Experiences of receiving Cognitive Analytic Therapy (CAT) for those with complex secondary care mental health difficulties

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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: Date:

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I dedicate this work to Jamie and Mia with my love.

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ABSTRACT

Purpose

Cognitive Analytic Therapy (CAT) was established as a time-limited and integrative psychotherapeutic approach (Ryle, 1995). A review was conducted to identify what is known about the service user's experience of CAT. Following this empirical research exploring service user's experience of CAT for those with complex mental health difficulties was completed. An executive summary of the empirical research undertaken has also been developed for service users.

Method

A systematic search of HDAS, Web of Science, Cochrane and Ethos was conducted. As a result, twelve papers were selected for review. These were appraised using CASP tools and then thematically synthesised. Following this, six semi-structured interviews were completed with service users exploring their experience of CAT. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results

The literature review and empirical research highlighted that CAT tools helped service users to gain an understanding of themselves. However, CAT also evoked negative emotions in terms of feeling scared, worried and a painful process. Service users reported gaining knowledge and skills and considered the therapeutic relationship important. The literature review identified how CAT in a group is experienced differently to one-to-one CAT and the empirical research identified how service users with complex mental health difficulties can find it difficult to make changes following CAT.

Conclusions

The review and empirical research highlight the helpfulness of CAT in developing service user's understanding of themselves and how CAT evokes strong emotions. It is suggested that therapists need to adopt a more compassionate stance in the delivery of CAT and give more attention to containment and signs of rupture to the therapeutic relationship. The empirical research identified how it can be difficult to make changes following CAT and suggests incorporating systemic working for service users with complex mental health problems.

Chapter 1: A systematic review and synthesis of service user's experience of Cognitive Analytic Therapy

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ABSTRACT

Purpose

Cognitive Analytic Therapy (CAT) was developed as a time-limited and integrative psychotherapeutic approach (Ryle, 1995). There are still considerable gaps within the literature exploring the service user's experience of receiving this psychotherapeutic approach. This review aims to identify what is known about the service user's experience of CAT.

Method

A systematic search of HDAS, Web of Science, Cochrane and Ethos was conducted. Following this, twelve papers were selected for review. These appraised using CASP appraisal tools and then thematically synthesised.

Results

Service users have mixed perceptions of CAT tools. Some service users reported that CAT tools helped them to gain an understanding of themselves. However, some found it to be a frightening experience. Service users reported gaining knowledge and skills, considered the therapeutic relationship important, experienced CAT in a group differently to one-to-one CAT and experienced strong emotions in terms of feeling scared, worried and a painful process.

Conclusions

The review highlights the helpfulness of CAT in developing service user's understanding of themselves and how CAT evokes strong emotions. The review suggests how CAT therapists may need to adopt a more tentative, hopeful and compassionate stance and give more attention to containment. Further research also is recommended.

Keywords: Cognitive Analytic Therapy, service user's experience, psychotherapy.

Practitioner points

- CAT is useful in helping service users understand themselves better
- Therapists need to adopt a more tentative and compassionate stance when delivering CAT due to the strong negative emotions evoked.
- Therapists need to give attention to the service user's emotional experience of the therapy and signs of ruptures to the therapeutic relationship.

Introduction

Cognitive Analytic Therapy: Theory and Practice

Cognitive Analytic Therapy (CAT) is an integrative psychotherapeutic approach. It is time-limited and is usually structured within a 16 or 24 session course, including a follow- up session (Kerr, 2005; Ryle & Kerr, 2002). CAT aims to identify target problems (TP's) which is what the service user is bringing as the current problem in their life, for example, a service user might report that they are 'feeling low'. This could lead to the target problem of 'I find it hard to look after myself and stay well'. Target problems are underpinned by Target Problem Procedures (TPP's) (Ryle, 1979b). Target Problem Procedures are unhelpful patterns of thoughts, feelings, actions, events and relationships that are maintaining the problem. Therefore, 'I find it hard to look after myself and stay well' could be underpinned by a problem procedure of feeling inadequate. Therefore, the aim is to feel in control so the person then tries to do too much, feels burnt out, becomes unwell, feels inadequate and then tries to do too much again. These unhelpful patterns are presented in both the form of a diagram and a letter (sequential diagrammatic reformulation and reformulation letter). Reformulation has been described as central to CAT (Kerr, 2005; Ryle & Beard, 1993; Ryle & Kerr, 2002). The client can then identify what is maintaining the problem and start to change these patterns to reduce the problem which is called the revision stage. 'Exits' are a CAT term which refers to ways of 'exiting' from the patterns that have been maintaining the problem. An example of an exit could be that the service user decides 'to not do too much and that it's okay to not do everything all of the time'.

'Reciprocal roles' make sense of how the service user relates to others and themselves and how this is also maintaining the problem and are included in the reformulation. An example of a 'reciprocal role' of 'judgmental and critical' could develop from the service user's parents being judgemental of them which has led them to feel criticised. This reciprocal role has been internalised, for example, resulting in the service user being judgemental of

themselves or judgemental of other people. This leaves themselves or others feeling criticised. There is usually a goodbye letter in which the therapist and service user write to one another at the end of the therapy.

CAT Outcome Research

Calvert & Kellett (2014) conducted a systematic review of the outcome evidence base for CAT and identified that CAT outcome research is limited in its credibility due to not fully adhering to the control phase of the 'hourglass' model (Salkovskis, 1995) of psychotherapy evaluation. Nevertheless, more than half of the outcome studies conducted in CAT were of high quality and reported a statistically and clinically significant change across a range of outcome measures. This indicates that CAT can be an effective psychotherapeutic intervention for service users with a diagnosis of Personality Disorder and common mental health difficulties.

A review of the treatment of young people given the diagnosis of BPD (Biskin, 2013) found that service users in receipt of CAT therapy were found to experience a rapid recovery. However, this was not maintained at follow-up. Another review supports CAT as one of the most helpful approaches when working with adults and young people with a diagnosis of BPD (Gimeno & Chiclana, 2016). This review found that CAT reduced the symptoms of BPD, reduced risk factors associated with this diagnosis and improved service user's interpersonal functioning. A review of the literature for psychotherapeutic interventions for Anorexia Nervosa (Pittock & Mair, 2010) found that Cognitive Behaviour Therapy was not effective. However, CAT was as effective as Behavioural Family Therapy, interpersonal therapy (IPT), dietary advice (TAU) or non-specific supportive clinical management (NSSCM). The current evidence base for CAT is focused mainly on outcomes in CAT such as a reduction in presenting symptoms.

Service User's Experience of CAT

The service user's experience of CAT has been reported in case study form by Ryle & Beard (1993). A post-therapy interview was conducted 10 weeks after the end of the course of therapy. It was reported that the service user shared their experience of the reformulation process and how they had experienced changes due to the therapy. However, this case study only provided a section of the transcript from the interview without any meaningful qualitative analysis applied to the data or reporting of the findings relating to that service user's experience. Within the transcript, the service user reported that following therapy their 'anger' had 'improved a lot' and the worst thing about therapy was 'the fear of it not working'. They also reported feeling 'frightened' about talking about past events. Nevertheless, this case study does not provide a rigorous investigation and analysis of the service user's experience of CAT. Other studies have provided in-depth analysis and reporting of service user's experience of CAT.

