The Idealised Care Smokescreen: How the Tools we Share can be Used to Attack

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"The aim is to provide a non-blaming, supportive and containing framework that everyone uses to understand what are likely to be unhelpful responses and what is required of the team to avoid making things worse" (Dunn & Parry 1997)

We are CAT trained clinical Psychologists working in a large NHS mental health trust and have been using the CAT model over many years to try to help mental health staff develop a reflective space that will encourage relational thinking. Feedback from staff teams is often very positive with regard to the clarity and understanding that CAT brings to their every day duties including improved relationships with service users, a shared language for the team and enhanced team functioning. However, in recent years, we have experienced increasing unease at how the CAT map can potentially be used to blame and shame staff for ideally caring or rescuing. We have reflected that it is unlikely to be coincidental that these concerns have been noted during a period of austerity, where staff teams increasingly appear overwhelmed by the challenge of providing "good enough" care to more people, with limited resources. In essence, the accessibility of the CAT model with a simplified map is the key to teams "getting it" but may also provide quick ammunition for attack, or the legitimisation of limiting care. Such attacks may inadvertently create a smokescreen distracting from how service users may experience services as being neglectful or rejecting as they work to allocate resources as effectively as possible.

The context of concern

Long before the UK economic downturn, Kerr et al (2007) highlighted the challenges for CMHTs under increasing pressure to provide psychological interventions yet often struggling with large caseloads, limited training, support and supervision. The continuing trend of reduction in mental health beds (Ewbank, Thompson & McKenna 2017) has resulted in admission becoming less accessible and community and crisis teams needing to tolerate greater levels of risk Many clients have a huge level of complexity where eliciting and receiving care is often a central difficulty. Services can respond to such complexity by inadvertently repeating problematic relational patterns such as rejection or a desire to rescue. This can lead to problems in the staff team such as splitting, stress and burnout, the latter often manifesting itself in staff sickness (Onyett et al 1997). The service user may experience their problematic sense of self reinforced as they experience "more of the same".

In anticipation of funding cuts in a culture of economic austerity, mental health trusts embraced wide-scale service transformation as a solution to the dilemma of how to meet need in uncertain economic times (Kings Fund, 2015). This has led to many standardised care pathways advocating time-limited intervention, with the expectation of prompt discharge into primary care. Often a recovery orientated approach is utilised, with a focus on personal responsibility and self management. However services have been warned of limitations and absence of evidence for over-relying on this approach (Kings Fund, 2015). Service user groups such as Recovery In The Bin (2018) also expressed concerns that attempting to treat all service users within "one size fits all" services is likely to be unhelpful and potentially harmful for many people, especially the majority who have unequal access to society's resources and opportunities. Alongside these limitations, public expectations of services have been elevated by political rhetoric as politicians promote prescriptive standards they have set, without allocating adequate resources to implement them. For example, our trust quality strategy states that our aim is to deliver the perfect patient experience each and every time (Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), 2015). The mismatch between resources and expectations may be increased in services subject to competitive commissioning arrangements, where the more explicit threat to survival may mean that difficulties cannot be openly named.

Using CAT with teams

Developing reflective practice has long been recognised as essential for services to work effectively with complex clients. One of the NICE quality standards for personality disorders highlights how staff require support through supervision to manage stress associated with managing interpersonal relationships and boundaries (NICE 2015). Over the last decade, there has been increasing application of CAT informed formulation to develop staff understanding and reflection These have ranged from clients giving permission for their map to be shared with teams (Dunn & Parry 1997), CAT mapping in meetings with

teams (Kerr 1999, Carradice 2004), CAT consultancy with a client and/or their care co-ordinator (Kellett et al 2014, Carradice 2013) and providing CAT skills training at case management level (Thompson et al 2008, Marshall et al 2013, Annesley & Jones, 2016). Staff have reported finding CAT to be an accessible relational model that can boost clinical confidence, improve clinical practice, facilitate a deeper understanding of relationships with clients and improve team cohesion, morale and communication.

We have offered several adaptations of the interventions outlined, with the format and content varying dependent on the presentation of the client under consideration and the team's zone of proximal development. This takes into account the team's level of interest, psychological training, motivation and goals for the session. We would always provide or verify that the team had previously been provided with an orientation to CAT. This would include an introduction to the concept of restricted repertoires of reciprocal roles of abusing-abused, neglected/abandoning/rejecting- neglected/abandoned/rejected and ideally caring/rescuing-ideally cared for. Most staff groups appear able to reflect on this and consider examples of the "push and pulls" of relationships.

