"IAPTrogenic effect?": CAT theory as a tool to consider potential systemic patterns of iatrogenic harm within the context of Improving Access to Psychological Therapies (IAPT) Services

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Aims

To use CAT theory and SDRs to consider how systemic relationships at an interpersonal, intrapersonal, group and hierarchical level may contribute to iatrogenic effect amongst individuals presenting at IAPT services

To reflect upon my own RRPs within this context.

Introduction

This essay attempts to utilise CAT theory as a tool to consider iatrogenic harm within the systemic context of the IAPT programme. Despite government pledges to increase mental health funding it is well documented services are greatly under resourced (e.g; Addicott, Maguire, Honeyman, & Jabbal, 2015).

I will attempt to use CAT to highlight the need for more effective use of public spending through improved configuration of IAPT services, to improve patient care in real terms. Rizq (2012) argues that IAPT, within an NHS 'market for care' culture, has constructed a 'virtual reality' where focus upon targets, outcomes, protocols and policies is valued over attention to patients' psychological needs.

I will consider examples from my clinical practice and typical scenarios within the IAPT service I worked in to explore this theme. Historically this service, a primary mental health service, had morphed into an IAPT service in an area where intergenerational unemployment/social deprivation were commonplace. Additionally, secondary care services had increasingly stringent referral criteria. Despite raising concerns therapists were instructed to work with high volumes of clients who would traditionally have been referred into secondary care, in order to hit IAPT prevalence (numbers into treatment) targets, yet were also measured in terms of IAPT defined "recovery". The service had high levels of staff sickness and turnover and multiple grievances relating to bullying had been made by staff about management.

The reason for picking this theme is CAT is arguably a valuable tool to inform improved and ethical IAPT service delivery. Secondly, working in this context evoked a strong response in me, and many of my colleagues, and it is hoped reflecting upon this theme through a CAT lens will assist me to better understand my own RRPs within the broader system. I hope this will assist in a realistic appraisal of the extent to which I can positively influence service delivery and perhaps go some way to constructively assist others to increase awareness of the potential to unwittingly collude with iatrogenic harm and better manage potential inter and intra personal tensions within this context.

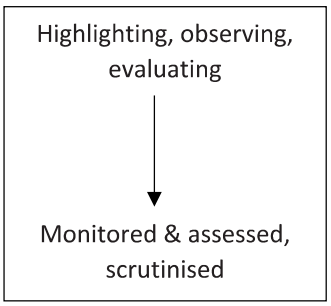
Reciprocal roles within the IAPT hierarchy

This section attempts to consider possible RRs within the IAPT hierarchy that potentially strengthen assumptions at various levels that lead to iatrogenic harm becoming invisible and systemic. It could be argued this is currently outside IAPT's ZPD.

As public awareness of mental health issues has increased significantly over recent years so has pressure upon government to provide effective services (highlighting, observing, evaluating to monitored & assessed, scrutinised). IAPT seemed a worthy step in this regard but is driven by an economical assumption that the more people who are treated by "evidence based" treatment equates to a more productive economy (Layard et al, 2007). Combined with the assumption that opening mental health provision to market competition, via Any Qualified Provider (AQP) and Payment by Results (PbR), is the mechanism by which to achieve this goal arguably results in an over focus upon a target driven culture in which IAPT has become increasingly distanced from NICE guidelines as there is a striving to deliver more for less. The following RRs may come into play (directive to compliant) (powerful, demanding, out of touch to pleasing, striving, compliant and

Diagram 1

Increased visibility, public awareness of mental health issues



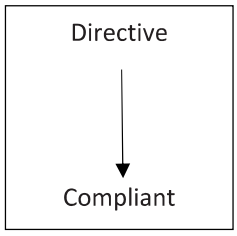
Voting Public

Government

Aim: Demonstrate 'expanding provision of public easily accessible effective treatment' as cost effectively as possible

Assumption: The quicker people are processed through "IAPT/evidence based" treatment the greater the impact upon the wellbeing of society. Creating an environment of market competition will facilitate this whilst driving down costs.