Rationale for review

There are currently no published systematic reviews of the service user's experience of CAT. Policymakers and consumers of reviews are becoming increasingly interested in intervention need. And whether particular interventions are helpful and how they can be improved (Thomas & Harden, 2008). It could be argued that outcome measures can answer part of these questions. However, exploring the experiences of the recipients of these interventions can provide a more in-depth understanding. There has been a shift in the language used in policy-making to understanding the 'patient's experience' (Department of Health, 2009). Therefore, synthesising the available literature in this area could provide further insight into the service user's experience. Furthermore, it could inform clinical practice and service provision. Finally, this review will identify any current gaps in the evidence base concerning service user's experience of CAT and suggests recommendations for future research.

The review question: What is known about service user's experience of Cognitive Analytic Therapy?

Method

Search Strategy

The present literature review focused on exploring what is known about the service user's experience of CAT. Papers were searched using the HDAS database host whereby the following databases were searched; AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO and PubMed. The Web of Science database host, Cochrane Library and ETHOS were also searched. An initial search on what was known about the service user's experience of CAT was conducted by searching specific aspects of CAT to looking more broadly at CAT studies. This involved using search terms such as 'Reformulation in cognitive analytic therapy' or simply 'Cognitive Analytic Therapy'. This scoping exercise was conducted to gain an initial idea of what was known in this area and where obvious gaps exist. It was noticed that there was limited literature available on the service user's experience of CAT. Therefore, an open search term of "cognitive analytic*" was employed. This was to enable the search to produce as much literature as possible to then screen. Both the abstract and the title were searched with this search term and there were no limiters applied. At this point, no further papers were being yielded and so it was considered that the number of databases searched was adequately covering the literature available. Duplicates were removed either using the database system to remove duplicates in HDAS or by sorting the results by publication date and then hand removing the duplicates. The ETHOS database produced literature in the form of doctoral theses. This was searched due to the novelty of this area of research. Grey literature, such as thesis projects, was searched to reduce the impact of publication bias on the review (Ferguson & Brannick, 2012). Although some of the thesis projects were available either through the database or by contacting the author, some were not available and therefore were not included within this review as a result.

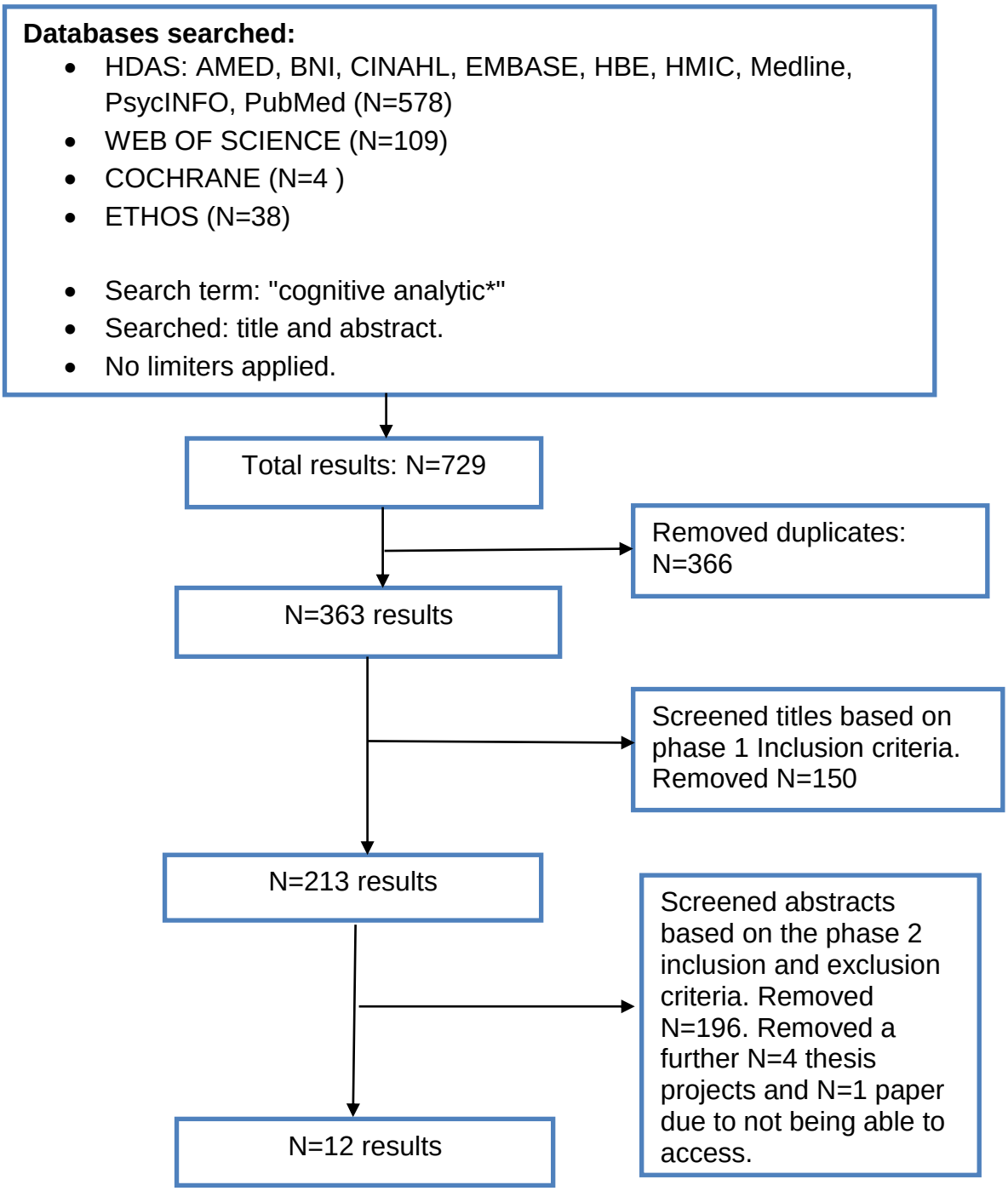
Eligibility criteria

It was important that the experience of receiving the therapy was under investigation rather than a reduction in symptoms. Therefore, papers reporting outcome measures that were only measuring symptom reduction were excluded. It was decided that having a two-phase approach to screening the papers would reduce the chance of the reviewer missing relevant papers early in the screening process. Therefore, a more general inclusion criterion were developed for the screening of titles and a more detailed inclusion and exclusion criteria was developed for screening the abstracts. Due to the limited amount of literature available on the service user's experience of CAT, both qualitative and quantitative studies were included within the search. Appendix 25 includes a full list of the exclusion and inclusion criteria.

Paper selection and data extraction

The search produced 729 results, 366 duplicates were removed, a further 150 papers were removed by screening the titles based on the inclusion criteria phase 1. A further 196 papers were then removed by screening the abstracts using the inclusion and exclusion criteria phase 2. Databases and authors were contacted to request thesis projects that were not accessible online. However, four thesis projects and one paper were still not available and therefore removed (Croft, 2014; Ntonias, 1991; Osborne, 2011; Spence, 2015; Wildgoose, 1997). Following this, twelve articles were retained for review (Figure 1). Data was extracted regarding the main characteristics of the papers and summarised in a table (Appendix 7).

