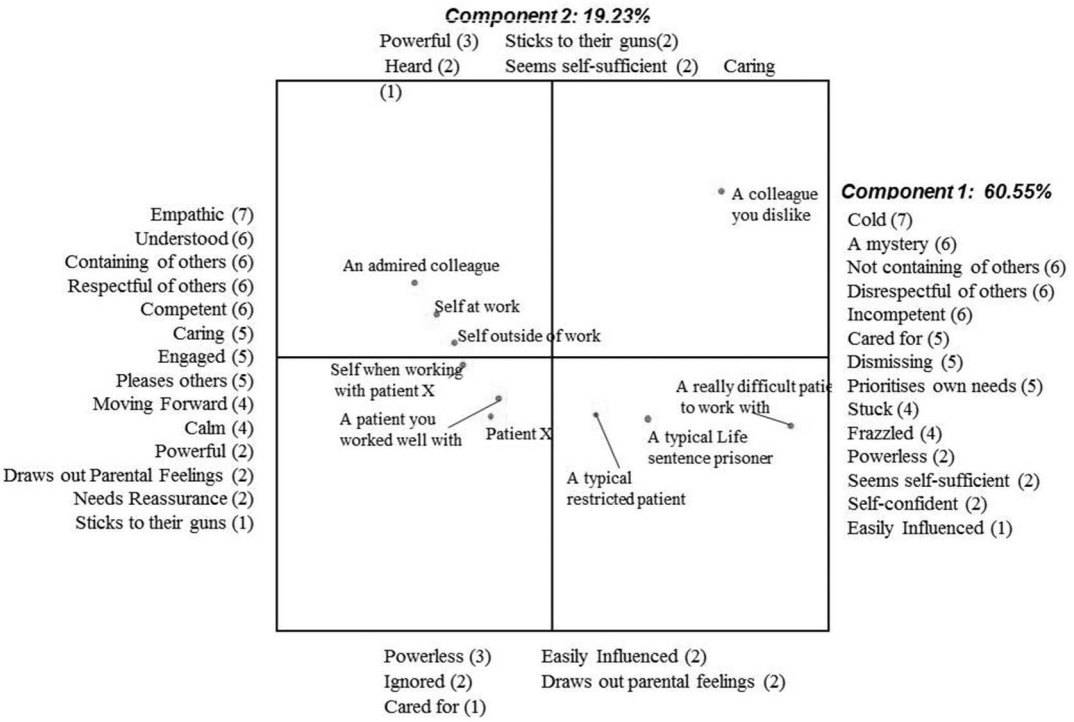


Figure 4: Biplot of Consensus Matrix for Post Intervention Grids

The two components extracted in the PCA for the post intervention grids (figure 4) accounted for 79.78% of variance. The first component accounted for 60.55% of variance and was broadly consistent with the primary dimension extracted in the pre-intervention analysis and differentiated patient and non-patient roles. The relative position of the elements was broadly consistent, with patient and non-patient roles being separated, though there is some shift in *Patient X* towards the other elements identified towards the positive pole. The second component (19.23%) was broadly consistent with the pre-intervention PCA, being formed from constructs related to competence. *Patient X* has moved to be more strongly associated with the constructs *easily influenced, draws out parental feelings* and *needs reassurance*. This is consistent with the content of the CAT chats. *Patient X* was most closely associated with *A patient you worked well with* perhaps indicating that staff felt that they could have a positive working relationship with the patient.

Individual outcomes

The correlation between pre and post grids was computed for all seven participants. This demonstrated correlations in the range of 0.56 to 0.79. Consistent with the Procrustes analysis P8 demonstrated the lowest

correlation between pre and post intervention grids, indicating a greater level of shift than evident in the other participants. Interestingly, the element *Self when working with patient X* showed a low pre-post correlation (< 0.5) for six of seven participants. To examine changes in complexity the measure of Percentage Variance Accounted for by First Factor (PVAFF) and number of components accounting for 80% of variance was calculated (Bell, 2004; Caputi et al., 2011; Hare et al., 2012). A lower PVAFF value indicates greater cognitive complexity. A higher number of factors indicates greater complexity (Bell, 2004). No clear pattern emerged in the data. Two participants demonstrated increased complexity, whilst five demonstrated decreased complexity or no change.

		Pre Intervention		Post Intervention	
	Pre-Post Correlation	PVAFF* Pre Intervention	Number of Components to > 80% variance explained	PVAFF Post Intervention	Number of Components to > 80% variance explained
P1	0.64	55.18	3	40.31	4
P2	0.60	54.88	3	67.39	2
P3	0.64	39.10	4	55.69	3
P4	0.76	52.01	3	63.76	3
P6	0.75	61.13	3	73.29	2
P7	0.79	65.85	2	58.00	3
P8	0.56	64.97	2	74.07	2

*Percentage Variance Accounted for by First Factor

Table 6: Measures of Cognitive Complexity

To validate the findings of the group level analysis, the individual PCAs for each grid were examined (Ralley et al., 2009). The differentiation between staff and patient roles was present in all pre intervention grids except for P4. However, *Patient X* was more closely associated with self-elements than with other patient elements in the post intervention grids for five participants (P1, P2, P3, P7 and P8), consistent with the overall post intervention grid (Figure 4). At post intervention, four participants (P1, P2, P5, P7) aligned *Patient X* with a component containing themes relevant to the CAT reformulation discussion such as *needs reassurance, draws out parental feelings* and *draws out parental feelings*. This shift may indicate a positive effect of the CAT reformulation session in generating useful shifts in how participants saw *Patient X*. Post session validation was completed with four participants, where the main patterns present in the PCA of their grids were discussed and agreed.

twice???

Discussion

The study, using a novel methodology, aimed to examine the impact of a CAT reformulation session on the extent to which a common understanding of a patient was shared across a staff team. The repertory grid measure was acceptable to staff as a means to test changes as a result of the intervention. The grid developed led to a meaningful pattern of representation, both in the group outcomes presented and in individual outcomes. The attribution of observed changes to CAT specific components is tentative given the lack of a control group.

Previous research looking at repertory grids with staff teams had sample sizes of 10-14 staff members (Ellis, 1999; Hare et al., 2012; Ralley et al., 2009; Woodrow et al., 2012), compared to the eight participants of the current study. Though repertory grid method provides rich data, it relies on a range of further measures or analysis for interpretation. In particular, multiple grid analysis relies on assumptions of similar approaches among participants of rating and understanding items (Ralley et al., 2009; Woodrow et al., 2012). The number of constructs used (15) was higher than in several studies and may have been a factor in leading to more principal components in the participants' grids (Caputi et al., 2011). The two dimensional graphs used in the analysis may obscure some differentiation between elements as further factors are not represented. A further difficulty encountered was that the participants overall had extensive CAT knowledge. This may have contributed to the low level of correlation for the *Self when working with patient X item* from pre intervention to post intervention, indicating a willingness to shift positions. This is consistent with CAT, which emphasises that our relational positions shift according to context. The potential of contextual reformulation to leave staff members feeling exposed (Davies et al., 2013) may have been more readily acceptable to this group due to their pre-existing knowledge of this approach. During piloting, participants anecdotally suggested the task was interesting and thought provoking, demonstrating the utility of the repertory grid as a tool, but unfortunately leading to difficulties in tapping underlying systems of construal. The shift to using constructs less aligned to typical CAT reciprocal roles overcame this difficulty.

Consistent with previous research on staff attitudes (e.g. Ralley et al., 2009) participants separated patient and non-patient roles at pre-intervention. Patient elements were more closely associated with negative construct poles as compared to non-patient elements. However, some patient roles, including *Patient X,* were identified as more similar to the

non-patient elements than to other patient elements. The *Patient I worked well with* element was generally placed close to the self-elements indicating that it may have been construed as an *ideal client* role commonly used in personal construct research on attitudes (Ralley et al., 2009). The *Self when working with Patient X* element was the most closely related of the self-elements to *Patient X*. In considering the therapeutic relationship, this can be seen as positive, as the staff member shifts their position to be more attuned to *Patient X*. Consistent with CAT, this closeness may also represent staff members being influenced by the reciprocal roles of *Patient X* (Ryle & Kerr, 2002).

Following the CAT chat, there was some indication that participants clustered together more closely in terms of their construal of *Patient X*, with six of seven participants having relatively low levels of difference (Table 3, Figure 2). This may indicate a more consistent conceptualisation of *Patient X* following the CAT reformulation session, and may indicate a benefit of this approach in reducing 'splitting' in teams (Summers, 2006). Case formulation without direct involvement of the patient risks ascribing difficulties to internal deficits (Moore & Drennan, 2013). CAT based reformulation due to its relational focus, may overcome this difficulty.

An unexpected finding was no increase in cognitive complexity found following the CAT reformulation session. The results indicated no clear pattern, though a tightening of construal was noted for several participants. Looking at the individual PCA graphs, it appears that for several participants the intervention was associated with the development of a second component relevant to the content of the CAT reformulation session. This process may explain the reduced complexity, due to the CAT session focusing in on key reciprocal roles relevant to *Patient X*. This finding highlights the specific nature of the CAT chat as an intervention, it is focused on work between a team and an individual patient as compared to approaches focused on developing skill in formulation in general, which may increase flexibility of understanding.

Conclusion

The current study provides some preliminary evidence that CAT based formulation sessions can increase consistency amongst staff members' in their individual construal of a patient. It also demonstrates use of repertory grid data in CAT and the rich suite of grid analysis techniques which can be useful for both research and clinical practice.

The study found some increase in the similarity of participant grids following completion of the CAT chat. A combined principal components analysis of all participants' grids demonstrated a shift in how the subject of the CAT chat was seen following the session. The shift was consistent with the map developed in the CAT chat sessions. The paper also demonstrated measures of cognitive complexity as well as individual level analysis of repertory grid data. The overall shift in terms of how *Patient X* was construed as a result of the CAT chat was positive, if limited. The scope for participants to demonstrate change was limited as the solution derived at pre-intervention showed that staff generally saw *Patient X* in a positive light. A longer term follow-up may demonstrate further changes as the staff use the reformulation developed to work with *Patient X*.

The implementation of CAT reformulation sessions for staff teams is supplemented by staff training. Six of the participants in the current study had attended previous CAT training. This prior exposure to CAT informed practice may have influenced the generally positive perception of *Patient X* prior to the intervention. Further research with staff members with limited CAT exposure may be useful in demonstrating the extent of shift in perspective achievable through this approach.

The model used in the current study does not involve the patient directly, and rather focuses on the staff team's perspective of working with the patient. This approach may have the added benefits of giving staff space to think creatively and express concerns (Summers, 2006). CAT informed reformulation contrasts with training in developing formulations (Minoudis et al., 2013), instead of using a skilled facilitator to draw together the perspectives of the participants in the reformulation sessions. The British Psychological Society (BPS, 2007) highlights the role of formulation in teams as a means to influence a culture towards psychological understandings. CAT informed reformulation sessions, with their explicit relational focus, may be particularly helpful in developing a shared language amongst staff teams and increase psychological understanding of the patient. □

REFERENCES

Bell, R. C. (2004). When is my grid cognitively complex and when is it simple? Some approaches to deciding. *Personal Construct Theory and Practice*, 1, 28-32.

Bell, R. C. (2009). Griddled with angst: A roller-coaster ride on the repertory grid. In J. Butler (Ed.) *Reflections in personal construct theory*, 145-158. Chichester: John Wiley & Sons

Berry,K., Barrowclough, C., & Wearden,A. (2009).A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy*, 37,39–48. doi:10.1017/S1352465808005018

Blundell, J., Wittkowski, A., Wieck, A., & Hare, D. J. (2012). Using the Repertory Grid Technique to Examine Nursing Staff's Construal of Mothers with Mental Health Problems. *Clinical Psychology & Psychotherapy*, 19(3), 260-269. doi:10.1002/cpp.747

British Psychological Society (2007). New Ways of Working for Applied Psychologists in Health and Social Care – Working Psychologically in Teams. Leicester: British Psychological Society

Buljac-Samardzic, M., Dekker-van Doorn, C. M., van Wijngaarden, J. D. H., & van Wijk, K. P. (2010). Interventions to improve team effectiveness: A systematic review. *Health Policy*, 94(3), 183-195. doi:http://dx.doi.org/10.1016/j.healthpol.2009.09.015

Calvert, R., & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, 87(3), 253-277. doi:10.1111/papt.12020

Caputi, P., Bell, R. C., & Hennessy, D. (2011). Analyzing grids: New and traditional approaches. In P. Caputi, L. L. Viney, B. M. Walker & N. Crittenden (Eds.), *Personal Construct Methodology*, 159-181. United Kingdom: Wiley-Blackwell.

Caputi, P., & Reddy, P. (1999). A comparison of triadic and dyadic methods of personal construct elicitation. *Journal of Constructivist Psychology*, 12(3), 253-264.

Carradice, A. (2013). 'Five-Session CAT' Consultancy: Using CAT to Guide Care Planning with People Diagnosed with Personality Disorder within Community Mental Health Teams. *Clinical Psychology & Psychotherapy*, 20(4), 359-367. doi:10.1002/cpp.1812

Caruso, R., Biancosino, B., Borghi, C., Marmai, L., Kerr, I. B., & Grassi, L. (2013). Working with the 'difficult'patient: The use of a

contextual cognitive-analytic therapy based training in improving team function in a routine psychiatry service setting. *Community Mental Health Journal*, 49(6), 722-727.

Castiglioni, M., Faccio, E., Veronese, G., & Bell, R. C. (2012). The Semantics of Power Among People With Eating Disorders. *Journal of Constructivist Psychology*, 26(1), 62-76. doi:10.1080/10720537.2013.740263

Castiglioni, M., Veronese, G., Pepe, A., & Villegas, M. (2014). The Semantics of Freedom in Agoraphobic Patients: An Empirical Study. *Journal of Constructivist Psychology*, 27(2), 120-136. doi:10.1080/10720537.2013.806874

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice*, 85(4), 424-435. doi:10.1111/j.2044-8341.2011.02041.x

Davies, J., Black, S., Bentley, N., & Nagi, C. (2013). Forensic case formulation: Theoretical, ethical and practical issues. *Criminal Behaviour and Mental Health*, 23(4), 304-314. doi:10.1002/cbm.1882

Davies, J., Howells, K., & Jones, L. (2007). Evaluating innovative treatments in forensic mental health: A role for single case methodology? *Journal of Forensic Psychiatry & Psychology*, 18(3), 353-367. doi:10.1080/14789940701443173

Easterby-Smith, M. (1980). The design, analysis and interpretation of repertory grids. *International Journal of Man-Machine Studies*, 13(1), 3-24.