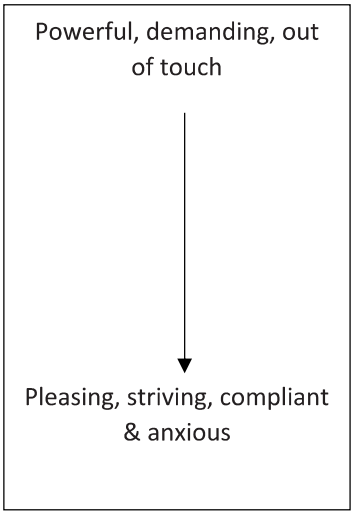
Behaviour: Set out directives/policy nationally to commissioning groups and reward hitting national targets (that do not take into account local demographics / specific vulnerable cohorts)



Commissioning groups

Aim & behaviour: Select service provider 'best' able to meet national targets as cost effectively as possible

Assumption: Achieving national targets = a pragmatic approach to increasing the wellbeing of the local community as a whole and increases funding stream to further enhance local service provision.



Service provider (senior management)

Aim & behaviour: Target focused. Meet targets at any cost (autocratic management). Averse to open dialogue for fear of loss of bid/contract/position

Assumptions: Achieving targets at any cost shows got what it takes to succeed in these challenging times and is good for successful service and personal career progression. Some therapy is better than no therapy.

anxious) resulting in organisations being averse to open dialogue for fear of loss of bid/contract/position.

Whilst individuals at all levels will challenge this position there is arguably a powerful context in which unhelpful and damaging assumptions may be reinforced.

Diagram 1 attempts to illustrate this.

These assumptions have implications for RRs between management and clinicians. Carson and Bristow (2015) suggest the following RR behaviours within the context of difficult times for the NHS;

decision making) these patterns are likely to be more problematic.

Ryle and Kerr (2002, p205) point out "it is important to consider iatrogenic causes of difficulty including individual staff and/or institutional psychopathology" which may include "inadequate communication … that may determine the extent to which staff are drawn into, or elicit, antagonistic or apparently sabotaging behaviour on the part of a patient".

In my experience this environment resulted in a shift towards having a very transient work force and the majority of long standing, experienced therapists

in relation to feeling like they are presented with a dilemma such as;

Either attempt to reasonably/ ethically/professionally meet the needs of the client but risk coming into conflict with management

Or comply with management directives in order to reduce conflict but experience internal conflict/ loss of professional identity.

Practitioners less aware of potentially damaging patterns may be inclined to comply/unwittingly collude with iatrogenic behaviour. This could be negatively reinforced and some