Figure 1: Flow chart to show the process of selection



Quality assessment tools

Eleven of the twelve studies selected for review were critically appraised using the CASP (Critical Appraisal Skills Programme, 2017) for qualitative research. This tool consists of 10 questions to guide the reviewer to consider the validity and quality of the study (Appendix 1). Although five of the twelve studies used a mixed-methods design, the quantitative aspects of four of these studies were not included because they did not investigate the service user's experience of CAT. Components that were not included in the synthesis were not appraised to not provide the reader with a misleading quality rating. One of the twelve studies used a quantitative design only and so was reviewed using the CASP (Critical Appraisal Skills Programme, 2017) for case-control studies consisting of 10 questions (Appendix 2). One of the mixed methods studies was appraised using both the qualitative and the case-control CASP. All twelve studies were also reviewed against an additional question that was not included within the CASP appraisal tools used; 'Was there service user or carer involvement during the design or conduct of the study?' This question was added due to service user and carer involvement being considered important for the production of high-quality research (British Psychological Society, 2008; Health Research Authority, 2016). All twelve studies reviewed have been included in the synthesis regardless of their quality rating. This is due to there being limited evidence available investigating service user's experience of CAT.

Synthesis

Thematic synthesis (Thomas & Harden, 2008) was the approach applied to the twelve studies. It was decided that this would be the most appropriate method of synthesis to apply due to the majority of the data on the service user's experience of CAT being qualitative. The synthesising of data from several primary studies has been described as a method of going beyond the simple description of a collection of studies to producing a novel interpretation (Thorne et al., 2004). It has been informed by thematic analysis and uses techniques from this approach to identify and develop themes

across research (Thomas & Harden, 2008). Therefore, all available direct quotes from service users were extracted from the studies and synthesised across three stages. Where direct quotes or only quantitative data relating to service user's experience was available the results section or quantitative data was open coded. For the direct quotes, the first stage was line-by-line open coding of the data. The second stage was the organisation of these codes into descriptive themes and the third stage involved the development of analytical themes (Thomas & Harden, 2008). The process of synthesising the data was inductive. A service user and carer consultant with lived experience of being both a service user and a carer were involved in the thematic synthesis.

One of the twelve studies used only a quantitative design and quantitative data was also extracted from one mixed-methods study. Therefore, this data was converted into qualitative data to then be included within the thematic synthesis. This was achieved by open coding the quantitative data concerning the service user's experience of CAT. This process has been described in Bélanger, Rodríguez & Groleau (2011) and entails variables from quantitative studies being extracted, described and then summarised in a table to create qualitative codes. These qualitative codes were then included within the thematic synthesis. Appendix 3 details how quantitative data was extracted and converted into qualitative data for the quantitative study and one mixed-methods study in the present review (Tzouramanis et al., 2010; Stockton, 2012). It was considered that not converting this data would have limited these studies ability to be synthesised with the other ten studies in a meaningful way.

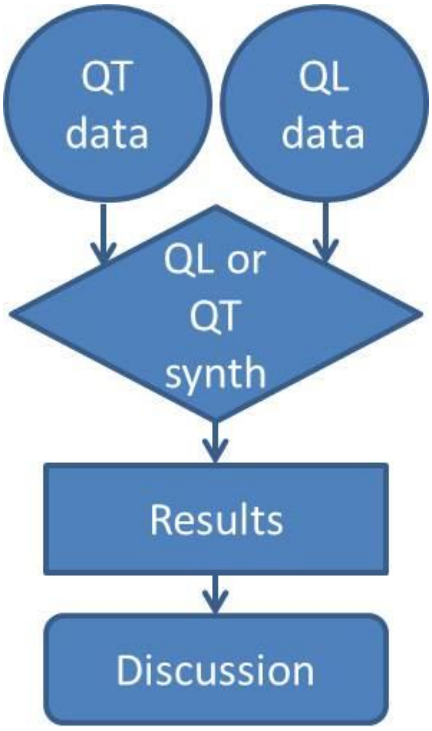
The text was also coded from the results section of three of the studies when there were no direct quotes available (Evans & Parry, 1996; Kellett & Hardy, 2014; Stockton, 2012) (Appendix 3). Only the text that was referring to what service users had reported was coded. This approach was used so that the data synthesised was from the perspective of the service user and not an interpretation of the service user's experience of CAT by the researcher. Any text that was preceded or followed by 'reported by the service user/client',

‘the service user/client reported’, ‘the service user/client described’ or ‘described by the service user/client’ was considered to be from the service user’s perspective and thus included.

The data from the twelve studies have been integrated at the level of data extraction by employing a data-based convergent synthesis design (Hong, Pluye, Bujold & Wassef, 2017) (Figure 2). In this design, qualitative and quantitative data is extracted from primary studies and then qualitative data is converted into quantitative data or quantitative data is converted into qualitative data. Dependent on which way the data is converted it is then synthesised together using either qualitative or quantitative methodology.

A summary of what was synthesised from each study is available in Appendix 6. All quotations from participants and any text and findings open coded from each study were entered verbatim into Nvivo 10 software for thematic synthesis (QSR International, Melbourne, Australia). A reflective diary was kept in the form of memos which were made during the analysis process. This was to aid the author to consider how their views and experiences may be influencing the analysis of the quotes and the resulting themes.

Figure 2: Data-based convergent synthesis design (Hong, Pluye, Bujold & Wassef, 2017).



Key for abbreviations

- **QT data**: quantitative data
- **QL data:** qualitative data
- **QT or QL synth:** qualitative or quantitative synthesis

Results

The findings of the studies will be set out within this section, including any important information regarding the findings of the appraisal. The studies have been categorised into studies exploring the service user's experience of the course of CAT, CAT tools, specific phases of CAT and group CAT. Only findings that are relevant to the review question will be presented. Following this, a thematic synthesis will be reported which will detail the themes and subthemes across the studies regarding the service user's experience of CAT.

Study Characteristics & Quality Appraisal

All of the twelve papers reviewed were of high quality except for one which was of medium quality (Evans & Parry, 1996). The appraisal highlighted many strengths and limitations across the twelve studies. The main strengths were that most of the studies provided examples of direct quotes from service users to illustrate themes and considered the role of the researcher in the analysis of the data. The main limitation of eleven studies was that service users were not involved in the development or conduct of the studies. A summary of each of the selected papers for review are included within a summary table (Appendix 7). The results of the quality appraisal are also summarised within Appendix 8. Papers were categorised into a high, medium and low quality based on the extent to which they met the appraisal criteria (high = all criteria met; medium = criteria partially met; low = few criteria or no criteria were met).

The Course of CAT

Three studies investigated the service user's experience of the full course of CAT (Kellett, Bennett, Ryle & Thake, 2013**;** Kellett & Hardy, 2014; Tzouramanis et al, 2010). Two of these studies used the change interview to investigate the service user's experience of CAT (Kellett, Bennett, Ryle & Thake, 2013**;** Kellett & Hardy, 2014). In contrast, Tzouramanis et al (2010)

administered the Post Therapy questionnaire to gather service user's perspectives. This questionnaire produced quantitative data whereas the change interview involved a one-to-one interview about any change experienced and whether it was due to the intervention. Two of the studies investigated a sample with a diagnosis of Personality Disorder (Kellett, Bennett, Ryle & Thake, 2013; Kellett & Hardy, 2014) and one with a diagnosis of Panic Disorder (Evans & Parry, 1996). Within one study service users generally reported a high degree of change following a course of CAT and that this change was attributed to receiving this therapy (Kellett, Bennett, Ryle & Thake, 2013). Although selector bias and how this was minimised was reported, there was no discussion of how the findings were validated in terms of triangulation.