As ideally caring patterns are not directly internalised from caring relationships, we tend to prioritise explaining these in more depth to help staff make sense of this concept. Jenaway (2007) highlights how we can map out a normal healthy stage of development where the infant exists within two extreme states of being perfectly cared for by a perfectly attuned carer or when the infant is wet, hungry and neglected whilst they are waiting for their needs to be met. Consistent parental care allows the baby to learn the middle ground of being able to tolerate hunger and still know that they are loved and the care will arrive. We then go on to share Sue Gerhardt's (2004) understanding of how the "double whammy of a child depending on someone who both isn't there for them emotionally and also actively abuses or rejects them in some way, can leave them with a kind of emotional "unfinished business". This describes how, as the child grows up, they continue seeking the baby's experience of perfect unity with an attuned mother, and long to be properly taken care of with their needs, anticipated, understood and fulfilled without words. The adult may remain highly dependent on others, as they continue to hope that the magical other will make them feel "alright". This can set people up for repeated disappointment and rejection, and reinforce their experience of their needs being neglected.

Sometimes it is possible for staff to link procedures that occur between staff and clients to organisational dynamics and culture. For example clinicians may identify with the pressure to rescue to minimise risk or recognise the pull to "reject" via discharge when feeling overwhelmed with their caseloads. When exploring such patterns with staff, we would highlight the inevitability of both clinicians and services at times joining the dance and repeating problematic relational patterns. As such the therapeutic task is to "step out of the dance". We hope that sharing examples from our practices of times we have ended up "on the map" helps create a safer space for reflection. We aim to counter the view that feelings responses are "unprofessional" or "interfering noise" (Sheard et al, 2000).

Recent concerns "You're spoiling the child"

Although we have in general received positive feedback, when using CAT with staff teams (Finch et al, 2018), we have also had reason to reflect on the possible unintended consequences of providing a narrative around idealised care and rescuing in the context of overstretched mental health services. We would continue to encourage noticing pulls to rescue and provide idealised care and would still advocate stepping out of such dances. This is because such care is ultimately unsustainable, resulting in the client feeling let down in the end. The alternative of providing limited but "good enough care" allows a person to experiment relating via healthier roles. Yet we also have noted that terms such as over caring, rescuing and encouraging dependency have being used in pejorative terms, as examples of wasted resources, with little balance of the other neglecting/rejecting reciprocal roles that are also re-enacted. From our experiences, we are not sure that a dominant narrative of over-caring reflects the balance of the work we encounter in services. Most care coordinators that we know no longer have the time.

One of us recently experienced one of the most challenging meetings of their career when meeting with a care coordinator to discuss concerns about a client. The client was entering a pattern of withdrawal from appointments with all services (a usual precursor to self harm or suicide attempts). The therapist was concerned by the apparent lack of compassion shown by the care coordinator and felt stone walled by a series of statements such as "she needs to take responsibility for her own mental health" and "it's her choice it's down to her" The therapist noticed herself struggling to stay off the map and resist a more attacking response to being told that we are "no longer a tea and sympathy service". Nevertheless she was able to restrain herself and respond that she "didn't think that we ever were." This experience brought to mind critiques of the biomedical model (e.g. Kerr et al 2007) which assumes that people will engage with treatment in a rational and cooperative

manner, whilst many clients' social circumstances and developmental histories have not equipped them with the skills and opportunities to manage care-giving relationships in this way.

We also recall a situation where a client had shared their concerns at their therapy appointments regularly starting a few minutes late, as the appointment was scheduled back to back after another clinical meeting. The therapists' colleagues were sympathetic when hearing of the "criticism" their hard-working co-worker had received, and supportive comments were made reflecting on the client's "neediness" and stating "I wish I only had to wait 5 minutes every time I went to see my GP". However the therapist acknowledged that rather than this reflecting the client expecting too much, the therapeutic frame offered to the patient should have been more consistent. Exploring this within therapy, allowed the client to share how painful he experienced waiting, because as a child waiting usually meant that nobody came. Consequently the patient expressing their concerns from an adult position allowed an important enactment to be named, an apology to be offered and discussion to take place together to consider practical solutions to the difficulty. Yet it was the therapeutic space that allowed the patient's "demands" to be understood alongside his developmental history. It troubles us that outside this protected context, in the general busyness of services, it may not be possible to keep the whole map in mind. Consequently, patients' valid distress could be dismissed as "expecting perfect care".