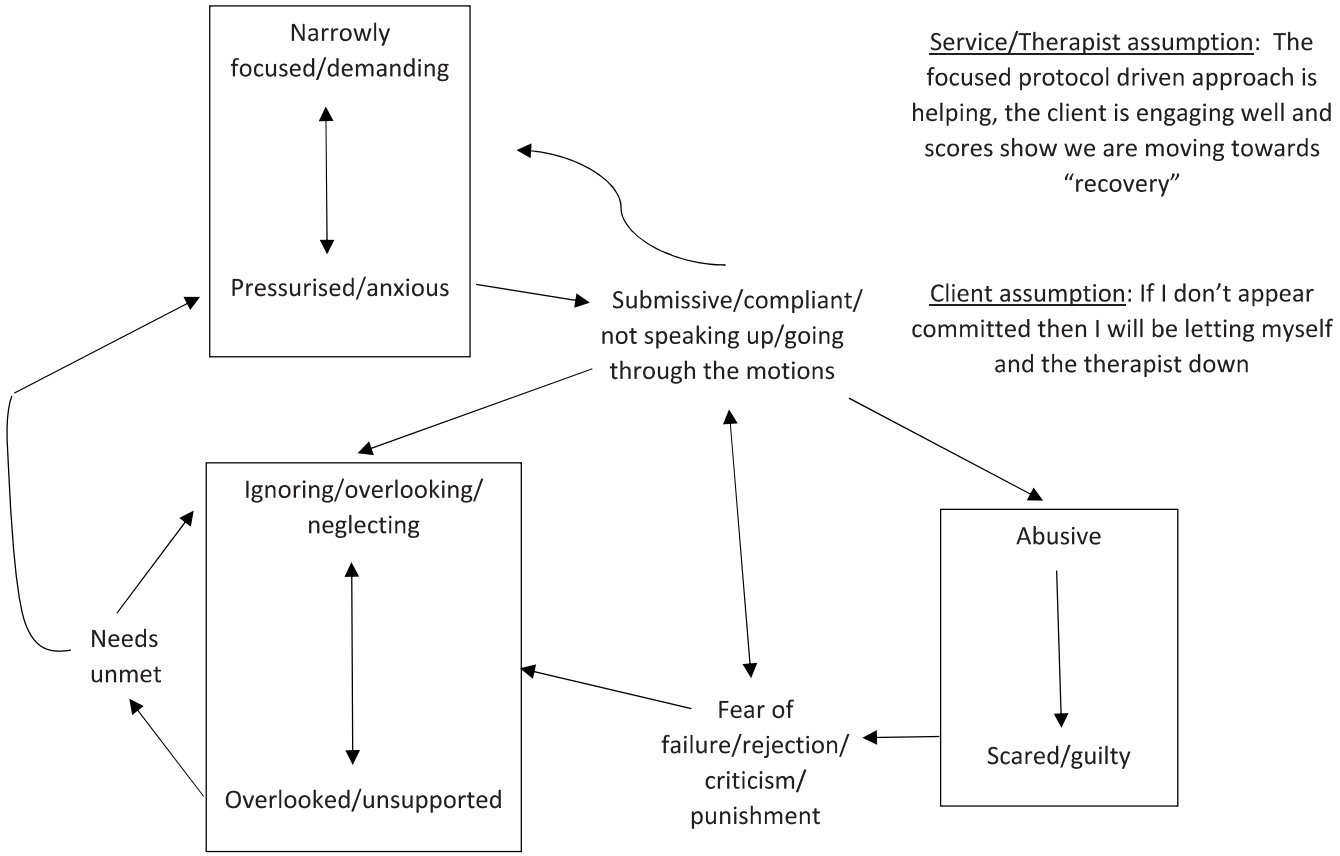
Management	**Staff**
The Bully Manager:	
Increases workloads while reducing resources.	Overstretched & stressed.
Shows no understanding of what is needed.	Unable to maintain standards: Experience conflict, anxiety, loss of respect.
Not listening. Dogmatic.	Unheard, no voice. Unable to influence.
Avoids personal contact.	Cut off.
Treats without respect/contempt.	Angry/hostile compliance or fight back.
Forcing, or using implicit threats.	Angry: Silent or Stand up for Rights.

These patterns are potentially more likely to occur if management is predominantly occupied by individuals with no/little experience delivering psychological therapies and/or a heavily medicalised orientation. If combined with narcissistic leadership, what Thomas (2010) refers to as type 1 leadership: (authoritarian with task oriented

leaving the service. This typically followed having taken numerous steps to try and address what may be referred to as an "inconvenient truth" for management but still being faced with the above dynamics. It takes time to secure a new job so even those wishing to leave have to navigate the present context and may occupy or shift between positions

clinicians would say things such as "I dread management supervision, I don't raise any concerns so I stay under the radar!" "It's about ticking the boxes so they stay off your case!" "If their (client's IAPT) scores indicate recovery I reinforce how well they are doing and quickly close their case!"

Diagram 2



Lilly

Diagram 2 attempts to highlight how this may constitute a parallel process that could be particularly anti-therapeutic for clients such as Lilly, the subject of the accompanying case study, who learnt to deal with a history of chronic abuse through submissive compliance and appeasement.

The therapist may occupy the top poles in relation to the client but also the bottom poles in relation to management. The therapist assumption in the bottom pole could for example shift to "if I don't hit my personal targets I'm at risk of losing my job". The system arguably incentivises efforts to be narrowly focused upon achieving IAPT "recovery" as opposed to facilitating a more genuine dialogue that is ultimately in the best interests of the individual. Consequently clients may appear to "recover" therefore strengthening dysfunctional assumptions as suggested in diagram 1.