Tzouramanis et al (2010) found the following helpful for service users; having a new understanding, self-monitoring, CAT being time-limited and the relationship with the therapist. Some of these findings fit with the available literature on CAT (Hamill, Ried & Reynolds, 2008). Furthermore, Tzouramanis et al (2010) used an appropriate and validated questionnaire to measure the service user's experience of CAT. However, there was limited discussion regarding potential confounders. In contrast, Kellett & Hardy (2014) reported that CAT helped the service user with seeing people differently, being able to manage paranoid thoughts and stopping playing 'the game'. This study chose an appropriate methodology to meet its aims. However, the findings from both Kellett & Hardy (2014) and Tzouramanis et al (2010) have limited generalisability due to the former being a case study and the latter being conducted in Greece.

CAT Tools

Four studies investigated the service user's experience of CAT Tools (Hamill, Ried & Reynolds, 2008; Rayner, Thompson & Walsh, 2011; Stockton, 2012; Taplin, 2015). One study focused on CAT tools generally (Rayner, Thompson & Walsh, 2011), two focused on letters (Hamill, Ried & Reynolds, 2008; Stockton, 2012) and one focused on sequential diagrammatical

formulations (Taplin, 2015). All studies were qualitative except for Stockton (2012). This study was a mixed-methods study and used the Working Alliance Inventory and the Helpful Aspects of Therapy Questionnaire. All qualitative studies used different analysis techniques; Hamill, Ried & Reynolds (2008) employed thematic analysis, Rayner, Thompson & Walsh (2011) used grounded theory and Taplin (2015) employed Interpretative Phenomenological Analysis (IPA). The samples consisted of service users with Depression or Anxiety (Hamill, Ried & Reynolds, 2008), Depression or Post Traumatic Stress Disorder (PTSD) (Rayner, Thompson & Walsh, 2011), Depression (Stockton, 2012) or different diagnoses (Taplin, 2015).

Hamill, Ried & Reynolds (2008) found that CAT letters helped service users 'make connections'. The letters helped service users connect to themselves by gaining varying degrees of understanding of themselves and self-awareness (represented by the theme 'Connecting to Self'). They helped them to feel a connection with their therapist and develop trust (represented by the theme 'Connecting to Therapist'). Some reported that the letters helped structure the therapy, for example, '*[The reformulation letter] made me more satisfied knowing what we covered in the past and a structure of what the future things would be'* (represented by the theme 'Connecting to the Therapy Process'). Finally, therapeutic letters were used as a method of communicating with people around them (Connecting to Others). This study provided a clear justification for the analysis employed and the analysis was sufficiently rigorous. In contrast to Hamill, Ried & Reynolds (2008), Stockton (2012) found that narrative reformulation did not improve the working alliance between the therapist and service user or the helpfulness of the therapy. This study took into account potentially confounding variables.

Rayner, Thompson & Walsh (2011) identified the following themes; 'being with the therapist', 'keeping it real' and 'understanding and feeling'. Furthermore, service users reported that the traits of the therapist, how comfortable they felt with the therapist and doing something rather than just talking were important. Feeling comfortable could be considered similar to the 'connecting to therapist' theme in Hamill, Ried & Reynolds (2008).

Service users reported becoming more self-aware and developing an understanding of their feelings and could also be seen to be similar to the 'connecting to self' theme. 'CAT tools' were considered as influencing all the themes. However, mixed effects were reported, with some finding them helpful and others finding them too complex or incongruent to how they thought. 'Doing with' emerged as an overarching theme as service users found doing things with the therapist and actively working together was very important, for example, '*You don't just sit back and let it all happen, you know your therapist isn't going to wave a little magic wand and it's all going to be okay. It's working alongside'.* The researchers considered what their influence on the study was throughout by having regular meetings and recording their possible influences in a diary. However, it was noted that ethical considerations were only partially reported.

Taplin (2015) found the Sequential Diagrammatical Reformulation (SDR) helped service users with understanding themselves and helped with making sense of experiences (represented by the theme 'chaos to clarity'). It was described as a method for change and as a tool used both inside and outside of the sessions (represented by the theme 'the change process'). This theme is similar to the findings reported by Rayner, Thompson & Walsh (2011). There were mixed experiences regarding the impact that the SDR had on the service user's relationship with their therapist (represented by the theme 'relational dynamics'). This finding may be similar to Rayner, Thompson & Walsh (2011) as service users reported the importance of feeling comfortable with the therapist. This study received full points on the critical appraisal review. Unlike the other studies, it included service user involvement during the development stage of the study.

Specific Phases of CAT

Four studies investigated specific phases in CAT (Evans & Parry, 1996; Fusekova, 2011; Shine & Westacott, 2010; Sandhu, Kellett & Hardy, 2017). Two studies focused on service user's experience of the reformulation phase (Evans & Parry, 1996; Shine & Westacott, 2010) and two studies focused on

the revision phase which is the stage when service users are encouraged to change unhelpful patterns (Fusekova, 2011; Sandhu, Kellett & Hardy, 2017). All four studies analysed qualitative data and employed template analysis (Shine & Westacott, 2010), grounded theory (Fusekova, 2011) and content analysis (Sandhu, Kellett & Hardy, 2017). Evans & Parry (1996) did not describe the method of data analysis used.

Evans & Parry (1996) reported that the reformulation had a large impact on service users. It is difficult to assess the rigour of this study and the researcher's potential influence on the analysis. However, the study did provide direct quotes from service users which provide a useful insight into how service users experience the reformulation phase.

Shine & Westacott (2010) identified seven themes relating to the reformulation stage; feeling heard, understanding patterns, space to talk, feeling accepted, having something tangible, working together, and feeling exposed. Service users reported that they felt listened to and understood. The reformulation session was described as being helpful for service users in understanding their patterns of thoughts and behaviours. The process helped service users have the opportunity and time to talk about the difficulties they were experiencing, for example, *'having space to talk about those problems with somebody else. . . erm. . . and somebody away from your immediate circle of people who. . . might pass judgement on you'.* Service users felt accepted through the process which enabled them to be more open with the therapist. The SDR and the reformulation letter were described as something tangible to take away. Service users felt that the reformulation sessions were about working with the therapist and that it felt collaborative. The theme of 'feeling exposed' consists of service users describing feeling uncomfortable at times. In contrast to Evans & Parry (1996), the study was presented so that its rigour can be assessed. Furthermore, the potential influence of the researcher on the analysis process was considered.