Ellis, J. M. (1999). Nursing care of older people: a personal construct theory perspective. *Journal of Advanced Nursing*, 29(1), 160-168.

Fransella, F., Bell, R. C., & Bannister, D. (2004). *A manual for repertory grid technique* (2nd ed.). Chichester: John Wiley & Sons.

Golynkina, K., & Ryle, A. (1999). The identification and characteristics of the partially dissociated states of patients with borderline personality disorder. *British Journal of Medical Psychology*, 72(4), 429-445.

Gower, J. C. (1975). Generalized procrustes analysis. *Psychometrika*, 40(1), 33-51.

Grice, J. W. (2006). IDIOGRID manual version 2.4: Idiographic analysis with repertory grids. (Version 2.4). Oklahoma: Oklahoma State University.

Grice, J. W. (2007). Generalized Procrustes Analysis Example with Annotation. Available from http://psychology.okstate.edu/faculty/jgrice/personalitylab/GPA_Idiogrid_Example.pdf (Accessed 11/01/2019)

Grice, J. W., & Assad, K. K. (2009). Generalized procrustes analysis: a tool for exploring aggregates and persons. *Applied Multivariate Research*, 13(1), 93-112.

Hare, D. J., Durand, M., Hendy, S., & Wittkowski, A. (2012). Thinking About Challenging Behavior: A Repertory Grid Study of Inpatient Staff Beliefs. *Intellectual and Developmental Disabilities*, 50(6), 468-478. doi:doi:10.1352/1934-9556-50.06.468

Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: a controlled study in assertive outreach. *Journal of Psychiatric and Mental Health Nursing*, 21(8), 687-697. doi:10.1111/jpm.12123

Kelly, G. A. (1955). *The psychology of personal constructs*. Volume 1: A theory of personality. New York: WW Norton and Company.

Kemp, N., Bickerdike, A. & Bingham, C. (2017). 'Map and Talk' – A cognitive analytic therapy informed approach to reflective practice in a forensic setting. *International Journal of Cognitive Analytic Therapy and Relational Mental Health*, 1, pp147-163

Kerr, I. B., Dent-Brown, K., & Parry, G. D. (2007). Psychotherapy and mental health teams. *International Review of Psychiatry*, 19(1), 63-80. doi:doi:10.1080/09540260601109380

Kirkland, J., & Baron, E. (2015). Using a cognitive analytic approach to formulate a complex sexual and violent offender to inform multi-agency working: developing a shared understanding. *Journal of Sexual Aggression*, 21(3), 394-405 doi:10.1080/13552600.2014.939596

Leiman, M. (1994). The development of cognitive analytic therapy. *International Journal of short-Term psychotherapy*, 9(2-3), 67-82.

Minoudis, P., Craissati, J., Shaw, J., McMurran, M., Freestone, M., Chuan, S. J., & Leonard, A. (2013). An evaluation of case

formulation training and consultation with probation officers. *Criminal Behaviour and Mental Health*, 23(4), 252-262. doi:10.1002/cbm.1890

Mitzman, S.F. (2010). Cognitive analytic therapy and the role of brief assessment and contextual reformulation: The jigsaw puzzle of offending. *Reformulation*, Summer, pp26-30

Moore, E. (2012). Personality disorder: its impact on staff and the role of supervision. *Advances in Psychiatric Treatment*, 18(1), 44-55. doi: 10.1192/apt.bp.107.004754

Moore, E., & Drennan, G. (2013). Complex forensic case formulation in recovery-oriented services: Some implications for routine practice. *Criminal Behaviour and Mental Health*, 23(4), 230-240. doi:10.1002/cbm.1885

Murphy, S. A., Osborne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging & Mental Health*, 17(4), 441-448. doi:10.1080/13607863.2013.765829

Paget, A., & Ellett, L. (2014). Relationships Among Self, Others, and Persecutors in Individuals With Persecutory Delusions : A Repertory Grid Analysis. *Behavior Therapy*, 45(2), 273-282.

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. (2012). The antecedents of violence and aggression within psychiatric in-patient settings (English). *Acta psychiatrica scandinavica*, 125(6), 425-439.

Pollock, P. H. (1996). Clinical issues in the cognitive analytic therapy of sexually abused women who commit violent offences against their partners. *British Journal of Medical Psychology*, 69(2), 117-127. doi:10.1111/j.2044-8341.1996.tb01856.x

Pollock, P. H., & Kear-Colwell, J. J. (1994). Women who stab: a personal construct analysis of sexual victimization and offending behaviour. *British Journal of Medical Psychology*, 67(1), 13-22.

Potter, S. (2010). Words with arrows: The benefits of mapping whilst talking. *Reformulation*, 34, 37–45.

Ralley, C., Allott, R., Hare, D. J., & Wittkowski, A. (2009). The use of the repertory grid technique to examine staff beliefs about clients

with dual diagnosis. *Clinical Psychology & Psychotherapy*, 16(2), 148-158. doi:10.1002/cpp.606

Randal, C., Bucci, S., Morera, T., Barrett, M., & Pratt, D. (2016). Mindfulness Based Cognitive Therapy for Psychosis: Measuring Psychological Change Using Repertory Grids. *Clinical Psychology & Psychotherapy*, 23, 496–508. doi: 10.1002/cpp.1966.

Roth, A., & Fonagy, P. (2006). *What Works for Whom?: A Critical Review of Psychotherapy Research*. New York: Guilford Press.

Royal College of Psychiatrists (2012). Standards for Psychotherapy in medium Secure units. CCQI132. London: Royal College of Psychiatrists.

Ryle, A. (1985). Cognitive theory, object relations and the self. *British Journal of Medical Psychology*, 58(1), 1-7.

Ryle, A. (1991). The Origins and Main Features of Cognitive Analytic Therapy. In Ryle, A. (Ed.) *Cognitive Analytic Therapy: Active Participation in Change. A New Integration in Brief Psychotherapy*, 1-14. Chichester: John Wiley & Sons

Ryle, A., & Kerr, I. B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*. Chichester: John Wiley & Sons.

Ryle, A., & Lunghi, M. (1970). The dyad grid: a modification of repertory grid technique. *British Journal of Psychiatry*, 117(538), 323-327.

Ryle, A., & Marlowe, M. J. (1995). Cognitive analytic therapy of borderline personality disorder: Theory and practice and the clinical and research uses of the self states sequential diagram. *International Journal of short-Term psychotherapy*, 10, 21-34.

Ryle, A., Poynton, A. M., & Brockman, B. J. (1990). *Cognitive-analytic therapy: Active participation in change: A new integration in brief psychotherapy*: John Wiley & Sons.

Saúl, L. A., López-González, M. A., Moreno-Pulido, A., Corbella, S., Compañ, V., & Feixas, G. (2012). Bibliometric Review of the Repertory Grid Technique: 1998–2007. *Journal of Constructivist Psychology*, 25(2), 112-131. doi:10.1080/10720537.2012.651065

Summers, A. (2006). Psychological formulations in psychiatric care: staff views on their impact. *The Psychiatrist*, 30(9), 341-343. doi:10.1192/pb.30.9.341

Thompson, A. R., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J., & Kerr, I. B. (2008). Multidisciplinary community mental health team staff's experience of a 'skills level' training course in cognitive analytic therapy. *International Journal of Mental Health Nursing*, 17(2), 131-137. doi:10.1111/j.1447-0349.2008.00521.x

Winter, D.A. (2003). Repertory grid technique as a psychotherapy research measure. *Psychotherapy Research*, 13, 25-42.

Woodrow, C., Fox, J. R. E., & Hare, D. J. (2012). Staff construal of inpatients with anorexia nervosa. *Clinical Psychology & Psychotherapy*, 19(1), 70-77. doi:10.1002/cpp.735

Cognitive Analytic Therapy in the provision of care for mental health staff in an Employee Psychology Service

SARAH CRAVEN-STAINES

Abstract:
The recognition of burnout amongst staff working within mental health services is not a new concept. Yet the ability to support the mental wellbeing of our staff has been limited and variable in nature dependent upon the service in which they work. In 2015, a large mental health trust in the North East of England recognised the mental health needs of staff given the growing numbers of sickness absence relating to work-related stress, anxiety and depression. In response, the Trust agreed to pilot an Employee Psychology Service, to provide staff access to clinical psychologists and psychological therapies, with an aim of supporting staff experiencing work-related stress. The following article is a reflection upon how Cognitive Analytic Therapy (CAT) can be used in such a service, to offer therapy individually to staff members as well as with staff teams within the wider organisation. This article reports significant differences in pre and post outcome measures from a small sample size (n=15) of staff clients; as well as qualitative quotes recognising the value of using CAT in organisations.

Keywords: Cognitive Analytic Therapy; Staff; employee support; mental health; team reformulation

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Introduction to the Service

The Mental Health Trust, within which this work was completed, is committed to supporting the health and wellbeing of staff. As a result, after two years of pilot, a permanent service is available for staff who

may be experiencing significant episodes of work-related stress, anxiety and/or depression. The Employee Psychology Service (EPS) has been running in the Trust since 2015 and is led by a full-time Consultant Clinical Psychologist, one Clinical Psychologist (author SCS) one day per week and a full-time psychological therapist (at the time of writing this article). Referrals are received from Employee Support Officers who provide support for staff experiencing difficulties in their health and wellbeing. Through an initial assessment within the EPS, a joint decision is made between the staff member and clinician about the therapeutic model used, based on client need and therapist availability.

The following article, aims to reflect upon the provision of Cognitive Analytic Therapy (CAT) within the EPS, recognising the uniqueness of CAT in providing both a relational and organisational approach to working with staff. Due to this, the article will form two main parts:
(a) reflecting on the use of CAT directly in 1:1 therapy with staff; and
(b) reflecting on the contextual use of CAT within the EPS.

Introducing work-related stress

Cartwright and Cooper (1997) identified that there are six general categories, which can be triggers of work-related stress. These are: factors intrinsic to the job itself (physical environment, workload, working hours etc.); roles in the organisation (e.g. role responsibilities, role ambiguity, conflict, overload); social relationships at work (e.g. with supervisors, colleagues, clients etc.); career development; and organisational development. Similar stressors are seen as the precipitating factors that, lead staff to being referred to the EPS. Whilst it is recognised that the aim is to focus upon 'work-related stress', often this does not come without ongoing or existing difficulties within the staff member's life outside of work, or in their own historical background.

The persistence of work-related stress can often lead on to burnout and depression in staff. Maslach (1982) reported that 'burnout' is the experience of emotional overload and exhaustion, which occurs when people become closely involved and feel over-burdened by the emotional demands of working with people who are distressed. Often individuals reach a point of feeling 'drained' and as a result lack the energy or motivation to continue to work. Maslach (1982) highlighted that if such a situation continues to occur, there is a risk that the staff member will become detached from emotional involvement with the clients they are working with, as a means of coping. Walsh and Walsh (2009) reviewed

the existing literature to investigate the risks mental health staff face to their own mental health and found that contributing factors included frequent contact with severely ill patients, organisational change, uncertainty about role and low support.

CAT as a framework to conceptualise work-related stress

Walsh (1996) used CAT to consider the roles that staff members can often be caught within in relation to themselves and others when working within the helping professions. She acknowledged that when things go well, staff can often feel worthy and valued. However, should situations become difficult, individuals could be left to feel minimised, useless or worthless. Staff are often drawn into a helping professions role through the desire to care and for others to feel gratefully cared for (Lloyd, 2011).

As the political climate of the NHS continues to change, staff face increasing demands, tight deadlines, and mounting targets. Jones and Childs (2007) discussed the reforms in the NHS through a CAT lens, in writing a reformulation letter. In doing so, they identified numerous reciprocal roles that staff face, such as controlling–controlled, threatening – powerless and dismissing–ignored. Such roles often leave staff feeling overlooked and without a voice to express how they are feeling. Prioritising staff's own need for care, therefore, becomes a necessity in an environment where individuals are struggling to cope and maintain their workload, resulting in increased rates of sickness. Managers within the Trust that this article refers to, are aware of such need to reduce sickness absence, and therefore are often willing to invest in time spent to support staff and their mental wellbeing.

Whilst staff often view managers as those in the 'pain inducing' end of the reciprocal roles (e.g. controlling, threatening, dismissing), CAT can be helpful in supporting both staff and managers to understand the interacting systems that they can all be drawn into. A shared understanding can acknowledge unhelpful dynamics due to the external pressure placed upon all staff within their differing positions. As a result, acknowledgement of how managers also encounter the 'pain experiencing' end of the role can be helpful to allow staff to recognise the reciprocity in roles. Carson and Bristow (2015) spoke of the importance of collaborating with NHS management to aid change.

My own position within the Employee Psychology Service

After having worked for 9 years post qualification in a Community Mental Health Team for Older People, I took a change of career some two years ago and began a split post as Academic Tutor for the Doctorate in Clinical Psychology Programme at Teesside University as well as working as a Clinical Psychologist within the Employee Psychology Service. As a CAT practitioner, and with a strong belief in the applicability of CAT to different settings, I felt that there would be a lot for CAT to offer through being utilised within the EPS. My role not only entailed meeting staff on a 1:1 basis for direct therapy, but also working with teams in distress, who were struggling to function and had high sickness rates.

The use of CAT directly in 1:1 therapy with staff

I was aware that the pace of working with staff clients would be different to working with older adults. Not only has there been a high demand for EPS, with increasing referrals each month, there was also recognition that the period of work should be shorter in nature. For the first time in my career, I was beginning to become familiar with working within contracts of 8 or 12 session CAT, much shorter than I had previously been used to. Despite this, what I did find was that given that I was now working with staff, they had a wealth of psychological knowledge, as the majority were clinical staff and embedded within multidisciplinary teams of their own. Whilst many had not worked directly using CAT, they understood concepts relatively easily, which helped with the shorter time frame.

