The experience of staff practising "Five Session CAT" consultancy for the first time: Preliminary findings.

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Introduction

Abstract

CAT Practitioners within a UK north east NHS Trust (Tees, Esk and Wear Valleys (TEWV)) are using CAT formulations as an aid for managing clients' care within secondary care mental health teams, inpatient wards and tertiary services. This has involved "Five Session CAT" consultancy as a new service development. The aim of this pilot study was to understand the experience of "Five Session CAT" from the perspectives of CAT practitioners and care co-ordinators (community nurses) who were all using the approach for the first time, in order to inform our services of any benefits or challenges within this process so that the model could be developed and adapted. We struggled to obtain consent from clients to be interviewed about their experiences at this pilot stage and we feel the lack of the client's voice is the main limitation of this study. However, our results provide some interesting points for further discussion and to inform further research requirements within this area.

The Context

UK community mental health teams are increasingly expected to provide psychological interventions for clients with severe and complex presentations, often with some form of Personality Disorder (PD) diagnosis, yet this is within a context of staff frequently struggling with huge caseloads, limited training and minimal support/ supervision (Kerr et al., 2007).

"PD – No longer a diagnosis of exclusion" (NIHME, 2003) was an important shift in UK mental health policy to acknowledge the rights of this client group to mental health services, but also highlighted the urgent need for staff training. Eliciting and receiving care is often the central area of difficulty for clients with a PD diagnosis, and it is well documented that services can often repeat the problematic relational patterns of clients' early experiences. Clients can experience abrupt state shifts and their pleas for help, followed by their apparent rejection of help offered, can elicit service responses of rejection or a desire to rescue. This can reinforce damaging relational patterns for clients whilst teams may struggle with splitting, stress and burn-out (Dunn & Parry 1997; Fonagy & Bateman, 2006; Kerr, 1999; Main, 1957). Although the need for a reflective and relational organisational space when working with more complex clients is widely recognised (Personality Disorder Institute, n.d.), it is often not available to staff, particularly when services are under resourced and under pressure. However, there is increasing use of psychological formulations with teams as an aid for managing clinical care (Johnstone, L. (Ed) 2015). There is a limited evidence base for this type of work, with Cognitive Behavioural Therapy (CBT) and CAT approaches to formulating with teams being the two main structured approaches evaluated (Kellett et al., 2014). The main theoretical and clinical difference between the two is CAT's focus on, and mapping of, the relationship between the team and client as a possible reflection of typical relational patterns learnt in childhood (Kerr et al., 2007).

The growing literature for using CAT formulations with teams as an aid to managing client care outlines the benefits of shifting potential team conflict over complex clients from a personal level to a more psychological/ relational understanding of the client, and therefore minimising unhelpful responses (Annesley & Jones, 2016; Carradice, 2004; Dunn & Parry, 1997; Kerr et al., 2007; Marshall, 2014).

Staff in mental health services report CAT to be an accessible relational model which can aid clinical confidence, facilitate a deeper understanding of relationships with clients, and improve team cohesion, morale and communication (Jones et al., 2012; Kellett et al., 2014; Thompson et al., 2008).

"Five Session CAT" consultancy (Carradice, 2013) is one example of using CAT within staff teams to work with care co-ordinators and their clients who present with complex difficulties, but for various reasons are unlikely to be able to make use of psychological therapy and often have significant risks and instability in their lives. The approach differs from many other approaches to formulating with teams in that it involves BOTH the client and care co-ordinator in the development of the formulation but also has echoes of the early "Using CAT" work such as Dunn & Parry's work in Hull (1997) where the client was involved in the development of the formulation.

We believe that formulating in this way helps to ameliorate some of the concerns expressed by some clinicians (Robson & Quayle, 2009) regarding the limitations of written formulations which remain largely inaccessible within reports with little or no involvement of the client.

Within "Five Session CAT" consultancy the CAT practitioner works together with the client and care co-ordinator to develop a CAT map of the repeating relational patterns/states central to the formulation (including the relationship between the client and the care co-ordinator/service if all parties involved can tolerate this) with the aim of informing case management and supporting positive interventions. It is not CAT therapy. In our Trust (TEWV), we have begun to name it "Five Session CAT Care Planning" in order to assist with clarity of its aims. "Five Session CAT" was developed to work in a containing way with a predominantly "here and now focus" for clients whose difficulties often involve state shifting, powerful dynamics, difficult relationships with services, dissociation and difficulties with emotional regulation such as becoming easily overwhelmed and/or self-harming. Most often care co-ordinators refer clients with whom they are struggling and an important aim of the work is to develop their psychological understanding of their relationship with the client and support more effective interactions.