Fusekova (2011) identified important aspects of developing exits. The main finding was about 'opening up new perspectives'. Service users described

how they would discuss with the therapist things that they had not considered previously. This led to service users having a more in-depth understanding of themselves. Service users reported that they would develop new ideas of exits and exit strategies with the therapist which were 'common sense' but felt different and 'novel', for example, *'it was obvious, wasn't it? It was obvious. It was plainly obvious. But when you are stuck in that sort of [rut]... It's easy to be objective from an outsider's point of view*'. Service users described how they felt that they did not have the level of understanding needed to generate the exits themselves which are why they felt novel. Finally, service users described how they would try out the planned exits. Planned exits are strategies that have been generated and decided upon in advance with the therapist. In contrast, one-off exits are those that happen which may not have been planned. One-off exits were considered as important to service users. One-off exits can also lead to other one-off exits such as developing the motivation to make changes. A limitation of this study was that only service users who were considered to have received a successful intervention were interviewed which could bias the findings. However, similar to Shine & Westacott (2010), the study considered the researcher's role in the analysis process by keeping a reflective journal. Nevertheless, there was limited information provided regarding ethical considerations.

Sandhu, Kellett & Hardy (2017) identified stages within the revision phase. Stage 1 was identified as 'developing an observing self' whereby service users were able to become more self-reflective and described being able to recognise patterns. This is a similar finding to Fusekova (2011) in developing an understanding of themselves. Stage 2 was identified as a 'change in procedures and roles' whereby service users became able to engage in different roles and procedures. Stage 3 was identified as 'support and maintenance of change' whereby service users described how the SDR is helpful to refer back to in terms of the exits, for example, '*these are strategies and tools that you can look at and, and, and think yeah, I've got a, I have a choice to, now…..if I'm in this situation here then my choice now isn't just that way, it's that way*'. This study considered the relationship

between the researcher and the data by having coders that were blind to the outcome and the competency of the therapist. However, similar to Fusekova (2011), there was not an adequate amount of information regarding ethical considerations reported. Furthermore, there was no reporting of the author reflecting throughout the analysis process which could have provided more assurance in terms of the rigour of the study.

Group CAT

One study investigated the service user's experience of CAT delivered in a group setting (Ruppert, 2013). Qualitative data was collected through focus groups and analysed using template analysis. The results highlighted that service users found the diagrams and letters helpful. However, they reported that they needed more direction from those facilitating the group. This was particularly the case for recording exits on their diagrams. The author provided their epistemological position and discussed this in relation to the collection and analysis of the data.

Thematic Synthesis

The thematic synthesis of the data from the twelve papers yielded several themes and subthemes. A table is provided (Appendix 4) showing which papers the quotes came from, the themes and subthemes they support from the synthesis and the themes they were supporting within the original paper. The table was constructed to provide the reader with the original context of the quotes that have been extracted and used for the synthesis. An example section of a transcript of the quotes and corresponding codes is also provided (Appendix 5).

The superordinate themes and subthemes that emerged from the twelve papers were CAT tools (diagram, reformulation letter, goodbye letter and letters), experienced change (learnt to trust and personal changes), gaining knowledge and skills (learnt about patterns and learnt to do things differently), reflecting on the Process (endings, exits, expectations,

therapeutic relationship and the process), strong feelings and being in a group (Table 1).

Table 1: Superordinate themes and subthemes

Superordinate themes	Subthemes
CAT tools	Diagram
	Goodbye letter
	Letters
	Reformulation letter
Experienced change	Learnt to trust
	Personal changes
Gaining knowledge and skills	Learnt about patterns
	Learnt to do things differently
Reflecting on the process	Endings
	Exists
	Expectations
	Therapeutic relationship
	The process
Strong feelings	No subthemes
Being in a group	No subthemes

Theme 1: CAT Tools

This theme was related to the tools that are used in CAT.

The Diagram

This subtheme related to how helpful the service users found the diagram. Service users talked about how they felt when they saw the diagram and how they used it during therapy and after therapy. Some felt that the diagram was very powerful and helpful in understanding themselves. However, some reported that they experienced powerful negative emotions when they looked at their diagram or that they felt it did not change anything.

"No purpose. It was just his writing and you know you were just kind of looking at it" **suggesting it is the therapist's tool (not the service-user):** ***"A useful tool for him…an important part of his work"*****. (Sunita: extracted from Taplin, 2015).**

". . . if I have a big dip, or I feel, I start to feel a bit shaky, I'll go back to [the diagram] and try and 'right, what's this about, what's happening here?' **(Elaine: extracted from Rayner, Thompson & Walsh, 2011).**

Reformulation letter

The reformulation letter was reported to have helped provide a focus during therapy, increased the service user's understanding, helped in forming trust between themselves and the therapist and provided reassurance. However, service users also described strong emotions when hearing the reformulation.

"The other doctors listened, but I thought are they taking it all in, do they care…..At first I felt the same with my therapist but since iv had the reformulation **I had 100% trust in** ***her" (*****KI: extracted from Evans & Parry, 1996).**

The goodbye letter

The goodbye letter was seen as a tool to enable the service user to communicate things that they might not have said. It was considered to be an important and enjoyable experience.

"well our goodbye letter is obviously something I will keep for many years so it is very significant and important to me so keep it all as well" **(S: extracted from Ruppert, 2013).**

The letter

Service users describe letters in CAT as helping provide a structure for moving forward, feeling heard and listened to by their therapist. However, they could evoke strong emotions and were described as shocking. Some service users also reported reading it but never using it.

"A bit shocking really, because it was all problems, so it was problem had. i(didn't mention the g(H)d parts of my life. It was a summary of the bad parts, and it was a bit shocking. A bit of a jolt really" **(Mary: extracted from Shine & Westacott, 2010).**

Theme 2: Experienced change

This theme is about how service users reported how CAT had brought about change for them.

Learning to Trust

Some service users described how they became more trusting during and after therapy. However, not all service users felt like they could trust their therapist.

"it's about developing that trust" **(Elaine: extracted from Rayner, Thompson & Walsh, 2011).**

"Other treatment I've had in the past I've kind of built up a trust relationship you know… where I can, I feel as if I can tell you these things what are going on in my mind… and I didn't feel that with with my therapist, I didn't feel it at all… I felt as if he was the enemy and I was fighting that enemy". **(Ben: extracted from Taplin, 2015).**

Personal changes

Service users talked about how they experienced personal changes during CAT such as becoming more self-aware and having more self-compassion.

". . . like reading a very sad book. You have empathy for that person even though that person is actually you" **(Clare: extracted from Rayner, Thompson & Walsh, 2011).**

"*I demand perfection from myself and the only reason I demand perfection from myself is because my father always did; then it gives me the chance to say, well, other people aren't perfect. Nobody is perfect, in fact. So why should I be?"* **(Client 8: extracted from Fusekova, 2011).**

Theme 3: Knowledge and skills

Service users described how they had gained new knowledge and skills during CAT.

Learning about patterns

It was reported that learning about patterns was helpful.

"And you know it made me want to get in there and get it sorted because it'd . . . it did recognize what the problems were, it was on a bit of paper, you could break it down and sort it out . . ." **(Maggie: extracted from Hamill, Ried & Reynolds, 2008).**

Doing things differently

It was described that learning new strategies and ways of approaching things was helpful.

"It's like there's, a door is open to give you a model of trying to manage your life if you like." **(Elaine: extracted from Rayner, Thompson & Walsh, 2011).**

Theme 4: Reflecting on the process

Service users reflected on the process involved in the therapy itself and how they experienced these processes.