Staff often came to the EPS with an ongoing work-related difficulty (often increased demands upon role, working over and above contracted hours to meet such demands, difficulties in relationships with teams and managers, or change to structure of teams). However, generally through deeper discussion, staff clients often reported difficulties within their personal lives (e.g. relational problems or breakdown, past abuse and increased strain on home life). Often the work-related stress, personal difficulties and past life events sat hand in hand, as the problematic patterns they were becoming caught within, naturally mirrored one another. This is a similar reflection to that which Appleby (2003) made in working within an occupational health department. She too recognised that whilst the main precipitant for staff may be a work-related problem, a personal issue is also often present, and there can frequently be links made with much earlier pain.

For staff clients seen within EPS, there were often competing pressures with a desire to 'perfectly care for' others versus frequently feeling 'criticised', 'crushed', 'overwhelmed', 'shamed' and 'powerless'. Such feelings were experienced in relation to the organisation and management, as well as the self when increased demands are unable to be sustained. The pain-experiencing end of reciprocal roles highlighted within the sequential diagrammatic reformulations (SDRs) throughout therapy, naturally linked to past experiences, and often as a result, the work-related stressor was a trigger for the core pain.

The benefit of CAT in this instance is its reciprocity and ability to collaboratively draw together an understanding of core pain, its foundation and how it continues to re-emerge in day-to-day situations. Staff clients often reported that creating an understanding of their reciprocal roles and problematic patterns was vital for the change process to begin to occur. Commonly, the stage of recognition before revision, led staff to feel uncertain and anxious about how to make change, yet their motivation outside of sessions to begin to recognise and seek revision often led to movement and modification occurring relatively quickly.

In the 2 years of working 1 day per week in the service, 20 staff completed CAT interventions. Pre and post objective measures were used to assess staff wellbeing post therapy and full data is held for 15 staff. Measures used were: Generalised Anxiety Disorder – 7 (GAD-7; Spitzer, Kroenke, Williams, et al., 2006); Patient Health Questionnaire – 9 (PHQ-9; Kroenke, Spitzer and Williams, 2001) and the Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear and Griest, 2002). It is often seen in EPS that staff under-report distress in initial sessions for fear of being seen as incompetent or unable to fulfil their roles. This, therefore, needs to be taken into consideration when analysing the data. Whilst the numbers of pre and post outcome measures are limited, paired sample T-tests were conducted to identify any significant differences between pre and post therapy aggregate scores (for the GAD-7; PHQ-9; WSAS).

There was a significant difference in scores for the GAD-7 pre therapy (M=11.18; SD=5.54) and GAD-7 post therapy (M=3.06; SD=2.71) scores; $t=(14)5.5, p<0.01$. Similarly, significant differences in scores for the PHQ-9 pre therapy (M=13.18; SD=8.68) and PHQ-9 post therapy (M=3.31; SD=2.75); $t=(14)4.3$, $p<0.01$ were found. Finally, there was a significant difference in scores noted for the WSAS pre therapy (M=19.12; SD=12.31) and the WSAS post therapy scores (M=4.18; SD=3.41); $t=(14)4.7$, $p<0.01$.

	Pre-CAT		Post-CAT		95% confidence interval of the difference		*df*	*t*	*p*
	M	SD	M	SD	Lower	Upper			
GAD-7	11.19	5.54	3.06 2.71		4.76	10.84	14	5.5	.000
PHQ-9	13.18	8.68	3.31 2.75		4.98	14.48	14	4.3	.000
WSAS	19.12	12.31	4.18 3.41		8.21	21.79	14	4.7	.000

Table 1: Breakdown of significant pre and post measures using T-tests

The preliminary findings are encouraging and indicate a significant reduction in scores on each objective measure post therapy in comparison to pre therapy. Individuals' scores on the GAD-7 showed a change from the 'moderate' range to the 'mild' range, whilst on the PHQ-9, scores reduced from the 'moderate' to 'minimal' range. Finally, for the WSAS, individuals' scores reduced from the 'significant functional impairment with less severe clinical symptomatology' range to the 'below subclinical population'. The preliminary findings are, however, open to limitations, particularly in terms of a lack of control group and thus the potential for naturally occurring positive change over time. Despite this, the findings were also backed up by positive qualitative feedback from staff:

> 'I believe that with the tools you have given me and the talks we have had I am in a much better place to keep myself safe and on an even keel. I cannot express how highly I think of yourself, and the sessions we have had.'

> 'The sessions have been invaluable. . . life changing in fact! Thank you so much for helping me to find 'me' again. Never to be forgotten!'

The contextual use of CAT within the EPS

The Employee Psychology Service also provides a broader, outward facing role, particularly in supporting wider staff groups who are struggling. Often, when teams have blanket targets and demands, or when difficulties arise in professional relationships, it is not one person alone who is struggling, rather the whole team. Therefore, offering CAT as an approach to reformulating problematic patterns within a system can benefit a wider approach to team functioning.

Appleby (2003) reflected upon how often there is similarity between pain, procedural coping strategies and reciprocal roles in clients, staff and managers. The understanding of projection of these onto one another and into the culture can often highlight how the whole system is behaving. She went onto describe that 'problem' areas in healthcare often occur when communication has broken down, and it is often seen that there isn't time for staff meetings or training events. In doing so, teamwork and support begins to diminish, leading to splitting and a greater degree of helplessness amongst staff.

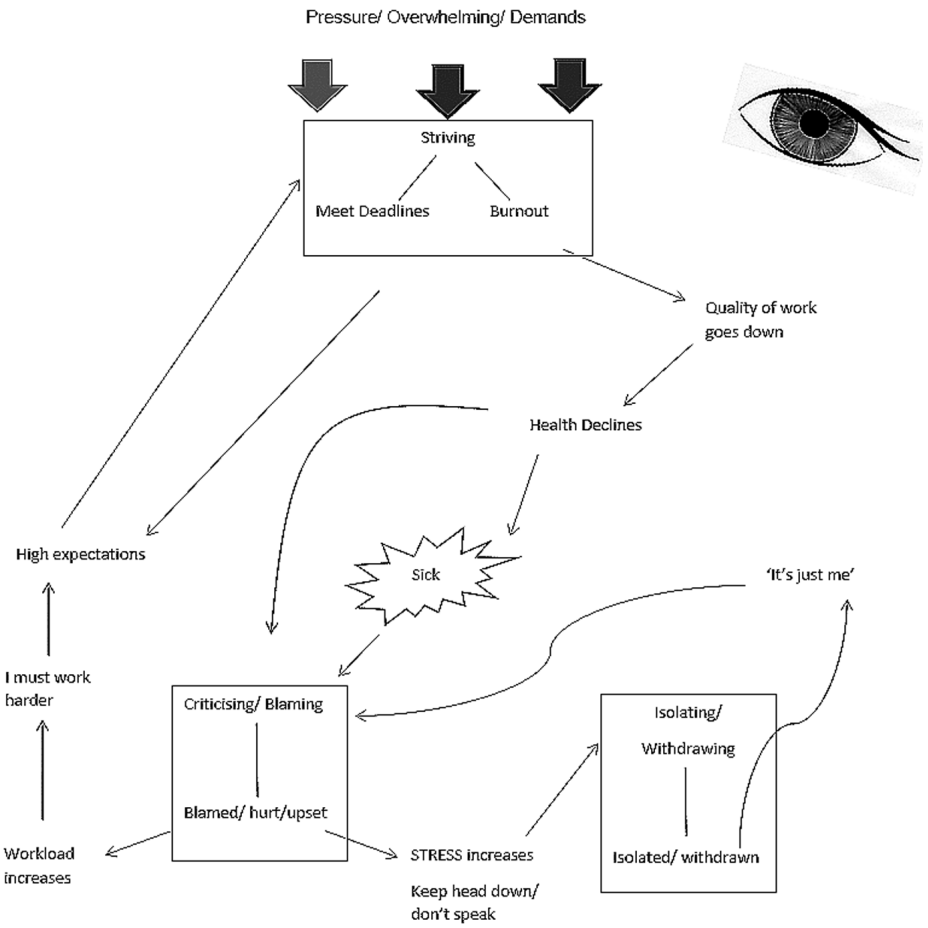
I worked for over 18 months with one of our corporate teams, who requested support at a point in which they were all beginning to experience a sense of burnout, and an inability to continue to function as they were. The team have provided consent for their experience and SDR to be shared within this article. Upon meeting them, staff had been working over and above their contracted hours, were taking work home to meet the specified targets, and were struggling to effectively use annual leave allocations (or coming into work on planned days off). The team felt at breaking point and were uncertain of how to move forward. It was recognised that a wider team approach was needed to understand the difficulties they were being drawn into. Management were also in support of this, prioritising the release of staff to attend meetings.

I offered a CAT reformulation meeting to map some of the difficulties they were facing and to begin to create a shared understanding of the obstacles they were encountering. Figure 1. provides the SDR developed in the first meeting. A number of different themes were identified that the team felt contributed to the position they had found themselves in. These included: the political climate of the NHS; changes they faced due to new national guidance documents; changes in managers and changes in their own job descriptions. Due to frequent transformation, they had at times felt unsupported and lacked direction by higher management. The increase in workload within the team had led to a mounting pressure

to perform. Staff reflected upon the pride that they took within their roles, and thus how they often strived to make sure that all their work was to a high standard. Due to the increasing demand and pressures, however, they began to feel overwhelmed and would either become critical of themselves for feeling this way, or would withdraw and isolate themselves from the rest of the team, believing that they were alone in feeling like this and that others would be critical of them for not performing.

Patterns highlighted were similar to those of feeling overwhelmed and detached, as identified by Maslach (1982). Following months of working over to meet targets, they reached a point of burnout. This reinforced a sense of internal criticism within staff members, as they would believe they were letting the team down. At times, the pressure the team felt from higher management was also met with criticism, as targets were re-enforced, and they felt singled out, if deadlines were not met.

Figure 1: Sequential Diagramatic Reformulation of team functioning



Staunton, Lloyd and Potter (2015) used the Helper's Dance Checklist (Potter, 2013) to identify relational patterns within a learning disabilities service in a large Mental Health Trust. They found that staff often felt drawn into similar reciprocal roles to those identified here. Specifically, there was often a 'striving to meet demands' trap identified by staff coupled with reciprocal roles of criticising to criticised and judging to feeling judged, if such demands were unsustainable. There may therefore be universality to the problematic patterns and reciprocal roles experienced by staff in the helping professions.

For this team, through opening a dialogue of the experiences they faced together and by beginning to map the maladaptive coping strategies that they had been drawn into, individuals began to reflect upon the value of bringing the unspoken into the open and how helpful it was to hear that they were not alone in feeling the way they did. The team were also keen to acknowledge their strengths. Despite their weakening morale, they noted the internal strength they felt as a team. They had an identity, a sense of closeness and a healthy banter that could reverberate around the office. The team felt secure and safe within the workplace and shared a hope that things could get better in the future.

We were keen to draw upon the strengths in the meeting and to acknowledge how the staff group could build on these. Identifying exits to the problematic patterns were also important and together the team agreed on: altering how they managed the referral process; being clearer on their workload and feeling able to say 'no' when demands became too much; getting feedback from one another on their work (to allow them to step out of striving to be perfect); if demand began to outweigh capacity having a direct link to the Executive Management Team through their own manager; and having space each week allocated as a team to de-brief on cases. We also acknowledged the importance of positively reinforcing the achievements they made, particularly through promoting them in the staff E-Bulletin and registering for team of the week.

The team have valued the input provided by psychology and the opportunity to consider some of their problematic patterns. They recognised that whilst some of their improvements had happened either before or in parallel with the CAT reformulation meeting, the SDR helped them recognise their problematic patterns and how to step out of them. They pinned their SDR on the office wall in order to keep an observing eye on the team and the patterns. The team reported that they could think of other teams who would benefit from the same experience. Some qualitative feedback received from the attendees suggested the value of

having CAT reformulation meetings for teams:

> 'I always felt invigorated after a CAT reformulation session as I felt listened to; it gave me the confidence to approach my line manager to discuss my workload without *feeling guilty.'*

> 'The most important issues for me were to recognise when my "red flags" were starting to appear (working too many hours at home, not sleeping) and to be able to discuss these red flags within the group.'

The team agreed that routine meetings to reflect upon their SDR and exits would be beneficial and initially we arranged to meet every three months and then later on a six-monthly basis to review their progress. The team continued to face pressures and at times when we met, they recognised that they were back on the map and reflected upon whether or not they were still utilising the exits identified. In our more recent review, given the changing nature of the team with new staff members, the team requested to reformulate, mapping again any new procedures that they found challenging and seeking new revised exits from them. Overall, the CAT reformulation meetings provided staff with an opportunity to feel heard, valued, and supported. They were widely accepted and commended by staff. In addition, the CAT reformulation meetings allowed staff members to acknowledge pressures their own managers may be under and the reciprocity of the difficult roles.

Conclusion

Delivering a service that supports our employees in their mental health and wellbeing is a new venture and one that is proving worthwhile. Psychology has a lot to offer our employees as they face a huge amount of pressure from the organisational systems around them, whilst also facing their own personal challenges in life. The use of CAT within the EPS is only one area in a wider whole, with other staff members practising different therapeutic approaches. CAT, however, has a valuable position in working with staff both individually and within wider groups, as it offers a non-judgemental, collaborative and reciprocal way of working that can help normalise and understand the tensions staff face in their daily practice. It is hoped that this reflective piece is one of more to come, as the service develops and the outcome data grows in using CAT with staff groups. The use of CAT within the organisation is continuing to be promoted and staff will be encouraged to reflect upon the value of working with an observing eye on relational processes. □

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Firstly, for making this paper possible, many thanks to the team I worked within, who have allowed their story to be shared in this article. I would also like to express my gratitude to Dr Kate Freshwater (Consultant Clinical Psychology), Dr Sarah Dexter-Smith (Director of Therapies) and Dr Ash Summers (Programme Director) for their support and guidance throughout the writing of this article. Finally, with great thanks to Dr Steven Muncer (Research Tutor) for his statistical knowledge and support.