The CAT practitioner typically works with the client and care co-ordinator for five sessions, with a half hour meeting with just the care co-ordinator before and after which involves an explanation of the model and training in CAT concepts, and reflection on feelings and on the process.

Method

Given the early stages of introducing "Five Session CAT" within the trust, and only a small number of CAT practitioners having used the model, it felt appropriate to use a qualitative methodology to explore the experiences of the participants and to use thematic analysis to analyse the data (Patton, 1990).

Semi-structured interviews were developed, and taken to a meeting of CAT practitioners within the trust for feedback. The interview structure included exploring participants' feelings before, during and after "Five Session CAT"; their experience of the process; any changes apparent; and any challenges faced.

This allowed an understanding of particular areas regarding "Five Session CAT", but also for participants to take the lead on their experience. Interviews were undertaken with participants who had completed the process of "Five Session CAT" for the first time, this included a focus group of four CAT practitioners and four care co-ordinators who were approached by the researchers and interviewed individually.

Interviews were conducted by two of the authors, neither of whom had carried out "Five Session CAT" and therefore would not impose their views on the participants. Interviews were audio-recorded to allow the authors to analyse them later with accuracy, and take verbatim quotes where necessary.

Analysis

The interviews and focus group were analysed using thematic analysis, and emergent themes were established

Theme	Frequency of the theme in the care co-ordinator group (N=4)	Theme present in the focus group of CAT practitioners (N=4) (Y/N)	Example quote Care Co-ordinator (CC), CAT practitioner (CP)
New way of working	4	Y	"It was difficult to be an observer. I felt like I was sitting on my hands. I agreed to chip in to support the client" (CC) "It was a struggle to shift my way of working" (CP)
Increased awareness and understanding	4	Y	"It gave me permission to look at things differently" (CC) "The care co-ordinator recognised what she was doing in terms of rescuing the client, as well as increasing her empathy for the client." (CP)
Focus	4	N	"Having a focus, direction and understanding was the most valuable part. Also, something tangible to work with in the map." (CC)
Time Demands	3	Y	"It's quite time consuming. It was difficult to find two hours in the week when both myself and the care co-ordinator could see the client." (CP) "It was a challenge to protect that time. It seemed like a luxury, normally other pressures take over." (CC)

for the two groups interviewed. The interviews were listened to separately and themes derived separately by two of the authors as a step towards inter-rater reliability. Themes were then compared and the two authors found similar themes. Respondent validation was sought through feeding back themes to the focus group in order to confirm accuracy of the findings.

Results

The interviews were found to contain four main themes: new way of working, increased awareness and understanding, focus and time demands. Table 1 contains the main themes, proportion of care co-ordinators endorsing the theme, whether the theme was present within the focus group discussion and example quotations from participants. (See Table Opposite)

The first main theme of *new way of working* was emergent in both the care co-ordinators' interviews and the focus group discussion. For CAT practitioners, this was a new way of using CAT and required some adjustment. They reported that they were not used to keeping conversations with the client in the "here and now" in contrast to the exploration of early experiences in CAT therapy and found doing this difficult at times. Some CAT practitioners reported being guided by what the client raised and could tolerate, in order to ameliorate concern at being experienced as rejecting or dismissive of early experiences. They would acknowledge early experience in the mapping/formulating, if raised by the client, and would explain that this could be addressed further with more time such as within talking therapy or time with their care co-ordinator. Both CAT practitioners and care co-ordinators valued the flexibility of the "Five Session CAT" model and most of the CAT practitioners had adapted the model in some way as they felt appropriate to fit with client need. For example, some CAT practitioners and care co-ordinators offered some clients more than five sessions, since these clients wanted to talk about issues from their past and felt more able to talk about their early experience as the "Five Session CAT" progressed. In some cases, individual CAT therapy was offered shortly after the "Five session CAT" ended. This could be an important benefit of the approach in terms of making CAT more accessible to clients who may have previously felt unable to manage therapy.

CAT Practitioners took on the dual role of educator to the care co-ordinator, as well as reformulating with the client. It seemed to take a few sessions for both CAT practitioner and care co-ordinator to feel comfortable and clear about their roles. The model suggests that care co-ordinators are offered the opportunity to be as active as they can manage, which might mean noting their observations during the sessions, or in these cases some practitioners encouraged participation from the care co-ordinator when invited by the client.