Endings

Service users described not wanting the therapy to end and were unsure about how they might cope afterwards.

"I did get to rely on the people too much (sp) I wanted it to go on forever (pause) it's not realistic (pause)" (**D: extracted from Ruppert, 2013).**

Exits

Service users talked about their knowledge and experience of exits in CAT which are new decisions that the service user can make to enable change.

"the will to change, in whichever way you decide to change your life, in work, and how you respond to people and communicate - [this] is in effect an exit" **(Client 2: extracted from Fusekova, 2011).**

Expectations

Service users described how they had expectations before the therapy began and how these changed over the course of CAT.

***"Thought the group would help me to kind of find an even keel instead of going in from one extreme to another all the time in my life I thought I'd find a happy medium.."* (R: extracted from Ruppert, 2013).**

Relationship with therapist

Service users talked about the experience of the therapeutic relationship including therapist style and approach to the sessions.

***"Open therapeutic style of the therapist and that some direction was provided when requested was helpful"* (open coded from Kellett & Hardy, 2014).**

General experience of the process

Being able to just talk to someone and not be judged was a key experience that was communicated. It was reported that the therapy felt real in terms of day-to-day life and it being time-limited was helpful.

***". . . and that's what I liked about the therapy it wasn't sort of up in the clouds you know, it was real in terms of your day to day activities"* (Sheila: extracted from Rayner, Thompson & Walsh, 2011).**

Theme 5: Strong feelings

Service users described how they experienced strong feelings during therapy. These feelings included feeling scared, worried, it being tough,

painful and upsetting. However, despite experiencing strong and difficult emotions, some service users reported that it was worth it.

***"I was frightened I couldn't do it myself"* – Elaine: extracted from Rayner, Thompson & Walsh, 2011).**

***"It was a range of emotions (pause) it was upsetting, it was (pause) as I said it was daunting, it was scary*. (Scott: extracted from Taplin, 2015).**

Theme 6: Being in a group

Being in a group became a theme due to experiences of a group setting being noticeably different from other experiences of CAT. These experiences were very specific to CAT being delivered in a group context such as enjoying meeting new people and helping each other. The reflective diary was particularly helpful in enabling the author to consider this difference.

***"I umm I enjoyed the people that I've met here very much and they put my issues in focus for me"* (B: extracted from Ruppert, 2013).**

Discussion

Summary of findings

The six themes that emerged from the thematic synthesis provided insight into the service user's experience of CAT across a collection of primary research. CAT tools were a consistent experience communicated by service users which is understandable given that tools such as the sequential diagram and reformulation letter are described as central aspects of CAT (Ryle & Beard, 1993). The theme of 'experiences of change' highlights how the goal of CAT, similarly to other therapies, is to encourage and achieve change in people's lives. 'Gaining skills and knowledge' was a consistently reported experience of CAT. There were many different types of knowledge and skills that people learnt throughout the course of therapy such as learning about unhelpful patterns and being able to do something different and more helpful. 'Reflecting on the process' emerged from the synthesis due to service users sharing their experience of the processes involved in the therapy such as the therapeutic relationship and endings. 'Strong feelings' were communicated across the studies synthesised. These feelings were powerful and related to different points during the therapy. Taylor & Loewenthal (2001) also found that service users reported strong feelings regarding psychotherapy such as 'nerve-wracking', 'unnerving' and 'frightening'. Finally, many experiences related to CAT delivered in a group setting were considered to be separate in content from other themes. This may be due to CAT in a group context being a particularly different experience in many ways to one-to-one CAT.

Strengths and Limitations of the review

This review integrated and interpreted the service user's experience of CAT across the available literature using rigorous methods for systematic review and synthesis. It entailed a comprehensive search of both published and unpublished research using a detailed set of criteria. Using unpublished research is a strength of this review as it has reduced the potential for

publication bias (Ferguson & Brannick, 2012). A service user and carer consultant with lived experience was involved in the thematic synthesis which increases the quality of this review. Furthermore, most of the studies included were of good quality. It is frequently suggested that qualitative data is not generalizable and is specific to a particular context, researchers, people, place and time. Therefore, the synthesis of qualitative papers can be contested in terms of it potentially decontextualizing the findings of individual pieces of research (Sandelowski & Barroso, 2007). However, actions have been taken to try to keep as much of the context of the data used for the synthesis available. This has been by providing the reader with a table of where the quotes for the synthesised themes came from and what theme they were supporting in the primary paper (Appendix 4). Furthermore, an example of how quotes were coded is also made available to the reader (Appendix 6). The reflective diary helped enable the researcher to consider their epistemological position and how this has influenced the analytical process. It also helped with reflecting upon how different group CAT and one-to-one CAT is experienced. The diary also enabled the researcher to consider their own potential biases and allowed the researcher to maintain a more balanced approach to the data.

The lower scoring papers tended to not take into account the relationship between the researcher and the participants and were limited in their acknowledgment of the researcher's active role analysing qualitative data. These papers were generally mixed-methods studies that had a small qualitative component. Another limitation of this review is that there were some papers that were not accessible due to there being an embargo on them or the author or database not making them available. Therefore, there is unfortunately some evidence of service user's experience of CAT that is absent from this present review.

Clinical implications

This review highlights how CAT Tools are experienced by service users and particularly how they can be both helpful in understanding themselves and

others but also have more unwelcome associations for some service users in terms of producing powerful negative emotions such as fear. It is important for formulations to be shared in a meaningful and collaborative way (British Psychological Society, 2008). However, some of the findings from this review also suggest that some therapists, possibly unintentionally, impose formulations upon service users. CAT tools have had mixed responses. Therefore, how these are developed, shared and what is included should be considered carefully. Some service users reported not looking at the CAT Tools outside of the therapy room. Therefore, findings suggest that there is a need for support in increasing the transferability of CAT tools to 'real world' contexts, that therapists make CAT tools a more central component of the therapeutic process and how to prepare service users for the emotional impact of reading the letters and the reformulation diagram.

This review highlighted how CAT brings about change for service users in a positive way such as learning to trust others and personal changes. These changes suggest that the service user's experience provides further evidence for the ability of CAT to produce positive change in people's lives. Furthermore, CAT could be a particularly useful approach for those who are struggling to trust others. The process was also reflected upon which highlighted the importance of not just the content of the approach but also how it is delivered. The strong feelings that service users experience when undergoing CAT can help therapists consider this further in terms of how the approach is delivered. Therapists should be aware of how worried and frightened service users can feel during the course of CAT and how they might be able to attend to the service user's emotional world more explicitly. Service users can experience high levels of shame and self-criticism. There might be times that levels of shame and persecutory feelings are too great and CAT might be contra-indicated. Therefore, it is important that CAT therapists adopt a hopeful and compassionate stance and tend to any ruptures in the therapeutic relationship. A more compassion-focused approach or an alternative approach might be more helpful. Finally, in a time and funding constrained NHS context it can be tempting to provide a group

rather than one-to-one therapy. However, this synthesis highlights that they are two different experiences for service users.