Therapy with Lilly centred upon getting in touch with difficult feelings and expressing how she really felt. When disclosing feeling "sick" about therapy coming to an end, CAT highlighted expressing how she really felt constituted an exit from a long standing dysfunctional pattern. Without this framework I would previously have been inclined to reassure Lilly to minimise distress, both because it would seem compassionate, and conducive to encouraging IAPT defined recovery, yet would have unwittingly colluded in an enactment of overlooking Lilly.

Michael

For individuals with a chronic history of abuse, specifically repeated physical abuse in childhood a powerful damaging enactment could also be strongly reinforced/further entrenched. My current work as a therapist for a specialist Military Veterans service has provided more space to reflect how individuals such as Michael, can be negatively affected by IAPT services.

Schore (2013) outlines how a childhood where seeking emotional regulation from an attachment figure repeatedly resulted in further physical violence/ emotional dis-regulation and becomes built into expectation and contributes to significant somatoform dissociation whereby the client no longer experiences hyper-arousal when under threat but moves straight to hypo-arousal. This dissociated state results from the individual's threat system anticipating it will be overloaded and therefore shuts down. The individual loses any semblance of self and is a void state in which they are not even connected to the internal rhythms of

the body. Schore (2013) proposes that this often explains later self-harm/ violence as these very physical acts are attempts by the individual to bring the central nervous system back on line so as to connect with some semblance of self. Effective therapy creates a window in which the individual starts connecting with this vulnerable pole in order to learn it is safe to do so. Having taken the major step of seeking help only to perceive being abandoned will likely reinforce the dissociative state and undermine help seeking behaviour. Such client's significant levels of distress are at times likely to not be evident and therefore risk becoming invisible.

Michael repeatedly attempted to engage with IAPT services for years following leaving the army where he had been engaged for years in back to back active deployment. Michael's mental health deteriorated rapidly upon leaving the army and he engaged in self-harm, attacked his adult children and made several attempts to end his life. The army had been functional for Michael giving him a sense of purpose and semblance of self that kept the void state described by Schore (2013) at bay. Removal of this framework appeared to have put him back in this dreaded place. Frequently referred to IAPT services he was repeatedly discharged for missing more than 2 appointments. Non-attendance of some appointments was an attempt by Michael to not feel overwhelmed as the pace of therapy was outside his present ZPD but resulted in an enactment of being abandoned and he was subsequently later often admitted to secondary care for brief periods until these ensuing "crises" were over. Diagram 3 attempts to highlight how systemic procedures were experienced by Michael as enactments of his past.

This section attempts to consider how iatrogenic harm potentially results when a therapist simultaneously attempts to meet the needs of a patient and management directives primarily concerned with throughput targets. This relates to a not untypical scenario that would arise within a system with increasingly high threshold for entry to secondary care, and removal of initial gateway/screening in order to hit IAPT prevalence targets, and directives to have to offer some form of intervention within an increasingly limited number of sessions.