The next theme of increased awareness and understanding was shared across the groups. CAT practitioners thought that "Five Session CAT" consultancy was a valuable process as it allowed them to get to know the client in a way that a staff consultation would not, and supported them in developing a closer working relationship with the care co-ordinator. All CAT practitioners thought that the process had increased the psychological awareness within teams and it helped to spread use of the CAT model more widely. They felt that there seemed to be a greater understanding from the care co-ordinators in terms of how they might sometimes be re-enacting problematic relational patterns and this was reflected by the care co-ordinators. For example one care co-ordinator recognised that she had been pulled into overly rescuing the client. The CAT practitioners felt that this new understanding had increased the care co-ordinators' empathy for their client. This view was also echoed by care co-ordinators who felt that they had developed a deeper understanding of their client. They reported having learnt new information about the client, despite knowing them well, and that they were able to see the client's interpersonal difficulties more clearly. In agreement with the CAT practitioners, the care co-ordinators felt that this process had the effect of increasing their empathy towards the client. Care co-ordinators also valued the individual time with the CAT practitioners in terms of developing their understanding. This helped them to continue the work in between sessions and to strengthen their relationship with the client.

The theme of focus was found within all care co-ordinator interviews. Care co-ordinators reported that "Five Session CAT" gave them a period of time to focus on the client, rather than working reactively and they all reported that the map was a powerful tool in helping them focus their concentration and to understand thoughts and feelings. The session was a safe, containing place that helped them to feel comfortable and calm with no pressure and supported them to make sense of things. Furthermore, care co-ordinators felt that time with the CAT practitioner alone, before and after the client's session, gave them clarity and understanding, and they were then able to pass on this information and understanding to their client, particularly with the support of the map.

The final main theme of time demands was an issue highlighted in both the care co-ordinators' interviews and in the focus group discussion. CAT practitioners thought that the preliminary work involved was time consuming in terms of educating the teams prior to implementing this approach. Other CAT practitioners felt

that the benefits of "Five Session CAT" spread more effectively via word of mouth between care co-ordinators and that this process took time. There was a lot of planning involved in order to book blocks of five sessions in advance, and both CAT practitioners and care co-ordinators felt that matching busy diaries was a difficult process. There was also an issue of sticking to the structure of "Five Session CAT" and ensuring that the half hour before and after the hour session with the client was protected. The CAT practitioners felt that some care co-ordinators valued and protected this time, but others did not – which may well reflect the high demands placed on care co-ordinators' time and their large caseloads within the current NHS climate and the need to "push where it moves" and go with what the care co-ordinator can manage.

Discussion

This small service evaluation considers a complex situation where a new approach is being introduced into teams by CAT practitioners who were also beginning to learn how to use the approach for the first time. This new way of using CAT has generated much debate amongst CAT Practitioners regarding the common ground and differences between such brief shared formulations to guide ongoing work/care plans and doing CAT as a talking therapy.

The evaluation suggests that "Five Session CAT" Consultancy can be experienced as a valuable model and seems to be an example of how CAT can be used to reach complex individuals whom otherwise would not have had access to CAT/talking therapy. Qualitative data suggested that care co-ordinators felt they had a strengthened relationship with clients, helped by their increased level of understanding and empathy. It will be important to hear from clients on this issue.

It was evident from the interviews that CAT practitioners were adapting the 'Five Session' model with some providing more than five sessions. Practitioners seemed to value being able to use the model flexibly according to client need; for example acknowledging early experience within the formulation if the client raised this and seemed able to tolerate it, and some clients being able to more actively engage with the mapping/ drawing of the formulation. Flexible use of the model appears to enable its use in a variety of ways with clients at different levels of complexity/ distress. For example, for some: informing the care plan and enabling the ongoing working relationship with staff, and for others: providing a first step towards further talking therapy.

Of particular importance were the positive changes observed in the way the care co-ordinator and client related to one another. For some care co-ordinators the 'immediacy' of the model seemed beneficial as they were soon able to reflect on being pulled into unhelpful relational patterns (e.g. a rescuing role) and reported increased awareness of 'catching themselves' as this happened in the room with the client. The process also seemed to contain the care co-ordinators, reducing their anxieties and offering support and a reflective space in which to think about the client.

We have been encouraged by this initial feedback which fits our general impression that "Five Session CAT" is valued by services, particularly when adapted to fit the needs of the client and the particular service setting. Further research is needed in order to recruit larger numbers and to incorporate the clients' experience of the process.

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