REFERENCES

Appleby, K. (2003). Cognitive Analytic Therapy – its influence on my practice in the Occupational Health Speciality within a Clinical Psychology and Counselling Service. *Reformulation*, Spring, 18-24.

Carson, R. & Bristow, J. (2015). Collaborating with Management in the NHS in difficult times. *Reformulation,* Summer, 30-36.

Cartwright, S. & Cooper, C. L. (1997). *Managing Workplace Stress*. Thousand Oaks, CA: Sage Publications.

Jones, A. & Childs, D. (2007). Reformulating the NHS reforms. *Reformulation.* Summer, 7-10.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med.* 16(9), 606-13.

Lloyd, J. (2011). Consulting with staff teams. *Clinical Psychology and People with Learning Disabilities.* 9, 1.

Maslach, C. (1982). *Burnout: The cost of caring*. New Jersey: Prentice Hall.

Mundt, J. C., Marks, I. M., Shear, K.& Griest, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *The British Journal of Psychiatry*. 180 (5) 461-464.

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

Spitzer, R. L., Kroenke, K., Williams, J. B., et al. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med.* 166(10), 1092-1097.

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

Walsh, B. & Walsh, S. (2009). Is mental health work psychologically hazardous for staff? A critical review of the literature. *Journal of Mental Health.* 10 (2), 121-129.

Walsh, S. (1996). Adapting cognitive analytic therapy to make sense of psychologically harmful work environments. *British Journal of Medical Psychology.* 69, 3-20.

The challenge of psychotherapy across cultures:

issues arising in cognitive analytic therapy (CAT) for an older male presenting with depression and sexuality-related problems with a younger female therapist in a south Indian context

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Abstract:
Although people around the world in very different socio-cultural settings may experience what in Western cultures might be understood as individual psychological distress and disorder, serious problems exist cross-culturally for Western models of mental disorder and psychotherapy in adequately addressing these both conceptually and clinically. In many settings such experiences may, properly, not be attributed to or 'framed' as individual psychological distress or mental disorder either by the person concerned or those around them and might rather be understood and addressed from a more sociocentric view-point and possibly recourse to traditional healing practices.

Addressing 'psychological' distress and disorder cross-culturally also raises serious questions with regard to the ontological validity and 'universality' of Western models of mental disorder and treatment, notwithstanding possible common underlying genetic vulnerabilities, particularly given evolving understandings of the actively intersubjective and relational character of human development and the critical role of these and broader sociopolitical factors in mental health and disorder.

Arguably a model such as CAT, predicated as it is on a construct of a largely socially-constituted Self and with a therapeutic style that is overtly collaborative and jointly exploratory, might offer greater sensitivity and flexibility in approaching such problems cross-culturally. However there remains a need for further development

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of both theory and clinical practice cross-culturally. This includes notably development of a valid and helpful meta-conceptual framework within which to explore respectfully, and integrate into a holistic therapeutic approach, possibly quite diverse cultural and religious beliefs, practices and their meanings. Nonetheless anecdotal reports so far of the use of CAT cross-culturally are encouraging despite these evident challenges.

We report here a successful attempt to offer CAT to an older Indian male by a younger female therapist in a very different context from the one in which the model was developed. We consider some particularly challenging issues arising, including in relation to age, and to sexuality and use of pornography. The CAT relational framework was evidently important in addressing and productively managing the challenging dynamics that occurred within this therapeutic relationship, understood in CAT as reciprocal role enactments. Along with supervision and personal therapy this also enabled the therapist to work with a personally challenging case in a more genuinely compassionate manner. Experience of using CAT in such a context justifies, and confirms the need for, further and more extended studies of their validity and effectiveness cross-culturally.

Key words: Psychotherapy, cognitive analytic therapy, cross-cultural, relationality, sexuality, pornography, alcohol, India.

Introduction

Psychological distress, suffering and disorder in some form has undoubtedly occurred, although evidently to varying extents, in all human societies across the ages, with a multiplicity of causes. However the ways in which this is experienced, manifest, and understood varies enormously, as have the ways in which help may been sought and offered, if at all. In many settings worldwide very few people seek or are given help from Western style mental health services but may rather do so from, for example, members of an extended family or community, from religious practitioners, or from traditional healers. Significantly, people who experience distress or disorder may not seek help, seeing this as inappropriate or shameful, or may be fearful of the negative consequences of stigma (Thornicroft, 2006). This would include many in contemporary Western cultures despite a considerable increase in recent decades in the availability and popularity of psychological treatments in many countries. Many critics would see this 'psychologising' or 'medicalising' trend as, in part at least, an inappropriate professionalisation of human

distress and suffering, including for groups such as refugees, based on inappropriate, crude and limited models (see e.g. Ingleby, 1980; Bracken, 2002; Thomas et al., 2005; Summerfield, 2008; Middleton, 2015; Bracken, Giller and Summerfield, 2016; Melville and O'Brien, 2017; Kopua, Kopua and Bracken, 2019). Many would likewise criticise, without necessarily offering an adequate alternative conceptualisation, an increasing extension of Western psychiatric approaches into non-Western countries, as propounded notably for example by the Movement for Global Mental Health (see Patel et al., 2011), well-intentioned as that may be. It is noteworthy that these developments are inevitably having an effect on local approaches to treatment or indigenous healing practices, including in India (Sood, 2016).

These broad challenges also apply to the still evolving CAT model. Indeed given its use within established health services in the West, where many CAT practitioners work and where the model originated, some writers (see Foozoni, 2010; Lloyd and Pollard, 2019), whilst acknowledging the strengths of the CAT model, have criticised an arguable collusion with individually-focused, reductionist, biomedical 'illness' type approaches. This will, properly, continue to be an area for ongoing debate. However CAT theorists historically have trenchantly criticised the damaging limitations of such approaches and have predicated the model on a largely, although not entirely, socio-culturally formed and located Self and consequently on a whole-person, transdiagnostic therapeutic approach (Ryle and Kerr 2002; 2019; Kerr et al., 2015). Nonetheless, serious mental health problems resulting from pervasive, longstanding damage to the structures and processes of the Self, as for example described in the multiple self states model (MSSM) of personality type disorders (Ryle, 1997; Ryle and Fawkes, 2007) have been conceptualised therefore as 'disorder'. This may be frequently, but not always, characterised by disability and/or overt distress to Self or others. From this viewpoint, the frequently long-standing severity and structural complexity of such health problems is seen to merit description as 'disorder' in order to conceptualise and treat them, and it would be seen as a serious disservice therapeutically to these persons ('clients' or 'patients') to do otherwise, or describe them simply as 'distress'. However from this viewpoint descriptions of 'disorder' based simply on check lists of symptoms and behaviours, as occurs in e.g. the DSM (American Psychiatric Association, 2013) and ICD (World Health Organisation, 1990; 2019) systems, although originally well-intentioned efforts at improved validity, would be seen as seriously inadequate and often positively unhelpful (Ryle and Kerr, 2019; and see discussion by Frances, 2013).

CAT theorists would stress that such 'disorder' is multidimensional in character (including for example possibly the genetic through to the socio-political) but is also manifest in and experienced by an individual. Problematically, both the 'individual' Self and its disorders will be, both subjectively and 'objectively', highly variable culturally (see below). Historically, CAT theorists (Ryle and Kerr 2002; 2019) have therefore stressed the importance of culturally-sensitive, developmental biopsychosocial formulation and reformulation. Ryle and Kerr (2002; 2019) note that diagnosis and formulation play separate and complementary roles which need to be recognised. However clear and valid description of groups of 'disorders' are important for communication, treatment and research (see e.g. Chanen et al., 2008), whilst needing also to be individually-focused and culturally-sensitive. Some CAT authorities however (e.g. Mikael Leiman, *personal communication*) would consider such approaches to be inappropriate to the complex field of mental health and psychotherapy. These complex issues, partly semantic in nature, but with their serious implications, will properly continue to be an area of highly charged debate (see Margison, 2019).

Addressing psychological distress and disorder is complicated by the fact that the incidence and prevalence of problems varies enormously (see e.g. Wilkinson and Pickett, 2009), broadly speaking depending on personal and sociopolitical circumstances, and also on the collective well-being and function of a given society and its cultural character. This would include the extent to which it is individually-minded and focused, or more communal and collective. A very considerable literature now attests to the effects of factor such as inequality, poverty, or unemployment (Stieglitz, 2012; James, 2018; Krugman, 2020; Weich and Lewis, 1998; Wilkinson and Pickett, 2009). Strikingly these factors do not stand in a direct simple relationship, in that the experience of these factors depends also on the quality of collective life which may evidently be a mitigating factor. The latter may be adversely affected by collective loss of purpose and pride or a sense of belonging, as may occur in oppressed or demoralised classes or groups within any society, or within indigenous communities and cultures as a result of colonisation and its traumatic effects both economic and psychocultural (Fanon, 1961/1963; Kirmayer et al., 2003, 2017; Mills, 2014; NiaNia, Bush and White, 2016; Kopua, Kopua and Bracken, 2019). A history of economic colonialism and cultural hegemony e.g. as with the British in India (see case example below), along with recent forces of globalisation, will leave significant conscious and unconscious 'traces' in so-called developing, although possibly sophisticated and very old, cultures.

These various dimensions of mental health present a considerable challenge to any, including current Western, models whether more biomedical or socio-psychological, which implicitly aspire to be universal. Given the recognised social and cultural major determinants of mental health and disorder and its treatment, Ryle and Kerr (2019), argue that any meta-conceptualisation or adequate model must incorporate both psychologically and neurobiologically-based understandings of human intersubjectivity and relationality, both immediate and communal, in order to understand the aetiology and occurrence of mental disorder, however conceived. Understanding the ways in which many more sociocentric and traditional societies and cultures offer a form of 'resilience' as they function, and how they understand and address 'mental' distress and disorder more collectively could make an important contribution to improving Western models. It can be argued that these approaches with their implicit emphasis on relational and sociocultural dimensions of mental health and well-being also map onto and confirm what we do already 'know' and accept with regard to common effective treatment factors. These include notably strength of therapeutic alliance (see e.g. Roth and Fonagy, 2004; Castonguay and Beutler, 2006; Norcross, 2011; Lambert, 2013; Wampold and Imel, 2015), and to social 'connections' (see e.g. James 2018; Hari, 2017), and to the importance of social context in both presentation of disorders and in rehabilitation (see Harris, Brown and Robinson, 1999). But it is also evident that social context and the way in which it is internalised, including in more traditional societies, may also be part of the problem. This too requires a valid and more comprehensive model of mental health to address it.

This outline of a challenging situation is notably different from the descriptions of and approaches to cultural variability of mental disorder usually articulated in most Western models (see summaries in e.g. Sadock, Sadock and Ruiz, 2015; Harrison et al., 2018), even the more thoughtful. These typically see mental disorder as a constant, underlying, more or less endogenously-arising entity cross-culturally which may simply vary in its expression and detection rates, rather than being a different entity depending on context. Formally diagnosing someone as 'depressed' (and see case example below) and locating an illness 'within' them, even if there does exist some genetic vulnerability (see discussion by Plomin, 2018), is very different from saying this person is located within and shaped by a particular socio-cultural context, and has been a victim of a stressful, hostile context which may be dysfunctional and possibly 'unsurvivable' (and see discussion in Kirmayer et al., 2017).

Understandings of a largely socio-culturally constructed self as articulated in CAT and also by group analysts and more explicitly relational psychodynamic therapies (Dalal, 1992; Mitchell, 2000; and see Bruner 2005; Brown and Zinkin 1994; Bateman, Brown, and Pedder, 2000) imply furthermore that the very 'felt sense' of the individual self and its sense of relation to others will be very different in different cultures. Any cross-culturally valid model or meta-conceptualisation of mental disorder will need to be adequately sensitive and flexible to accommodate differing concepts of self, its subjectivity, and its disorders, and to address the socio-cultural context in which any disorder may occur (see discussion by Krause, 1998; and Bhui and Morgan, 2007). This is a major challenge, implicitly addressing as it does multiple epistemological domains.

The cognitive analytic therapy model (see Ryle 1990; Ryle and Kerr 2002; 2019; Ryle et al., 2014; Kerr, Hepple and Blunden, 2016) arguably offers a deeper understanding of, and respect for, cultural diversity based on a concept or 'organising construct' of a largely relationally, dialogically (see Leiman, 2004) and socially-formed Self, underpinned developmentally by our human capacity and need for intersubjectivity and relationality. This is understood to underlie the transformative psycho-developmental process of 'internalisation' of socio-relational experience as proposed by Vygotsky (see summaries in the context of CAT in Ryle and Kerr 2002; 2019; Kerr, Hepple and Blunden, 2016; and see Wertsch, 1985; Bruner 2005). As such CAT can be seen to offer an attempt at a more comprehensive meta-cultural model of psychological development and disorder. In addition to understanding and working with the largely relational and social origins of the Self and its internalised reciprocal roles, CAT also offers an approach that helps people identify and modify unhelpful coping patterns (reciprocal role procedures) arising subsequently. These may manifest as both Self-other and Self-Self procedures which may be clinically 'symptomatic' (see case example below). Importantly all of these enactments of RRs and RRPs are likely to occur within the therapy relationship and challenge it. Identifying and working with these is a key aspect of CAT (see case example below) and contributes powerfully to the creation of a strong therapeutic alliance.

In many ways this paper represents the outcome of a dialogue its authors began following a presentation of this challenging case made by one of us (ATR), which seemed to merit publication, about how to attempt to locate and interpret this use of CAT within a broader consideration of the implications of socio-cultural context and the challenges this raises for models of mental disorder in general and also CAT. These are variously

major interests of both authors despite their differing backgrounds. We will now offer a description of a broadly successful therapy undertaken in south India and illustrate some of the very particular challenges arising in this context. This will highlight the considerable personal and therapeutic challenges faced by a young female therapist in this context working with a much older male with problems around intimacy and sexuality, abuse of alcohol and an associated 'depression'. This work occurs in the context of a presentation that would not be described as 'psychologically minded' in a Western therapeutic sense. We will also aim to reflect on and consider how and why this therapy was challenging and how it helped and enabled change. We will then also aim to reflect on the use of a model such as CAT in differing sociocultural contexts and to consider some of the possibly irresolvable challenges this may raise and their implications.