Diagram 3

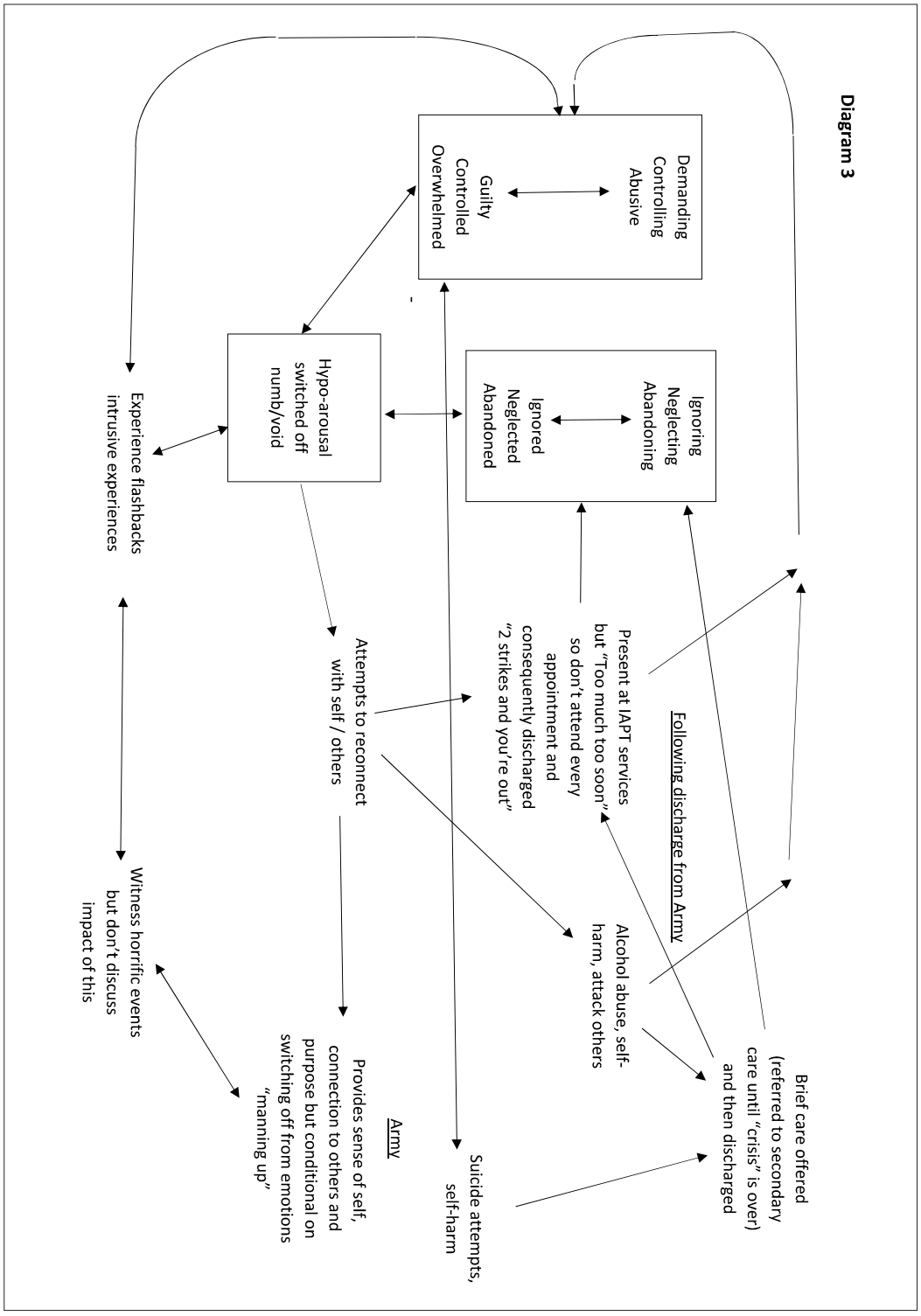