We have since reflected on these incidents and similar comments that we have heard in teams. In the first example, there was a sense that the terms used appeared "parroted" from a powerful other. We have since reflected that the apparent lack of compassion demonstrated by an individual clinician is likely to reflect a potential enactment reciprocating the demanding, dismissive attack of another. Such an attack could be direct through feedback from a management/ supervisory relationship or indirect through a team's learned response to organisational expectations (Welch, 2012, Walsh, 1996). We have observed that colleagues appear to feel inadequate and shamed about over-caring and rescuing. Being pulled into such understandable positions can be viewed as an attack on the professionalism of their care. We have also become aware of judgement or anxieties about anticipated judgement for "letting the side down" by not taking opportunities to discharge people and reduce the shared "burden" of the team. The science of compassion teaches us that in such threat focused climates it will be extremely difficult to demonstrate compassion towards ourselves and our service users (Gilbert 2013). An alternative position may be that staff who identify as caring, and struggle with or oppose the limitations placed on services may use ideas such as idealised care as a means to rationalise against their own discomfort at providing care that they believe to be "not as caring" as they provided in the past.

Potential Exits - Keeping the whole map in mind

The challenge therefore appears to be to help staff to think relationally and be open to using their feeling responses in circumstances where fully attuning to patients' needs may result in available care feeling insufficient or where efforts to offer a relationship risk being dismissed as "tea and sympathy". We offer the following thoughts:

As in individual therapy, one of the most helpful interventions a CAT therapist can offer teams is support to keep the whole map in mind. We must ensure that we balance sharing examples of how rejecting, neglecting or abusive enactments can occur within caring relationships and services, as well as explaining and providing examples of idealised care. It is also important to allow front line staff the opportunity to map their relationships to their teams and wider organization to encourage gentle reflection on how the pulls from these relationships can impact on their relationships with clients. We find that introducing Potter's 3 part model (2013), where the "dance" of the relationship is understood to be always influenced by the patient, worker and organisational dynamic, is a clear and normalising way of starting this process

Teams may be caught up in a dilemma of either succumbing to demands to provide standard care packages that they believe a person may struggle to engage with, or providing bespoke care that feels intuitively appropriate to the person without considering the system's resources, and sustainability. The latter position may occur as a response to difficult feelings such as hopelessness or defiance in response to the former. An exit from this would be for teams to begin honest dialogue and work towards a shared consensus about what is "good enough" care in their particular setting. This seems particularly relevant when the guidelines that care pathways and standards are derived from may be based on populations who do not reflect those we meet, or when interventions are implemented in an adapted form due to resource considerations. Discussing such matters openly in a multi-disciplinary team may highlight different views and theoretical perspectives. Within such conversations, it is likely to be helpful to use the CAT reformulation technique of anticipating any relational difficulties that may emerge from the different positions held within the team.

It is imperative that as well as team's naming the limitations of "good enough" care, teams must support each other

to name these issues directly with clients. In our experience, it can be difficult for staff who identify as caring to name that services cannot offer further help, or that services no longer have capacity to stay involved until it is the right time for them to be able to make use of their particular care pathway. Yet however difficult it may be in the moment to experience that client's (and staff's own) disappointment and frustration, this is likely to be less harmful than this being avoided or staff seeking to justify discharge on the basis of the person's improvement or their engagement with previous intervention, as this can be experienced as blaming. Moving away from locating all the difficulty in the individual also allows the person the opportunity to consider the impact that their social and political context may have directly on them, which could create an exit from self-critical or blaming procedures, and for some open up the possibility of engaging in intervention to seek change in their community.

Finally, we also think it is important to take opportunities to map with senior managers whenever we can (Carson & Bristow, 2015). This allows the opportunity for further dialogue about any discrepancy between what feels like good enough care within teams and the wider organisational pressures and standards. Exits could consider whether and in what circumstances there is scope for flexibility with care pathways, whilst still allowing organisational needs to be met. This is no easy task as the managers are under pressure to pretend that we can provide total quality/perfect care, which may require a level of denial which is at odds with the clear and accurate description of CAT (Vesey & Wilson, 2016). Such dialogue may also support clinicians such as ourselves to retain compassion and keep the whole map in mind as our senior colleagues grapple with the personal challenges of managing and allocating a limited resource in the face of the widespread and complex mental health needs in our society.

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