Case Example

(de-identified and with permission) (Therapist ATR)

(Cognitive Analytic Therapy for the wise old 'Dadaji' (grandfather) in India)

CAT was introduced in India in 2011 and the Indian Association for CAT (IACAT) was launched in 2012. This is supported also by the International Cognitive Analytic Therapy Association (ICATA). The IACAT is still in its early stages and is being established in Bangalore. As noted above, CAT provides a therapy model that views the Self as largely socially constructed and also a part of the social environment. A relational model such as CAT enables the therapist to work creatively, integrating both cultural and religious values into one's work whereby the client is viewed from a holistic perspective.

The current case presented in a culture where elders are considered the wisest and the head of the family (Jeste and Vahia, 2008). Advice is sought from them on issues that include intra-family conflict and their decision is the final one. In this case the client, an elderly gentleman aged 75, was seeking therapy from a female counsellor who was much younger which would be considered rather unusual in this culture. He presented furthermore with intimate issues around excess watching of pornography. This presentation will also highlight the changing client-therapist relationship over the course of therapy. Therapy raised culturally based struggles around the use of pornography by an elder and overcoming personal challenges and prejudices as a therapist, and also

learning to position oneself in a more compassionate role in relation to both therapist and client.

Bhaumik was a 75 year old client who presented to a fee-paying out-patient clinic where he paid a minimal amount through a sliding scale scheme. He stated that he was 'getting addicted to pornography and feeling depressed'. He had met with an automobile accident and since then avoided going out, so as to not be hit and be crippled. He lived by himself in the city and being alone, indoors, he was lonely, feeling depressed and the time he spent on pornographic material on the internet was increasing each day. He was worried that it would all 'go out of hand'.

Bhaumik's father served in the army until independence and was a disciplinarian. His mother was a home-maker and he was extremely close to her. Some of his siblings took an active role in disciplining him and he remembered being beaten by them. Bhaumik got married (this was arranged) at the age of 29. He had three children with his wife. All of them stayed in different cities while his wife stayed with the son. Bhaumik and his wife had conflicts from the early days of marriage owing to differences in background and expectations from the marriage. According to him she was not like his mother who took care of her husband. His wife was also in conflict with his mother who stayed with them until she passed away. A few years into their marriage, his wife accused him of infidelity and chose to live separately as he was sexually involved with other women. Bhaumik belonged to a voluntary fellowship, the membership of which was part of his identity. He was also an active member in the senior citizen's forum in his locality. He had stopped being involved in these since the accident and had barely any social interactions. He sought therapy when he was unable to stop watching pornography and thought he was getting depressed. The therapist and the client agreed to a contract of 16 sessions.

As the therapist and the client started work, there were evidently many challenges to overcome, including multiple cultural factors that influenced the therapeutic alliance. Three of them are explored below.

Age

Both the client and the therapist were of Indian origin – a culture where old age is associated with wisdom, respect and potential for spiritual growth. Human life is believed to comprise four stages (*ashramas*): 'Brahmacharya' or the Student Stage, 'Grihastha' or the Householder Stage, 'Vanaprastha' or the Hermit Stage, 'Sannyasa' or the Wandering

Ascetic Stage. At the Sannyasa stage, a person is supposed to be totally devoted to God. He is a *sannyasi*, has no home, no other attachment; he has renounced all desires, fears, hopes, duties, and responsibilities. All his worldly ties are broken, and his sole concern becomes attaining moksha or release from the circle of birth and death (Mondal, n.d.).

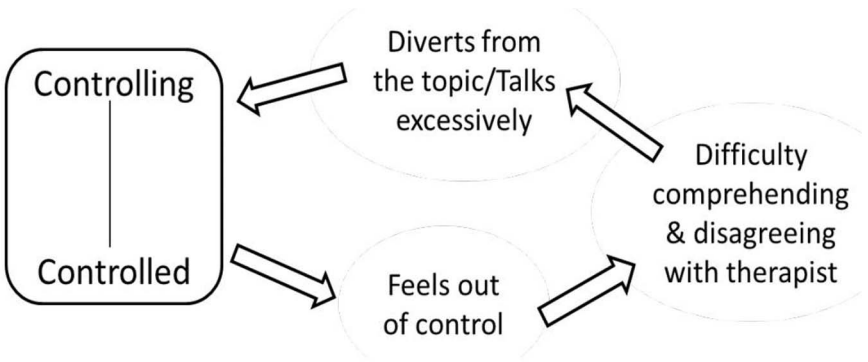
Bhar and Dhruvarajan (2001) and Jamuna (2000) as quoted in Jeste and Vahia (2008) have stated how Indian literature on philosophy and religion indicates that older people are generally considered wiser than their younger counterparts. Some more recent intergenerational considerations on ageing in India are offered by Bhat and Dhruvarajan (2001).

> *Ageing in India:* Often members in the family look up to the elders for advice and guidance in their lives. Ancient Indian philosophy also talks about how parents are nearly equal to God – *mathru devo bhava, pithru devo bhava* (Mother is god, Father is god). Taking care of parents is a sacred duty and failing that would have dire consequences in after life. They are treated with utmost respect by their children or anyone younger.

Hence for both the client and the therapist, it was a challenge to recognize and acknowledge the roles they played in the cultural context- to move from *wise elder–novice youngster* to work 'collaboratively'.

In the initial sessions Bhaumik seemed controlling of the sessions by diverting the discussions away from his difficulties. He would constantly direct the flow of the conversation.

Figure 1: The client in the sessions



The therapist often felt confused and helpless and struggled to explore his issues with him and to challenge him. She would in turn criticise the model as possibly not suitable for clients in their old-age.

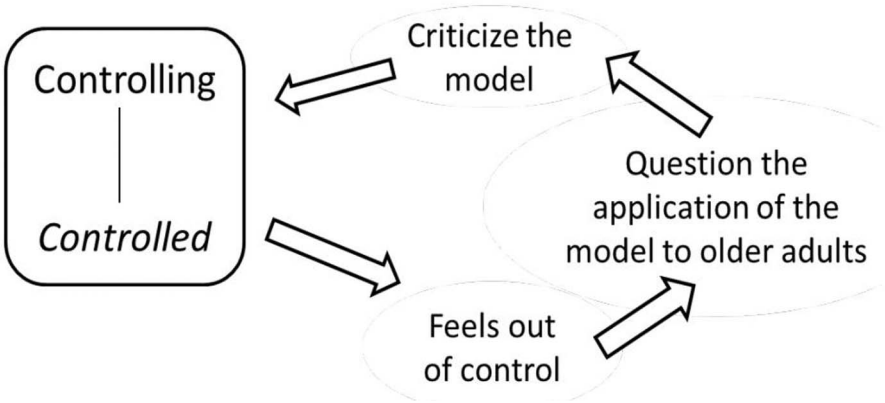


Figure 2: The therapist in the sessions

> 'I have noticed how each time we come around to talk about you, it is as if you push me away by talking about worldly affairs . . . it could be scary or even shameful to see what might come up if we were talking about you. It could be embarrassing. . .'

Sexuality in India

Another aspect of culture that influenced the therapeutic alliance was the issue of sexuality. Some of the ancient India texts like the Vedas and other texts on Hinduism and Buddism mention attitudes towards sex and how it is a central theme and natural component of the Indian psyche (Chakraborty and Thakurata, 2013). However these views on sex changed with the British rule in the 1800s and the 1900s. Victorian values stigmatized Indian sexual liberalism as 'barbaric'. A number of movements were set up like the Brahmo Samaj that worked towards 'reforming' Indian private and public life which led to a more puritanical attitude to sex even within marriage and the home (Chakraborty and Thakurata, 2013). In the current context, sexuality is considered as something to be discussed in hushed voices and discovered behind closed doors. Talking about sex, including sex education in schools, is still a contentious matter.

In Bhaumik's case, his wife and children had abandoned him because they had disapproved of his interactions with other women. They assumed that he was sexually involved with many women and were embarrassed. According to them it was unacceptable for someone in their old-age to have any desires including sexual. For the therapist to have a client in his old age to talk about his sexuality was not a familiar or common experience.

> 'I am a woman, almost one-third your age, maybe the age of your

grandchildren. I wonder if this makes it even more difficult or any easier for you to talk about sex and your addiction to pornography?'

For the client to seek therapy in such a context was probably a desperate cry for help. Drinking alcohol and sexualising difficult feelings had become ways of coping.

'Watching porn and masturbating probably makes you feel more alive and youthful and helps forget some of the physical and emotional vulnerabilities that one attributes to age?'

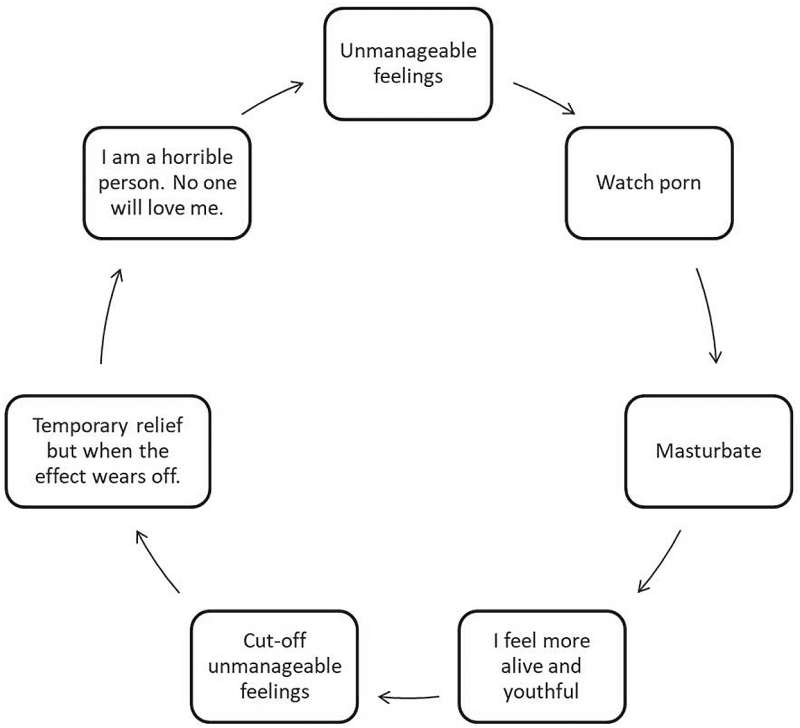


Figure 3: A trap showing a problematic sequence (RRP) of thoughts, emotions and behaviours

Managing the therapist's anxiety

The therapist was in the novice professional phase according to the model of therapist development by Ronnestad and Skovholt (in Skovholt, 2003). She was a recent graduate trying to define her professional identity. As described by the model, she was struggling with precision in boundary regulation, including issues of responsibility, setting realistic goals and so forth. Ronnestad and Skovholt state that disappointments with self

and with inadequate client progress can fuel a sense of inadequacy, which was true for her. Recognising areas of deficit, the therapist sought out personal therapy and regular supervision for her cases in order to be effective.

In the sessions when the client and the therapist started engaging with therapy, Bhaumik reported that he constantly imagined all women naked. This included the therapist too. The therapist wondered if he was managing unmanageable feelings arising in therapy by sexualising her.

> 'By sexualising me in your head, then I cannot be your therapist and we wouldn't have to talk about your difficulties. . .'

This recurred in therapy towards the ending. In the last few sessions the client reported a sudden increase in the number of images of naked women he imagined. He also stated that he was sad that the sessions were coming to an end.

> 'It is as if sadness is managed by sexualising it, so then you don't have to feel the sadness. Just like how you managed the home-sickness by sexualising it when you first lived away from home at the age of 19. Engaging in sex at that time had become a way of coping and it looks like now that we are going to end, you are managing the sadness in a similar manner.'

However Bhaumik did write a brief poignant, good-bye letter This was in English but with some Hindi words which are translated, as shown below:

> Attention Ms Ann,
>
> First of all thanks for the attention given to me for counselling in the past 15 weeks.
>
> I must confess that your counselling has helped me a lot in recovering from my depression which I was undergoing for various reasons.
>
> It also helped me in thinking about various aspects of my life and realising my weak points.
>
> I have confided in you to an extent which I have never done with anyone in my life.
>
> Your diagnosis of my problem was done well and understood by me.
>
> Life cannot be perfect but you made me realise that the best of the given situation is to accept and cherish.

I shall remain thankful to you for giving me enough encouragement to live peacefully.

Thanks. May God bless you and your family.

Bhaumik.

During this therapy it was uncomfortable for the therapist as a woman and she often struggled to be empathic in the sessions. Managing her own anxiety along with engaging with the client was a challenge. She constantly worked towards identifying her prejudices towards sexuality in old age. She questioned her own cultural beliefs about relating to an elder as being in a position above her, of being wiser, well adapted to life and not requiring help from a younger therapist. Constant supervision helped her to challenge some of her beliefs. Some of the anxiety was managed in personal therapy. Working with Bhaumik was a challenge for the therapist because it evoked a lot of her own anxieties. Being in constant supervision helped the therapist to be effective and in tune with herself. The client was committed and engaging in the sessions and was determined to change his life. It was difficult for him to talk about his problems with a woman but ultimately the CAT approach enabled him to engage well with the process. By the end of therapy he had become more aware of his thoughts and emotions. He had become much more accepting of himself and was beginning to get comfortable with the idea of letting go.

The work with Bhaumik clearly also involved recognition of how culture has a major role in the therapy room. The therapist's experience was consistent with the findings of Jim and Pistrang (2007) that a shared cultural background may not always be beneficial. However listening for and trying to make sense of the client's culture clearly helped in understanding his distress and to his feeling understood, and ultimately to a productive therapy outcome.