Areas for Future Research

Although the majority of the experiences reported in the reviewed papers were positive some minority voices were negative. Therefore, further research exploring negative experiences or outcomes of CAT could provide further insight. Investigating the factors that influence trust between the therapist and service users in CAT could be helpful due to trust being highlighted in this review. All of the papers reviewed did not involve service users throughout any of the research process. This is a concern as a service user and carers input is important if research is to more accurately represent the people it is intended to represent. Service user and carer involvement in research is considered vital for the production of high-quality research by a number of organisations (British Psychological Society, 2008; Health Research Authority, 2016). The reviewed studies only included service users with a single diagnosis or presenting difficulty. There is growing literature in terms of how ascribing labels to people can be unhelpful in terms of increasing both societal stigma and also feelings of shame and blame (Smail, 2015). Therefore, research that does not conform to the diagnostic medical model could in itself reduce stigma and blame. Furthermore, therapists are increasingly working with service users experiencing more complex difficulties that do not fit one diagnostic criteria. Therefore, there is a need for conducting research with people experiencing more than one severe and enduring difficulty rather than just one single diagnosis.

Most of the papers reviewed were co-authored by CAT therapists. These are therapists trained in CAT and could be considered to have an interest in positive findings. Therefore, research investigating service user's experience of CAT whereby all the authors are impartial in terms of whether the therapy provides positive or negative findings is important. None of the papers reviewed investigated the service user's experience of the course of CAT using IPA which could yield different findings as it enables the exploration of

idiographic, subjective experience and how individuals make sense of an experience. Therefore, it would be particularly suited to exploring an individual's experience of CAT.

Conclusion

This paper reviewed and synthesised research investigating service user's experience of CAT. The findings highlight how service users can gain an understanding of themselves but how it also evokes strong emotions. More research is needed to further understand the service user's experience of CAT for those with complex mental health difficulties.

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Chapter 2: Experiences of receiving Cognitive Analytic Therapy: for those with complex secondary care mental health difficulties

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ABSTRACT

Objectives

There is limited research on the service user's experience of CAT therapy. What is available has focused on service users with a single mental health diagnosis or where presenting difficulties have not been specified. Therefore the present research aimed to explore service user's experience of receiving CAT for those with complex secondary care mental health difficulties.

Method

Semi-structured interviews analysed using IPA, were used to explore the experiences of CAT therapy with service users with complex mental health difficulties. Service users (n=6) with complex mental health difficulties, who had accessed secondary mental health care services and who had received a course of CAT were interviewed about their experiences. Complex mental health difficulties were defined as service users who had more than one diagnosis or difficulty and where these diagnoses or difficulties were enduring and severe.

Results

The analysis yielded three superordinate themes with sub-themes within these which were changes due to CAT (Insight, personal gains, tools to cope and making changes), strong emotions (frustrated, scared and upset) and the process (being understood and accepted, ending therapy, therapeutic relationship and therapist attributes and approach). Participants described how CAT helped them gain insight and tools to cope. However, there were barriers to making changes and how there were strong negative emotions that could be evoked during therapy.

Conclusions

The findings of this study inform how CAT could be delivered to those with complex difficulties. Particularly in terms of considering the difficulties for service users to effect change and the emotional impact of CAT.

Keywords: Cognitive Analytic Therapy, service user's experience, complex mental health, psychotherapy.

Practitioner points

- CAT is useful for service users in gaining an understanding of themselves.
- Therapists need to foster a more compassionate approach during the formulation process and when trying to make changes.
- Therapists need to give attention to the service user's emotional experience and indications of ruptures in the therapeutic relationship.
- Therapists may need to also consider systemic working to increase the possibility of change for these service users.

Introduction

Cognitive Analytic Therapy: Theory and practice

Cognitive Analytic Therapy (CAT) is an integrative approach influenced by both analytic and cognitive models and is both collaborative and relational in nature (Kerr, 2005; Ryle & Kerr, 2002). The CAT model refers to Target Problem Procedures which are unhelpful patterns of thoughts, feelings, actions, events and relationships that are enabling the problem to be maintained (Ryle, 1979b). A target problem could be 'feeling anxious' which could then be underpinned by the problem procedure of feeling inadequate. Therefore, the aim is to feel admired so the person sets impossible standards for themselves, struggles to meet the high standards, becomes self-critical and becomes unwell. This leaves the person feeling inadequate and so then tries to do too much again.

All interventions used in CAT reference the formulation process with the reformulation diagram being a central part of the sessions (Ryle, 2004). Reformulation is the process of revising the formulation by accommodating and integrating new information that emerges during therapy. Reformulation in CAT is presented in either a reformulation letter or in the sequential diagrammatic reformulation which describes the unhelpful patterns that a person is engaged in (Ryle & Kerr, 2002; Kerr, 2005; Ryle & Beard, 1993). The concept of 'exits' is also an important element of CAT therapy. It refers to how a service user can leave the problem procedure and occurs during the revision phase. In CAT a goodbye letter is also written by the therapist to the service user and vice versa as a method of reflecting on the course of therapy.

Service user's experience of CAT

Previous studies have been conducted examining the service user's experience of CAT therapy. Three studies explored service user's experience of the full course of Cognitive Analytic Therapy (Kellett, Bennett,

Ryle & Thake, 2013**;** Kellett & Hardy, 2014; Tzouramanis et al, 2010). Service users mainly described a high degree of change due to receiving CAT (Kellett, Bennett, Ryle & Thake, 2013)**.** Tzouramanis et al (2010) reported that service users found having a new understanding of unhelpful patterns, being able to self-monitor, CAT being time-limited and the relationship with the therapist useful.

Four studies have focused their investigation on service user's experience of CAT Tools. Hamill, Ried & Reynolds (2008) identified that CAT letters enabled service users to make connections with themselves and others. However, Stockton (2012) found that the CAT letters did not contribute to the working alliance or to how helpful the therapy was. Rayner, Thompson and Walsh (2011) reported that the personal traits of the therapist, how comfortable they felt with the therapist and doing something practical rather than just talking were helpful. Taplin (2015) found the Sequential Diagrammatical Reformulation (SDR) helped service users with developing insight and to make sense of their experiences. It was described as a method for change and as a tool used both inside and outside of the sessions.

Two of the studies investigating service user's experience of the course of CAT involved service users only with a diagnosis of Personality Disorder or Panic Disorder (Kellett, Bennett, Ryle & Thake, 2013; Kellett & Hardy, 2014 & Tzouramanis et al, 2010). Furthermore, that focused on service user's experience of CAT Tools were comprised of service users with a diagnosis of Depression, Anxiety, Post-Traumatic Stress Disorder (PTSD) or different diagnoses. However, none of the studies had a sample of service users with reported complex mental health difficulties whereby they have more than one identified diagnosis or difficulties which are severe and enduring.

Four studies have explored phases in CAT such as the reformulation phase or the revision phase. Evans & Parry (1996) reported that the reformulation stage had a great impact on service users. Shine & Westacott (2010) described how service users felt listened to and understood during the

reformulation session. Reformulation was reported as being helpful in terms of service users understanding their patterns of thoughts and behaviours and in providing an opportunity to talk about the difficulties they have been experiencing. Furthermore, the SDR and the reformulation letter were reported as representing something tangible to take away. However, the theme of 'feeling exposed' encapsulated how service users felt uncomfortable for periods of the reformulation stage.