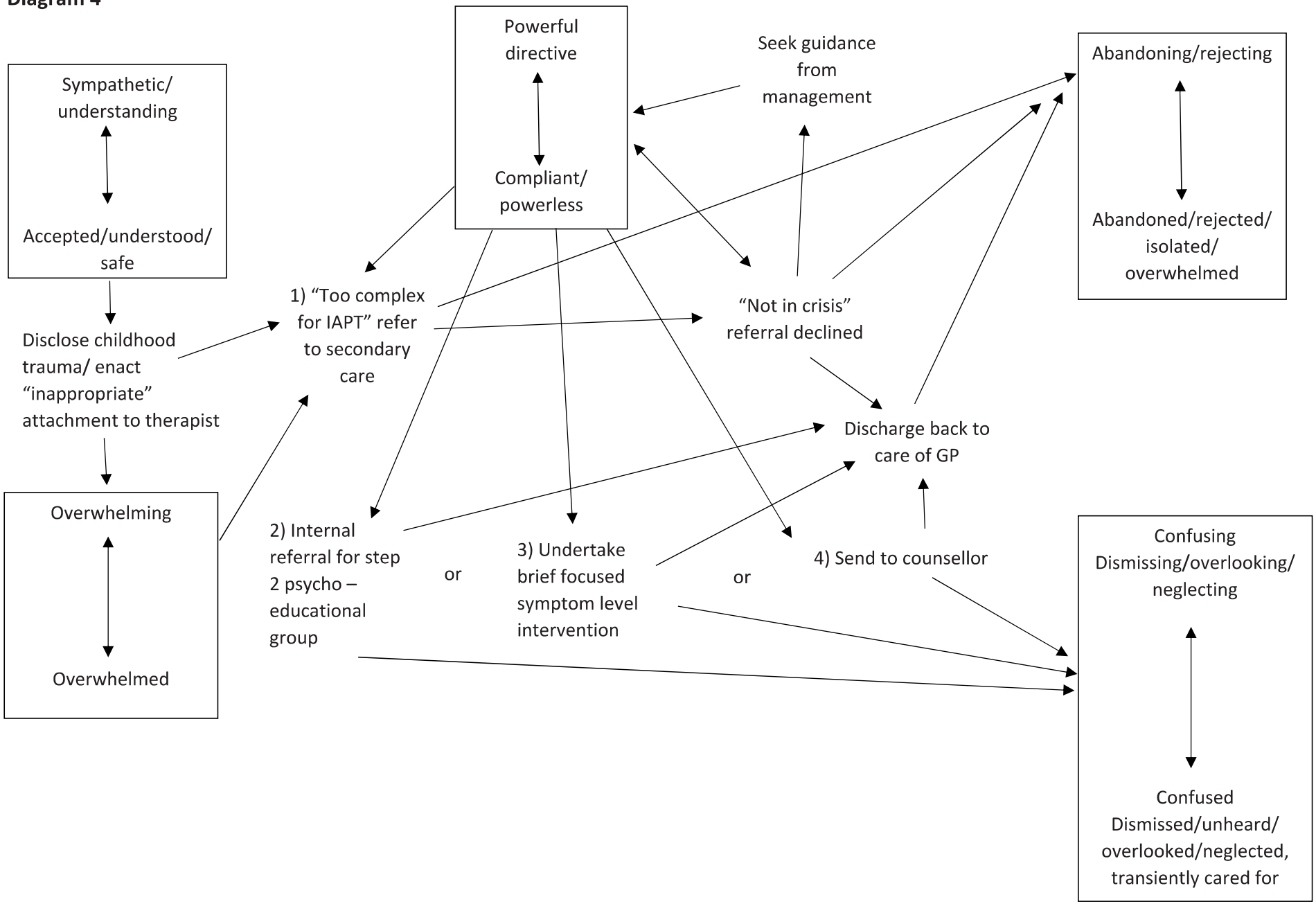