Discussion

This case history illustrates the successful use of CAT in engaging and working with a very challenging client in a socio-cultural setting quite different from the one in which the model was initially developed. It remains the case that a huge section of the population in this setting would be unfamiliar with the idea of therapy, or if they are then the idea of a fixed, time-limited contract would be perplexing for many. Resource limitations also restrict the availability of such treatments. However

Bhaumik completed a course of therapy and reported considerable improvements in his well-being overall and with his presenting problems. It also demonstrates, within the limitations of difficult life circumstances, a positive outcome, including by the client's account. Some of the challenging issues in this therapy arose around the status of male-female relations, of older-versus-younger persons, and was compounded by presenting problems around a real sense of 'depression' (whether or not this would be concordant with Western diagnostic categories), and around intimate and potentially shameful sexual practices. The latter are recognised to be especially challenging therapeutically in any setting (see discussions from a CAT perspective in Ryle and Kerr, 2019; Wood, 2006; Kellett, Simmonds-Buckley and Totterdell, 2017). Therapy also took place in the context of a challenging socio-economic context which, like many and probably most around the world, offered little support to disabled and unemployed, especially older persons. The client was furthermore facing further issues in relation to ageing and mortality, although in a culture where 'death' and re-birth are seen in a very different way from current common beliefs in the West.

Interestingly, an earlier version of the CAT psychotherapy file, now amended, commenced by stating that '. . . We have only one life'. Furthermore documents such as this are often reported to be hard to understand or use by clients in this Indian setting.

Nonetheless the account of therapy given above suggests that a model such as CAT, notwithstanding its origins, can be helpful in conceptualising presenting problems in a non-judgmental manner and in addressing difficult and personally challenging dynamics inevitably arising in the therapeutic relationship between a younger female therapist and an older male in this context. These dynamics were evidently challenging for both therapist and client in relation to and challenging personal identity and 'security' in an uncomfortable, fundamental sense. This extended well beyond the simple anticipated enactments of their clinical roles as therapist and client/patient. For the therapist this reminder of the importance of attending to security was salutary. Such dynamics (reciprocal role enactments) both clinically and culturally related are unavoidable in any setting and may often not be identified, but are perhaps more clearly thrown into relief and highlighted here. What does appear to have occurred however is that the CAT approach has enabled a making sense of, and resolving presenting problems, and working productively and non-judgmentally in a collaborative and compassionate way with the client. For the therapist this enabled an empathic response even although the client might have been expressing or enacting

behaviours which appeared contrary to her own personal beliefs. In terms of change process, it would appear that for Bhaumik recognising some of the (socio-culturally located) relational origins (RRs) of his beliefs and coping patterns (RRPs) enabled him to discuss and modify these so some extent at least. In so doing he was apparently able to derive a greater satisfaction and fulfilment in life. Therapy apparently also, more simply, undoubtedly enabled and offered an experience of dialogue and 'befriending' (see discussion by Harris et al., 1999) to an older male who was clearly very distressed and struggling. By his account this was helped greatly by the diagrammatic and written reformulations (the 'map' and letter). This work was also greatly assisted by ongoing supervision and self-reflection, in the context of personal therapy, on the part of the therapist, including in relation to some challenging and extremely uncomfortable 'sexualised' enactments by her client.

As such we might attempt to identify common factors operating cross-culturally and highlighted in more recent infant and developmental psychology (see review by Trevarthen, 2018) in terms of human mental health needs. These would include dialogue, meaning making, companionship and relationality, including extended and communal relationality, and a sense of pride and purpose in this (south Indian) context. In this context the approach offered appeared to be respectful, flexible, non-judgmental, collaborative and compassionate (see discussion by Youngson, 2012). It was also, importantly, localised (see Bruner, 2005). From a CAT perspective, it would be argued that such a 'localised', whole person and whole context approach should be routine in treatment approaches of whatever modality anywhere, including in the West. Indeed it has been previously suggested that any diagrammatic reformulation or 'map' is always, in effect, a 'micro-cultural' reformulation (Ryle and Kerr 2002; 2019). Such an approach would be at odds with the increasing, individually-focused, technologisation and commodification of health care in the West and worldwide. It would however be consistent with many more traditional sociocentric values and approaches.

The use of CAT as an individual therapy in such contexts is not without considerable challenges and will require further clinical and theoretical development of the model. This may include notably incorporating a recognition that work across cultures may involve acceptance and recognition of diverse beliefs, values and practices which will inevitably be a considerable, and perhaps insurmountable challenge to the beliefs and values of those from other cultures.

This has certainly been the personal therapeutic experience of both authors (see Ryle and Kerr, 2019; Rafi, 2015). This might include challenging the idea of the 'universality' of such beliefs and values, and of models of mental disorder (see discussion in Kerr, 2009). This recognition also implies the need for respect for the 'voices' of those living and those working therapeutically across different cultures. Cross-cultural and clinical diversity plays out notably also in the tensions between the rights of an individual and that of a sociocentric whole to which an individual may or may not feel part of, and to which they may or may not feel respect and obligations. Questionable Western-type 'aims' such as 'being assertive and individually successful', or seeing it as normal to diminish the importance of older people or to place them in care homes, may not appear desirable or morally appropriate in many more traditional cultures. Such problematic issues are inevitably experienced by many colleagues in therapeutic work in different cultures, and including by immigrant therapists (Akhtar, 2006). Seriously uncomfortable discrepancies, for example around issues of power and dominance and the ways in which they are internalised in health professionals from different cultures, have been poignantly noted by others working and supervising cross-culturally, including in an Indian situation (see Emilion and Brown, 2017).

We would argue that explorations such as those described above can potentially illuminate and contribute to our understandings of human mental disorder and its possible treatments. It is encouraging that in recent years, partly facilitated by the development of the International Cognitive Analytic Therapy Association (see www.internationalcat.org), therapeutic experience with CAT is accruing from cultures other than the British and Western one in which it initially developed, including in India. These include settings as diverse as Africa, Asia, Latin America, Australasia, and with some 'minority' indigenous or immigrant people in colonised, Westernised or Western countries. These developments were certainly enthusiastically welcomed by the late Anthony Ryle the creator of CAT (*personal communication*). Development of adequate models with which to acknowledge and address these issues is in itself an important aim. Further theoretical development and clinical studies are urgently needed, including in the Indian setting outlined above, and description and formal evaluation of this work is keenly anticipated. □

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REFERENCES

Akhtar, S. (2006). Technical challenges faced by the immigrant analyst. *Psychoanalytic Quarterly*, 75, 21-43.

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition). Washington, DC: American Psychiatric Association.

Bateman, A., Brown, D. and Pedder, J. (2000) *Introduction to Psychotherapy: an Outline of Psychodynamic Principles and Practice*. London: Routledge.

Bhat, A.K. and Dhruvarajan, R. (2001). Ageing in India: Drifting intergenerational relations, challenges and options. *Ageing and Society, 21,* 621-640.

Bhui, K.S. and Morgan, N (2007). Effective psychotherapy in a racially and culturally diverse society *Advances in Psychiatric Treatment*, 13, 187-193.

Bracken, P., Giller, J., & Summerfield, D. (2016). *Primum non nocere*: The moral case for a critical approach to global mental health. *Epidemiology and Psychiatric Sciences*, 25, 506–510.

Brown, D. and Zinkin, L. (Eds) (1994) *The Psyche and the Social World: Developments in Group-Analytic Theory.* London: Routledge.

Bruner, J. (2005). *Homo sapiens:* a localised species. *Behavioral and Brain Sciences*, 28, 694-695.

Castonguay, L.G. and Beutler, L. (2006). *Principles of Therapeutic Change That Work*, Oxford, Oxford University Press.

Chakraborty, K. and Thakurata, R. G. (2013). Indian concepts on sexuality. *Indian Journal of Psychiatry.* **55**, Suppl 2, S250-S255. doi: 10.4103/0019-5545.105546.

Chanen, A., Jackson, H.J., McCutcheon, L.K. and Jovev, M. (2008) Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *British Journal of Psychiatry,* **193**, 477-484. doi.org/10.1192/bjp.bp.107.048934.

Dalal, F.N. (1992) 'Race' and racism: an attempt to organise difference. *Group Analysis*, **26**, 277–293.

Emilion, J. and Brown, H. (2017). Intercultural supervision. In, D. Pickvance (Ed.) *Cognitive Analytic Supervision: A Relational Approach.* London, Routledge.

Fanon, F. (1961/1963). *Wretched of the Earth.* Trans C. Farrington, New York, Grove Press.

Fozooni, B. (2010). Cognitive analytic therapy: a sympathetic critique. *Psychotherapy and Politics International*, 8, 128-145. doi.org/10.1002/ppi.217

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM5, big pharma and the medicalization of ordinary life*. New York: Harper Collins.

Hari, J. (2018). *Lost Connections.* London, Bloomsbury.

Harris, T., Brown, G. and Robinson, R. (1999). Befriending as an intervention for chronic depression among women in an inner city I: Randomised controlled trial. *The British Journal of Psychiatry*, **174**, 219-24. doi: 10.1192/bjp.174.3.219

Harrison, P., Cowen, P., Burns, T. and Fazel, M. (2018). *Shorter Oxford Textbook of Psychiatry*, Oxford: Oxford University Press.

Ingleby, D. (1980). *Critical Psychiatry*. London, Karnac Books.

James, O. (2018). Childhood Relational Adversity and Maltreatment as the Primary Causes of Mental Disorder and Distress rather than 'Endogenous' Genetic or Neurobiological Factors. *International Journal of CAT and Relational Mental Health,* **2**, 9-36.

Jeste, D.V. and Vahia, I.V. (2008). Comparison of the conceptualisation of wisdom in ancient Indian literature with modern views. *Psychiatry: Interpersonal and Biological Processes*, **71**, 197-209.

Jim, J. and Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy research*. **17**, 461-473.

Kellett, S., Simmonds-Buckley, M. & Totterdell, P. (2017). Testing the Effectiveness of Cognitive Analytic Therapy for Hypersexuality Disorder: An Intensive Time-Series Evaluation. *Journal of Sex & Marital Therapy*, **43**, 501-516. doi.org/10.1080/0092623X.2016.1208129

Kerr, I.B. (2009). Addressing the socially-constituted self through a common language for mental health and social services: a cognitive-analytic perspective. In, J. Forbes and C. Watson (Eds) *Confluences of identity, knowledge and practice: building interprofessional social capital*. ESRC Seminar 4 Proceedings, Research Paper, 20, 21-38. Aberdeen, University of Aberdeen.

Kerr, I.B., Hepple, J. and Blunden J. (2016). Cognitive analytic therapy. In: J. Yakeley, J. Johnstone, G. Adshead, and L. Allison (Eds) *Medical Psychotherapy.* Oxford: Oxford University Press.

Kirmayer, L.J., Simpson, C. & Cargo, M. (2003) Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, **11**, Issue supp1, S15-S23.

Kirmayer, L.J., Gomez-Carrillo, A., and Veissière, S. (2017). Culture and depression in global mental health: An ecosocial approach to the phenomenology of psychiatric disorders. *Social Science and Medicine*, **183**, 163-168.

Kopua, D.M., Kopua, M.A.& Bracken, P. J. (2019). Mahi a Atua: A Māori approach to mental health, *Transcultural Psychiatry,* **0** (0), 1-15. doi.org/10.1177/1363461519851606

Krause, I. (1998). *Therapy Across Culture*. London: Sage Publications.

Krugman, P. (2020). *Arguing with Zombies: Economics, Politics and the Fight for a Better Future*. New York, W.W. Norton and Company.

Lambert, M. (2013). (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (6th Ed.) New York: John Wiley and Sons.

Leiman, M. (2004) Dialogical sequence analysis. In H. J. M. Hermans & G. Dimaggio (Eds) *The dialogical self in psychotherapy.* London: Brunner & Routledge.

Lloyd, J. and Pollard, R. (2019). (Eds) *Cognitive Analytic Therapy and the Politics of Mental Health.* London, Routledge.

Margison, F.M. (2019). *Cognitive Analytic Therapy and the Politics of Mental Health* review: Lloyd, J. and Pollard, R. (Eds). Book Review, *Int. J. of CAT and relational Mental Health.*

Melville, F. & O'Brien, J. (2017). Working with refugees: a CAT-based Relational Perspective. *International Journal of CAT and Relational Mental Health*, **1**, 54-70.

Middleton, H. (2015). The medical model. In, Lowenthal. D. (Ed) *Critical Psychotherapy, Psychoanalysis and Counselling: Implications For Practice.* Basingstoke, Palgrave Macmillan.

Mills, C. (2014). *Decolonising Global Mental Health: the Psychiatrisation of the Majority World.* London: Routledge.

Mitchell, S.A. (2000). *Relationality: From Attachment to Intersubjectivity*. Hillsdale, NJ: The Analytic Press.

Mondal, P. (n.d.). *Essay on the Theory of Purushartha*. www.Yourarticlelibrary.com.

Norcross J.C. (2011). *Psychotherapy Relationships That Work: Evidence-Based Responsiveness* (2nd Ed.) Oxford: Oxford University Press.

Ormay, A. P. (2012). *One Person is No Person: The Social Nature of Persons.* London: Routledge.

Patel, V. Boyce, N., Collins, P.Y., Saxena, S. and Horton, R. (2011). A renewed agenda for global mental health. *Lancet*, **378**, 1441-1442.

Plomin. R. (2018) *Blueprint: How DNA Makes Us Who We Are*. London, Allen Lane.

Rafi, A.T. (2015). Cognitive Analytic Therapy for Borderline Personality Disorder: A case study in India. *International Journal of Psychosocial Research, (Special Issue)*, 140-143.

Roth, A. and Fonagy, P. (2004). *What Works for Whom? A Critical Review of Psychotherapy Research.* (2nd Ed) New York: Guilford Press.

Ryle, A. (1990). *Cognitive Analytic Therapy: Active Participation in Change*. Chichester: Wiley.

Ryle, A. and Kerr, I.B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice.* Chichester, John Wiley and Sons.

Ryle, A. and Fawkes, L. (2007). Multiplicity of selves and others: Cognitive analytic therapy. *J. Clinical Psychology,* **63**, 165-174. doi.org/10.1002/jclp.20339

Ryle, A., Kellett, S., Hepple, J. and Calvert, R. (2014). Cognitive analytic therapy at 30. *Advances in Psychiatric Treatment*, **20**, 258-268. doi.org/10.1192/apt.bp.113.011817

Ryle, A. and Kerr, I.B. (2019) (*In Press)* (2nd Ed). *Introducing Cognitive Analytic Therapy: Principles and Practice of a Relational Approach to Mental Health*. Chichester, John Wiley and Sons.

Sadock, B.J., Sadock, V.A. and Ruiz, P. (2015). *Kaplan and Sadock's Synopsis of Psychiatry* (11th Ed), Philadelphia, Wolters Kluwer.

Skovolt, T. A. (2003). The journey of the counsellor and therapist: Research findings and perspectives on professional development. *Journal of Career Development,* **30**, 5-44.

Sood, A. (2016). The Global Mental Health movement and its impact on traditional healing in India: A case study of the Balaji temple in Rajasthan. *Transcultural Psychiatry*, **53**, 766–782.

Stieglitz, J. E. (2012). *The Price of Inequality: How Today's Divided Society Endangers Our Future*. New York: WW Norton.

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal,* **336**, 992. doi.org/10.1136/bmj.39513.441030.AD

Thomas, P., Bracken, P., Cutler, P., Hayward, R., May, R. and Yasmeen, S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health*, **4**, 23-32. doi.org/10.1108/17465729200500021

Thornicroft, G. (2006). *Shunned: Discrimination Against People with Mental Illness.* Oxford, Oxford University Press.

Trevarthen, C. (2017). The affectionate intersubjective intelligence of the infant and its innate motives for relational mental health. *International Journal of CAT and Relational Mental Health*, **1**, 11-53.

Weich, S. and Lewis, G. (1998). Poverty, unemployment and the common mental disorders. A population based study. *British Medical Journal,* **317**, 115-119.

Wertsch, J.V. (1985). *Vygotsky and the Social Formation of Mind*. Cambridge, MA: Harvard University Press.

Wilkinson, R., & Pickett, K. (2009). *The Spirit Level. Why More Equal Societies Almost Always Do Better.* London: Penguin Books.

Wampold, B. E. and Imel, Z.E. (2015). *The Great Psychotherapy Debate: Models, Methods and Findings*. (2nd Ed) New York: Routledge.

Wood, H. (2006). Psychoanalytically-informed CAT: a first treatment for problems of sexual relationships. In, J. Hiller, H. Wood, W. Bolton. *Sex, Mind, and Emotion: Innovation in Psychological Theory and Practice*. London, Karnac.

World Health Organisation (1992). *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

World Health Organisation (2019). (In Press) *International Classification of Diseases, 11th Revision (ICD-11)* Geneva: WHO.

Youngson, R. (2012). *Time to Care: How to Love Your Patients and Your Job*. Raglan, New Zealand: Rebelheart Publishers.

Reviews

Cognitive Analytic Therapy: Distinctive Features

Claire Corbridge, Laura Brummer and Phillipa Coid

2018, Routledge

This new introductory volume is an important and timely addition to the CAT bookshelf. CAT's popularity continues to grow, but it has never had an accessible introductory book which helps newcomers get to grips with the ideas in a brief and straightforward way. Anthony Ryle and Ian Kerr's 2002 *Introduction to Cognitive Analytic Therapy* sets out the CAT model in comprehensive style and its upcoming second edition will be an important statement of its current state of development. Elizabeth Wilde McCormick's *Change for the Better* has been another helpful point of entry for many, and it contains a lifetime's worth of CAT wisdom which has influenced countless CAT therapists and trainees' practice, but written as it is for clients, it is not intended as an entry point to the theoretical background of CAT. Ryle's writing contains an immense amount of technically and theoretically rich material, but can be dense and challenging to unpack, especially for those new to CAT. We needed a new introductory text and Claire Corbridge, Laura Brummer and Phillipa Coid have done an excellent job of filling the gap. They have skilfully performed the delicate task of staying true to the values, principles and practice of CAT as established by Anthony Ryle, but presenting them in a straightforward and accessible way.

The book is organised into 30 short chapters, in two halves: Theoretical Features and Practical Features of CAT. Each chapter runs to three or four pages and covers a key idea in CAT, from the PSORM to the dialogic perspective in the theory section, and from assessment to endings in the practical section. The authors give effective, *in a nutshell* summaries of each concept, backed up with typical examples drawn from clinical work, often with illustrative maps. There is comprehensive referencing to the extensive CAT literature, and one of the useful functions of this book is to provide up-

to-date signposting to the CAT literature on the varied topics covered. Bookending the core concepts, the authors give a brief account of CAT's historical development and of newer applications of CAT, including CAT in groups and indirect consultation work.

From a CAT trainer's point of view, this is an extremely useful resource. The book is now a set text on our Newcastle CAT Practitioner Training along with Ryle & Kerr's introduction. With its straightforward language, the book will be a helpful anchor for trainees going through the familiar process when learning CAT, of having a momentary grasp of a concept only for it to slip out of reach.

There are variations in CAT practice that go with geography and theoretical leaning, so inevitably readers may find some aspects of their own CAT practice emphasised more than others. With such a short format there are areas which can only be scratched at. Some areas of theory can only be signposted, such as CAT's engagement with the research on early infant development and attachment. The 'theory–practice' split in the book (which I understand is a requirement of the Distinctive Features publishing series) is, at times, an odd fit for CAT since it is a model in which theory–practice integration runs throughout. But none of these issues detract from the book's fundamental purpose as an accessible introduction.

Although recognising the limited scope of the book, I did miss mention of the connections being made between CAT and other contemporary psychotherapeutic practices, such as embodied approaches, and the developments in trauma work, facilitated by neuropsychological understandings. There is excellent coverage of CAT work with trauma, dissociation and fragmentation, but using the language of 'personality disorder' without any critical discussion of the problems with the label and diagnosis feels untenable in the current culture where these terms are rightly being re-evaluated. CAT is so in tune with a trauma-informed care approach which takes seriously people's experiences of adversity in the past and present. However, this is now a crowded marketplace of therapy models and we do need to update our language. Whilst it is no easy task we do need to, at least, acknowledge the controversies.

This book will be a relief to many trainees grappling with learning CAT and is a useful reference and refresher for any CAT practitioner. I am so glad the authors wrote it and managed to do it with such clear-cut language whilst holding the full richness of the model.

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Cognitive Analytic Therapy and the Politics of Mental Health

Eds. Julie Lloyd and Rachel Pollard

2019 London: Routledge
Pps: xviii and 263 PB: £31.99

This volume is part of an important conversation in contemporary psychology and psychotherapy: is psychotherapy a political activity? Should it be? If not, why not?

The editors start with a question about whether CAT has lived up to the initial radical agenda proposed by Anthony Ryle (2010). They comment:

> '[t]here is a tendency for radical ideas to drift towards the centre and sometimes even further, and for previously radical discourses to become entangled with more conservative and authoritarian discourses.'
> (Lloyd & Pollard, 2019, citing Parker, 1992)

The authors in this volume have taken these challenges seriously and embedded the ideas they arrive at firmly within a CAT framework.

Paradoxically, a good place to start is the closing chapter: Anne Benson writes about the politics of training (Benson, 2019). In introducing the chapter, she brings home the sheer impossibility of doing justice to the complex themes raised in the book, but helpfully focuses on the microcosm of the training world as it applies in CAT. She reminds us of a central theme of the book:

> 'Poverty, trauma, isolation, stigma and prejudice produce environments that are extremely harmful to the mental health of individuals, families, communities and society.'
> (Benson, 2019, p.238)

This theme covers the key message of the whole volume, and Benson starts by challenging our assumptions about ourselves:

> 'We are a predominantly able-bodied, middle-class, white, female, (although men are disproportionately represented in senior positions of power), cis-gender, heterosexual profession. Such characteristics place psychotherapists in the more powerful pole in most binary power relationships; White-Black, able-bodied-disabled, middle-class-working-class, wealthy-poor. People in more powerful positions are more likely to deny the existence of power differentials. . . Despite overwhelming evidence many deny the truth of these inequities or argue that they are coincidental or irrelevant.'
> (Benson, 2019, p.243)

She goes on to comment on how difficult, and even shaming, it can be for a trainer to facilitate a discussion about such a challenging topic; the powerful feelings of inferiority and (partially denied) power threaten one's sense of self and identity. So, many training

organisations pay no more than lip service by having the minimum required number of sessions on inequality, or racism, or other specified topic, without encouraging trainees to look at the wider political context of their work.

CAT should have an advantage in this area since *'as a model, [it] explicitly incorporates socio-cultural understanding in its core theoretical framework'* albeit not yet having achieved its full potential (Brown, 2010).

There may be academic pressures that place politics and psychotherapy in a marginal place in the curriculum, but we are reminded that some reasons for reluctance are closer to home. We might fear engaging in this discourse because of the tendency to split into 'goodies and baddies', and we might be on the wrong side of history. We may fear withdrawal of approval from our peers or our students for challenging the *status quo* on the one hand, or for embodying it on the other. In the end we may be criticised not just for our views but for who we are. Benson argues that it is *because* of this multi-level resistance that we need to be even more determined to place politics and psychotherapy near the centre of CAT training.

The book argues that it is not just a matter of a couple of speakers on a course talking about the impact of racism, or the effects of poverty on child development, important as they may be. A more far-reaching approach is suggested by working and teaching whole-heartedly within a social justice framework. This is defined as the condition in which '*society gives individuals and groups fair treatment and an equal share of benefits, resources and opportunities*'. (Chung and Bemak,2012, 27).

Looking at the positions of privilege and marginalisation of both therapist and client in an open dialogue is advocated. But this has to be addressed within the training structure empowering the therapist – a privileged position in itself – to be active. The activity is not fully pinned down in this chapter, but should be at the level of the institution, community, and even within public policy and international affairs.

In contrast, currently, Benson argues that training focuses to the exclusion of most other perspectives on intra- and interpersonal awareness.

Within a training programme we can establish space to 'know' rather than 'know about' in a direct encounter (Lowe, 2014, citing Bion, 1962). 'Knowing', rather than 'knowing about', is central to being an effective therapist. It is embedded in 'the minute particulars' of being a therapist (Hobson, 1985, citing William Blake). Most of us probably try to work in this way as part of our core beliefs as therapists. However, this book argues that this is often taken to mean no more than 'staying with' the immediate experience and helping to shape a shared narrative or conversation. Of course, that is important, but we are also trying to hold in mind the different dynamics of the institution and wider society.

This multi-level awareness is difficult to achieve, of course, and Benson advocates using group relations methodology developed through the Tavistock Institute to develop a safe space to explore these issues. These suggestions are welcome, but they do not really address how a therapist tries to change the *cause* of these power differentials. That is covered in a brief section about being political as a psychotherapist which ends by saying

> '[t]he next questions then concern how we individually and collectively choose to use our own power and work politically as psychotherapists *to make a difference*.' (My emphasis p. 251)

This comment about 'making a difference' highlights a recurring problem in writing about politics and mental health: it is the politics of the left that defines the territory. It is quite difficult to imagine a politics of the right in this discourse, and at times I wished that the authors had given some space to develop a different narrative. Would such a politics be about resurrecting the notion of individual freedom, or about psychotherapy outcomes being defined by benefit to society? If we do not try to articulate a right-of-centre politics of psychotherapy how can it be challenged?

Here, the book defines political goals in terms of a left-oriented agenda by increasing equality and giving a voice to the marginalised. In having this as a starting and finishing point in the book we are clearly part of a long-lived discourse in radical psychology.

One tradition has been to assist clients to make changes in their environment to generate enduring changes. How to make those changes and still stay within a psychotherapeutic tradition has always been problematic (Smail, 2001) and the work with colleagues (Smail & Hagan, 1997) introduced a contextual tool called 'power-mapping' that should fit very closely with developments within CAT of the Sequential Diagrammatic Formulation [SDR]. As Ryle commented, we need to '*recognise the harmful effects of both current and internalised historical and social factors'*.

But, Hagan and colleagues (2019, p. 46) make the point that there has been little progress in integrating power-mapping explicitly into CAT reformulation. They suggest a bridge between the explicit power analysis of Smail and colleagues with the more individually focussed nature of CAT commenting,

> 'However, it is within the scope of CAT to re-formulate in the light of an understanding of how power has been used in an individual's life, what threats they have and still experience, and how the settings in which they live may perpetuate threat and power abuse.' (Hagan et al, 2019. p.46)

This model is illustrated with a diagram that can helpfully connect work with an individual or family to the wider social context. They describe this in terms of a resonance between distal and proximal influences (i.e. socially distant and near impacts).

> 'Reciprocal roles and procedures are societally and culturally driven[distal] and influence relationships that are experienced as proximal, personal and

> individual. These are part of our habitus; the dispositions that encompass procedures or survival strategies such as appeasing, soldiering on and self-protection through avoidance, dissociation and hypervigilance.' (Hagan et all, 2019, p 46.)

Power-mapping does not just passively describe the situation an individual finds, but actively encourages the person to find and harness resources like education, being part of a group with shared aims, and most of all being able to describe and confront a situation rather than feeling intimidated, alone, and without a voice. Smail did, however, recognise the limitations placed on individuals by lack of resources, and how frustrating this can be when working with an individual who is trapped not just by internalised reciprocal roles from the personal past, but also by reciprocal roles played out within society as a whole.

We can see that an unyielding bureaucracy and an unresponsive social safety-net resonates with an internalised powerful-to-powerless RRP. This can feel so overwhelming that the therapist also feels defeated by the sheer enormity of what our client faces. So, it is inspiring to be reminded that a difference, however marginal, can be sustained even within our existing roles as therapists. A small step can be of value even when we may feel shameful about our lack of wider impact.