Diagram 4


Powerful directive
Compliant/ powerless
Seek guidance from management
Abandoning/rejecting
Abandoned/rejected/ isolated/ overwhelmed
Sympathetic/ understanding
Accepted/understood/ safe
Disclose childhood trauma/ enact "inappropriate" attachment to therapist
1) "Too complex for IAPT" refer to secondary care
"Not in crisis" referral declined
Discharge back to care of GP
Overwhelming
Overwhelmed
2) Internal referral for step 2 psycho – educational group
or
3) Undertake brief focused symptom level intervention
or
4) Send to counsellor
Confusing
Dismissing/overlooking/ neglecting
Confused
Dismissed/unheard/ overlooked/neglected, transiently cared for

Empathetic and understanding to accepted, understood and safe

A client initially referred with symptoms of 'anxiety and depression' establishes a therapeutic rapport with the therapist and feels listened to, understood and safe. This may relate to never having experienced attuned warmth and attention before and as such is seductive to the client who consequently discloses a history of childhood abuse possibly of a sexual nature. In some instances this may be accompanied by inappropriate attachment behaviour towards the therapist. An example may be the client having a confused romanticised/sexualised association to an apparent caring role.

Overwhelming to Overwhelmed

Following such a disclosure the client may feel overexposed/overwhelmed having rapidly shifted into a dissociated or partially dissociated self-state/pole of a reciprocal role. Depending on the level of experience of the therapist they could potentially feel overwhelmed due to such a presentation supposedly being outside the typical remit of IAPT 'mild to moderate Axis 1 presentations' and their conscious level of competence. This response could be exacerbated due to reduced resources and inability to access senior clinician consultation/support or supervision in a timely manner.

The client may experience the therapist's countertransference of feeling overwhelmed thus feeling they are a lost cause to evoke such a response in "the professional". This could lead to a sense of hopelessness and increase the potential for risk.

More experienced therapists may also feel overwhelmed due to reduced resources and experiential knowledge they are likely to become involved in protracted negotiations about how to appropriately meet the needs of the client with service interfaces that take an increasingly gatekeeping stance. Part of this may relate to this compromising their ability to focus upon management demands of hitting IAPT targets and relates to the RR (Powerful and directive to Compliant and powerless).

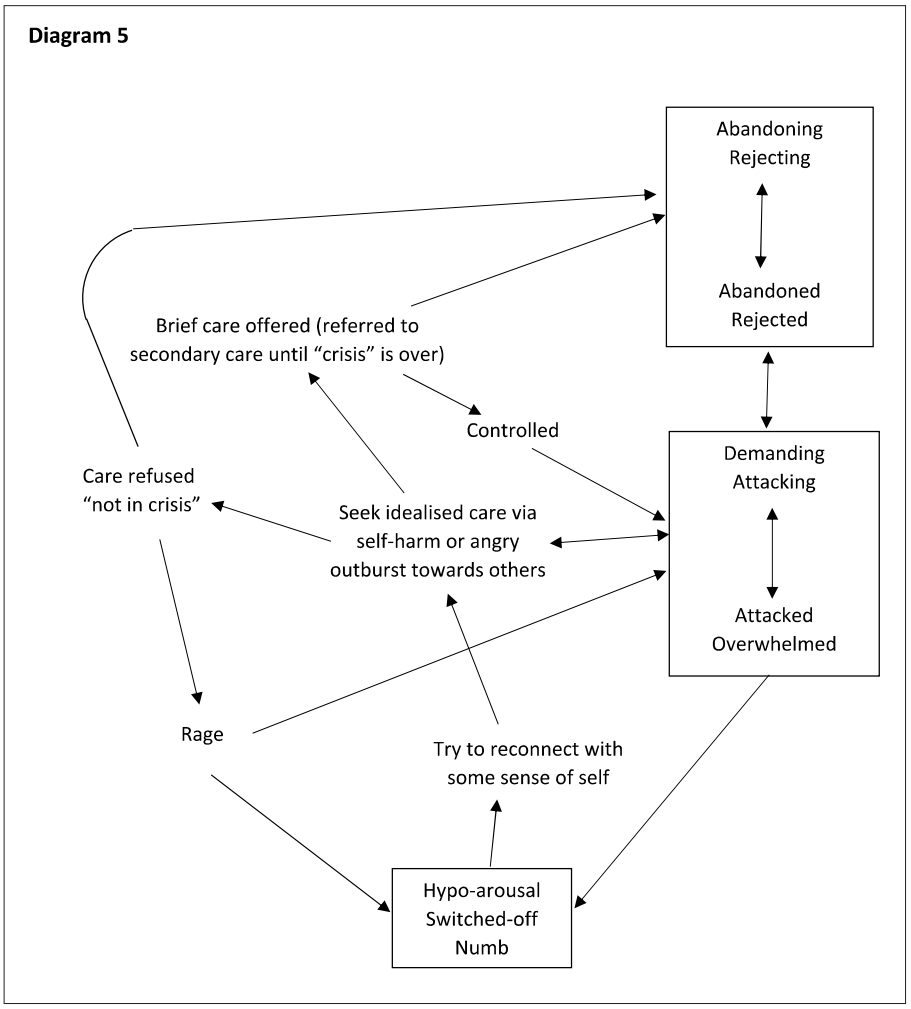
Repeated enactments of RRPs

Steps taken to try and meet the needs of the client may inadvertently shift the client back into the compliant pole of the RR whilst also potentially mobilising damaging responses from childhood of feeling abandoned, neglected/transiently cared for. Diagram 4 attempts to illustrate this.