One of the most impressive aspects of this book is the way it can shift from this intimate and personal level to dehumanisation at a global level. Brown (2019, pp28-32) explores these large-scale aspects:

> 'Marginalised communities necessarily evolve ways of expressing resistance and defiance because people on the receiving end of oppression have no choice but to accommodate to power in their choice of reciprocal role positions remaining vigilant in order to survive. . . [As] therapists we tend to encounter people who, as adults, do not have a sufficient range of role positions to help them function but also, we see people whose role positions are contradictory, fragmentary or intense.'

This leads to a discussion of extreme, but publicly sanctioned, dehumanising roles and the links to atrocities and political and sexual violence. These might involve, for example, psychologists and medical doctors who use their skill and understanding to make torture more effective by profoundly damaging the sense of self and connectedness of those tortured.

Brown draws on the work of Robert Lifton, who has written extensively on distortions of identity of oppressor and oppressed. Here he is quoted to critique the way in which a society can be shifted into 'malignant normality' (Lifton, 2017) where lies and distortion are normalised and individuals adapt to expectations that 'at another time they would have resisted or repulsed' (Brown, p.29):

> '[e]xtreme ideologies do much to create a malignant normality, which comes to pervade most institutions, including medical ones. Then ordinary people who work in those institutions adhere to that normality, often aided by bits and pieces of extreme ideology.

> The prevailing normality can be decisive because it excludes alternatives and provides strong pressures for destructive behaviour'.
> (Lifton, 2017, cited in Brown 2019, p.29)

In the same article, Lifton states:

> "[B]eyond that [Hippocratic] oath, and certainly beyond our adaptation to societal normality, we can be what I call *witnessing professionals*. We can extend our training and knowledge beyond its technical elements and make use of it to expose and reject, rather than become part of, unethical normality. In that way one would commit oneself not only to "do no harm", but to function only as a healer in any environment.'

This example of integration of concepts at the individual through global levels is reflected throughout the book. It is disturbingly up to date in helping us to make sense of politics in the modern world, and, also what we might do as psychotherapists in challenging some current political norms.

The book could easily have veered into becoming just a polemic, but potential readers can be assured that it is also grounded in clinical wisdom and courage. An outstanding example of this comes in the chapter 'Unequal Ground: Working with people affected by child sexual abuse' (Lloyd & Brown, 2019 pps. 149-174). The chapter opens with the authors sharing how unsure they felt about integrating their personal experience into the chapter. They discuss the dilemma of sharing their lived experience of abuse to show how it has enriched their work as therapists. However, they worry that being open might damage their credibility. They share the fear of being seen on the one hand as unassailable, powerful, 'smug' victims or as worthless 'trash', leading readers to apply diagnostic categories to them, or being seen as jumping on a 'me too' bandwagon.

They comment that 'hearing a child's experience may elicit visceral feelings, felt as sickening, tightness in the chest and gut and immediate feelings of wanting to detach or avoid, especially if the therapist wants to disavow knowledge about who the perpetrator was.'

The disavowal is not just a personal reluctance as Lloyd and Brown show: Paedophiles commonly put themselves in positions of power, being admired in prominent roles in the community. So, taking examples from recent scandals involving media stars, and powerful men in established positions within religion, whole communities can end up being silenced as well as those who have experienced the trauma.

The authors talk about being put in a problematic relationship to both truth and trust in others by their experience. They pose a question about their own experience: Do I stay distanced and looking through the wrong end of a telescope at the experience of abuse, or am I immersed in it and experience the pervasive feelings of bewilderment and shame? While talking from their lived experience, they also pose the same dilemma for the therapist role: Am I the

cool and detached professional here, or do I engage? This echoes the whole book in raising the fundamental question of what it means to engage.

I experienced visceral, vicarious shame to read about 'JL' as a trainee psychologist watching a family through a one-way screen when the psychiatrist commented 'Did you see how flirtatious that girl is?'

'She [JL] hadn't noticed any flirtation and the ignorance of the trainee psychiatrist could have adversely affected their work with the victim who had even less power than the psychology trainee. (JL hid in a loo weeping as she wondered if she had had been flirtatious herself without knowing it).'

Even more powerfully shaming of our profession is an account of how JL had been talking with colleagues, one of whom described that she

> '. . . could not stand people who had been sexually abused because those people insisted on describing what had happened. The others all agreed and vied with each other to describe how aversive they found survivors. . . I stood there terrified in case any of them had guessed my secret.'

As well as being a deeply moving and personal account, we can see here in miniature the politics of denial, projection, and fear of the 'other' played out in a group of professionals. This dynamic is still reflected at the level of society, although Lloyd and Brown both acknowledge that it is at least possible to speak of their experiences now, unlike a decade or so ago. Like many personal accounts, the personal meeting the political is a very powerful teacher. This chapter should be read by anyone working with persons who have been sexually abused.

This is not an easy book to read – it brings in many concepts that are on the fringe of psychotherapy discourse and I have had to go back and read around several topics to understand the points being made more fully, at times having to assimilate a whole new language. But there is a much deeper reason for it being a difficult read – the book challenges my assumptions. It simultaneously inspires me and instils foreboding about the future. Perhaps that queasy uncertainty is not an inappropriate place to be in our current political climate.

The book brings together political and social tensions alongside our identity as therapists in an uncomfortable but enriching journey. This book needs to be on the curriculum of CAT courses and beyond and will be a salutary and hopefully inspiring read for all teachers and practitioners.

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REFERENCES

Benson, A. (2019) A social justice framework for training in CAT: Inequalities, power and politics in psychotherapy. In: *Cognitive Analytic Therapy and the Politics of Mental Health*. Eds. Julie Lloyd and Rachel Pollard. London: Routledge pps. 239-252.

Bion, W. (1962) *Learning from Experience.* London: Karnac Books.

Brown, H. (2019) Reciprocal roles in an unequal world. In: *Cognitive Analytic Therapy and the Politics of Mental Health*. Eds. Julie Lloyd and Rachel Pollard. London: Routledge pps20-37.

Brown, R. (2010) Situating social inequality and collective action in cognitive analytic therapy. *Reformulation,* **35**, 28-34.

Chung, R. Bemak, F. (2012) S*ocial Justice Counselling: the next steps beyond multiculturalism*. Thousand Oaks, Ca: Sage.

Hagan, T. Armstrong N. Bostock, C. (2019) Putting the social into psychotherapy: Implications for CAT In: *Cognitive Analytic Therapy and the Politics of Mental Health*. Eds. Julie Lloyd and Rachel Pollard. London: Routledge. pps. 38-53.

Hagan, T. Smail, D. (1997) Power-mapping 1: Background and basic methodology. *Journal of Community and Applied Social Psychology,* **7**, 257-284.

Hobson, R.F. (1985) *Forms of Feeling: the heart of psychotherapy.* London: Tavistock, pps. 17-22.

Lifton, R.J. Malignant Normality. *Dissent [online magazine]* Spring 2017. www.dissentmagazine.org/article/malignant-normality-doctors (Accessed originally 06/03/18 and again 27/10/19).

Lowe, E. (2014) *Thinking space: promoting thinking about race, culture and diversity in psychotherapy and beyond*. London: Karnac Books.

Parker, I. (1992) *Discourse dynamics, critical analysis for social and individual psychology.* London: Routledge.

Ryle, A. (2010) The political sources of reciprocal role procedures. *Reformulation: Journal of the Association for Cognitive Analytic Therapy.* **34**, 6-7.

Smail, D. (2001). *The Nature of Unhappiness.* London: Robinson.

Power, Threat, Meaning: an overview

Johnstone, L. & Boyle M. (2018)

www.bps.org.uk/PTM-Main

Lucy Johnstone, one of the lead authors of the Power Threat Meaning Framework was a plenary speaker at the September 2019 national CAT conference in the UK. She spoke passionately and eloquently about the new paradigm for mental health which she and her colleagues had been working on in recent years. It was, and is, having a considerable and popular response in the UK. Her arguments were well-received by the CAT audience but with some reservations that echo also within the CAT approach as to how to keep the modelling of an approach open to change and development and multiple narratives.

This review is mainly of the overview text (Johnstone, L. & Boyle M. (2018). It is an extensive document of 135 pages and there are links to more detailed discussions. The full document is free and available online and offers a wide ranging and detailed practical and theoretical account of the framework (www.bps.org.uk/PTM-Main), which should find resonances and interest for any CAT practitioner. The general impression is of an important and carefully prepared body of work – boldly seeking to change the terms of the mental health debate away from an overly medical and emotionally individualised discourse to a more socially and contextually rooted one.

Reviewing for an international journal invites a perspective both on the implications for psychotherapy and mental health in the UK and its relevance to a wider international audience. Are there themes concerning the framing and ideology of mental health in play in other countries besides the UK? This review, perhaps at risk of being parochial, takes the key points of the PTM framework and looks for the parallels and resonances with CAT. Is there a match between the Power, Threat, Meaning framework (PTM) and CAT principles and practice?

Like CAT, the PTM framework is integrative and relational in its aims. Calling it a framework seems key. Like CAT it is not so much a model as an approach – a way of scaffolding the content and processes of psychological help. The PMT aims are: 'To support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors.' Its philosophy is to develop, 'A conceptual alternative to psychiatric classification in relation to emotional distress and troubles or troubling behaviour.' This fits too since CAT has always been wary of reductive use of diagnostic categories to shape and close

the story of treatment and formulation.

PTM as a framework recognises that any process of formulation is sustained by a multiplicity of views. It sees 'medicalising discourse as so deeply embedded' and puts doubt on the authority of linear cause and effect sequences, 'Causality is probabilistic and contingent'. PMT accounts of recovery, fit a consciousness raising or empowerment model. They are about freeing the patient/client/service user from the monoculture of a medicalised discourse towards a more pluralistic approach.

The framework is built around the idea of 'general patterns' which resembles the CAT ideas of target problem procedures and reciprocal role patterns arising from psychosocial roots. The idea of using personal narratives within general patterns as proposed by the framework fits very aptly with CAT although the converse is also true for CAT of using personal patterns in general narratives.

The idea behind the framework is to help open or restore narratives where they have been closed. To quote,

> 'One of the main purposes of the General Patterns is to support the construction of narratives in their various versions, as an alternative to psychiatric diagnoses. "Personal Narratives" in this sense can encompass individual, couple, family or social networks. Depending on the situation and (if relevant) the model of intervention; and narratives may be of any kind, from structured psychological formulations to self-authored personal stories expressed in writing or any other medium.' (P74)

The full account of the framework explores this more fully with detailed philosophical support.

In Summary (P90), the PMT framework asks directly 'What has happened to you?' leading to exploring how *power* operates in your life. The *threat* element is the feelings of hurt and trauma or neglect that arise from these dynamics. The *meaning* element is the response, which is part cognitive, narrative and defensive, in terms of how you cope (*the threat response*) – within your (limited, neglected) power resources – with these feelings of *threat* which are arising from the social and psychological dynamics of *power* around you.

The formulation element of the framework then reverses the power dynamics by asking what power or resources are there around you to change, resist or cope (and deal the threats, feelings and meanings that will/may follow)? The concluding element is to find ways of giving voice to this as the person's story. As a relational model of trauma and deprivation, CAT would be very at home with this framework, though might offer to add the Vygotskian scaffolding of therapeutic mapping, reformulation diagrams and letters.

Another parallel with CAT is the goal of seeking to break out of diagnostic language and finding another more client centred and socially aware language. The CAT idea has always been to build a relational scaffolding for seeing things differently by meeting and

joining with the client's words. This is the essence of re in reformulation in CAT. It is a co-creative reworking of the client's existing map of the world and their distress. This reformulating process is, in its moments of connection and rupture, the key mechanism of a consciousness raising therapy. The rich variety of instances of working with the PTM framework show much common ground in this respect with the CAT approach. Indeed, there are thirteen examples of existing, or developing, good practice in the appendix to the overview document and these highlight the open approach to the PTM framework, which is seeking to scaffold links and integrations, supporting and promoting innovative models of work that fill out the framework.

Thinking about the framework internationally, practitioners of CAT in many different countries will find resonances with UK situation: the rise of populism on the right and the left, a sense of losing control in the face of ever-increasing complexity in the context of globalisation and stark increases in social and economic inequality, a concern for identity change and conflict across gender, generational and ethnic difference and diversity. The push to responses which offer magical stories and idealised promises of taking back control and restoring order.

In these times, it makes great sense for CAT practitioners anywhere to give close attention to the values, ideas and methods of the PMT framework. It shares with CAT a demystifying, common-sense relational approach. CAT practitioners may draw clarity about their own wider therapy goals by seeing them through the eyes of this framework.

Tony Ryle warned CAT practitioners to not turn CAT into a Procrustean bed. In the Greek legend Procrustes was the bandit who cut and stretched travellers to fit the length of his bed. The more CAT has developed the more it morphed and changed to fit different contexts and no more so than internationally. But the *procrustean risk* is always there. The intention with the PTM framework is to offer an open approach. Open dialogue is one of its examples (P122). Perhaps like CAT, the risk PTM faces is to become pigeon-holed by its opponents, or to get trapped in its own, self-made, singular story in the context of campaigning for change. The Power, Threat, Meaning Framework perhaps has as its best promise to be a paradigm that can hold and enable multiple stories of formulation and change in mental health including those rooted in a medical and neuro-biological framework. Perhaps the same challenge faces CAT both in the UK and internationally as instanced by other contributions in this issue of the journal.

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REFERENCES

Johnstone, L. & Boyle M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018) *The Power Threat Meaning Framework: Overview* Leicester: British Psychological Society.

Johnstone, L. & Boyle M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018) *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour , as an alternative to functional psychiatric diagnosis. Overview* Leicester: British Psychological Society.

Hagan, T. Smail, D. (1997) Power-mapping 1: Background and basic methodology. *Journal of Community and Applied Social Psychology,* **7**, 257-284.

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Smith, Adam (1776): *An Inquiry Into the Nature and Causes of the Wealth of Nations*, London: Ward, Lock, Bowden & Co.

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Yunus, M, Moingeon, B and Lehmann-Ortega, L (2010): 'Building Social Business Models: Lessons from the Grameen Experience', *Long Range Planning*, Vol. 43 (2-3 April), Pp308-325.

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