Secondary care may be most appropriate to meet the client's needs and ideally services should be configured in a way that minimises the chances of clients being put through unnecessary distress by linking them into the most appropriate source of intervention as quickly as possible.

Furthermore, as was often the case within the context in which I worked, many referrals would be rejected by stretched secondary care services on the basis that the client was "not in crisis". In this instance the client may experience being abandoned yet again despite a rational conversation as to why the referral was declined. Additionally, this has the potential to reinforce in some individuals, especially those with borderline traits, the notion their needs will only be met by dramatic expressions of their distress thus increasing risk of suicidal behaviour and deliberate self-harm. Ryle and Kerr (2002, p151) point out how harm can be seen as a form of angry or help-seeking communication. See Diagram 5.

Diagram 5



Learning, Reflections and Conclusions

It has been difficult to consider how I potentially unwittingly colluded with enactments of unhelpful RRPs and could at times occupy the top pole of some of the RRs I have discussed. Working in IAPT since its inception I was generally considered a "high performer" according to these metrics. My personal reformulation heightened my awareness of my striving procedure and how this came into play within this context. On reflection an initial tendency to be self-critical about having potentially played a part in overlooking clients' needs/iatrogenic harm resulted in management becoming the target of my frustrations. This was arguably easy to do in an IAPT service that had developed into a particularly challenging configuration but by considering the broader relational context of IAPT has been helpful in lessening a shift towards either of these two positions. Opting to configure diagram 1 in a hierarchical formation may relate to feelings associated with occupying some of the lower poles of the RRs. Undertaking this essay formed part of an exit from these unhelpful procedures.

CAT has helped me develop a broader perspective. Brief symptom focused intervention can be very appropriate. However, if done in a vacuum with no reference to the relational it risks potentially dismissing/ignoring of the complexity of the more global presentation that ultimately could contribute to a sense of hopelessness in that the client has "tried this and it hasn't ultimately helped". Ryle and Kerr (2002, p212) present a case that demonstrates how attempts to work with symptoms of panic and anxiety may remain relatively ineffective unless the underlying RRPs are addressed. I view CAT as an overarching framework that has helped me better establish with the client when and why certain interventions are appropriate or contraindicated.

Whilst I previously felt uncomfortable quickly discharging clients for breaching IAPT attendance protocol I justified this on the basis of current lack of motivation. Thinking more relationally has helped me consider apparent lack of motivation beyond the notion of ambivalence.

In the case of Michael, eventually being able to work outside of rigid IAPT protocol and think more relationally facilitated understanding his difficulties from a broader, more compassionate perspective. Whilst he did not "recover" according to IAPT metrics this has to date resulted in a cessation of self-harm/violence and emergency admissions and these changes have clear social/financial implications.

I believe that using CAT informed interventions within IAPT settings has huge potential benefits including reducing a revolving door syndrome that was clearly evident in the service in which I worked. Individuals later presenting for further episodes of treatment, arguably as a result of not having addressed underlying RRPs, resulted in a distorted account of the percentage of the local community that were entering treatment (prevalence) and actually improving ("recovery").

By assisting individuals to better understand their symptoms in relation to underlying RRPs, CAT arguably increases individual's long term self-efficacy therefore reducing readmission rates and improving efficiency in real terms. Whilst PHQ9 and GAD7 measures used in IAPT are useful tools an over focus upon these metrics detracts from a more detailed narrative of what is actually occurring in real terms and as discussed can incentivise anti-therapeutic behaviour. If there is a willingness at all levels to acknowledge some of the difficulties inherent in the system I think CAT can play an important role in informing improved and ethical IAPT service delivery through highlighting potential iatrogenic patterns and the need for a review of how recovery is defined and measured. In addition to CAT informing wider strategic discourse on IAPT service improvement, more extensive steps to train IAPT staff in CAT informed interventions and having experienced CAT practitioners able to offer in service consultation would be positive steps in this regard.

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