Fusekova (2011) identified important aspects of developing exits during the revision phase of CAT such as 'opening up new perspectives' and developing new ideas of exits. Finally, service users described how they would try out the planned exits and how one-off exits were considered helpful to service users. Sandhu, Kellett & Hardy (2017) identified stages within the revision phase which were becoming more self-reflective, recognising patterns, engaging in different roles and procedures and referring to the SDR for exits. However, none of these studies was conducted with service users with identified complex mental health difficulties (Evans & Parry, 1996; Fusekova, 2011; Shine & Westacott, 2010 & Sandhu, Kellett, & Hardy, 2017).

Taplin (2015) employed Interpretative Phenomenological Analysis (IPA). However, this study only explored the experience of the SDR. This could have meant that this study missed other experiences relating to receiving CAT. Shine & Westacott (2010) used template analysis. Rayner, Thompson & Walsh (2011) and Fusekova (2011) used grounded theory. Sandhu, Kellett & Hardy (2017) and Stockton (2012) employed content analysis. These methods of analysis may not have been an appropriate method for exploring experiences of CAT. An improved understanding of service user's experience could be achieved by employing a potentially more suited qualitative approach to investigating an experience such as IPA. This analysis method could explore people's experiences of the full course of CAT and how they make sense of this. Therefore, yielding rich themes that are located within the service user's experience and providing a more in-depth understanding of this experience.

The majority of the studies exploring service user's experience of CAT were authored by qualified CAT therapists (Evans & Parry, 1996; Hamill, Ried & Reynolds, 2008; Kellett, Bennett, Ryle & Thake, 2013**;** Kellett & Hardy, 2014; Rayner, Thompson & Walsh, 2011; Sandhu, Kellett & Hardy, 2017 & Shine & Westacott, 2010). This may have introduced a bias into the conduct of these studies due to the potential for the authors to have a professional interest and need for service users to have a positive experience of CAT. It is unclear whether authors that were not identified as being CAT trained have received this training as this information may not be available. Service user involvement is now considered to be vital in the conduct of high-quality research (British Psychological Society, 2008; Health Research Authority, 2016). Taplin (2015) is the only study that has had service user involvement. However, this study only explored the experience of the SDR and not the full course of CAT.

None of the current studies investigating service user's experience of CAT has been with those with complex difficulties. Complex mental health difficulties can be defined as having more than one enduring and severe mental health difficulty or diagnosis (Rankin & Regan, 2004). Furthermore, the experiences reported by service users with complex mental health difficulties may differ. Studies investigating service user's experience of CAT vary in terms of the focus of the investigation, sample characteristics and the method of analysis used. However, there are currently no studies investigating service user's experience of the full CAT course, using Interpretative phenomenological analysis, having service user involvement, with authors that are not CAT trained and with those with complex mental health difficulties in a secondary care mental health setting rather than a reliance on diagnostic labels that could be experienced as stigmatising.

Research question: What are the experiences of receiving Cognitive Analytic Therapy: for those with complex secondary care mental health difficulties?

Method

Design

This study employed a retrospective qualitative design by conducting semi-structured interviews and using Interpretative Phenomenological Analysis (IPA) to analyse the interview transcripts.

Ethical approval

Before conducting this study, ethical approval was obtained from the Staffordshire University ethics committee, NHS Wales Research Ethics Committee 5, the Health Research Council and NHS Trust research and development (appendix 19, appendix 20, appendix 21 and appendix 22). A minor amendment to broaden recruitment to private practice was also approved by Staffordshire University ethics committee, which is now called the Midlands Partnership NHS Foundation Trust (MPFT) (appendix 23). Recruitment was broadened to the Association of Cognitive Analytic Therapy (ACAT) to enhance recruitment opportunities.

Recruitment procedures

Participants were recruited using purposive sampling due to the emphasis of IPA in exploring the experience of a given phenomenon (Smith & Osborn, 2003). In this study, the phenomenon is a course of CAT with an approximate duration of 24 sessions. All participants recruited had experienced a course of CAT and had complex mental health difficulties making it a homogenous sample. Therapists trained or currently training in CAT were contacted by the researcher either through MPFT or through ACAT to ask if they would be willing to identify potential participants. Therapists were either working for MPFT or working privately with service users with complex mental health difficulties. Complex mental health difficulties were defined as having more than one mental health difficulty or diagnosis such as relationship difficulties and anxiety and that both of these

were enduring and severe. Recruiting those with complex mental health difficulties aimed to reduce reliance on potentially stigmatizing diagnostic labels.

Six therapists located across different services and two different counties in the UK identified potential participants. They were provided with information about the study along with the inclusion and exclusion criteria and were asked to identify potential participants based on these criteria. The full details of the inclusion and exclusion criteria can be found within Appendix 24. Participants were given a pseudonym and identifiable information was removed from any quotes used. These steps were taken. These steps were taken to limit the likelihood of participants being identified.

Once potential participants were identified the therapists posted an invitation letter (Appendix 10), opt-in slip (Appendix 12) and participant information sheet so they had time to consider the study (Appendix 11). A prepaid envelope was also sent to the service user. The opt-in slip asked if they would like to be contacted by the researcher regarding the study. Once the researcher received a completed opt-in slip contact was made with the potential participant to organise a time and date to meet to provide more information about the study. The researcher provided the potential participant with the participant information sheet to read through again and given time to ask any questions (Appendix 11). Following this, if they wanted to take part in the study, the potential participant was given a consent form to complete (Appendix 13) before participating in the interview on the same day.

Sample characteristics

The participants were five females and one male aged between 25 and 47 years and all were White British (Table 2). Participants had received CAT from 1 month to 11 months before to taking part in the interview and received between 17 and 32 CAT sessions. All participants presented with complex mental health difficulties and had accessed secondary care mental health services within the NHS. There were no participants in the sample from

therapists working privately. Complex mental health difficulties within this study are defined as a person presenting with having multiple mental health diagnoses or difficulties and that these are profound, serious, enduring or intense (Rankin & Regan, 2004).

Table 2: Sample characteristics

Pseudonym	1. James	2. Becky	3. Claire	4. Kate	5. Jane	6. Stacey
Gender	Male	Female	Female	Female	Female	Female
Age (Years)	25	34	38	46	26	47
Ethnicity	White British	White British	White British	White British	White British	White British
Number of CAT sessions	17	20	24	32	24	27
Completed CAT	2 months ago	8 months ago	11 months ago	1 month ago	2 months ago	1 month ago

Interviewing procedure

Individual interviews were conducted within the service where the participant received the therapy. They lasted approximately one hour in duration with a range of 57 minutes to 60 minutes. The interviews were semi-structured and so were guided by an interview schedule (Appendix 14). This schedule was developed based on CAT theory and practice, the current literature concerning CAT and service user's experience of CAT and psychotherapy in general. Some thought was given to what may be absent from the literature in service user's experience of CAT such as their experience of any ruptures in the therapeutic relationship and their experience of how these were resolved if they were. The schedule was developed through consultation with the research team. A service user and carer consultant who has lived

experience of being a service user and a carer was a co-researcher in this study and so also helped to develop the interview schedule.

During the interview, the schedule was used as a guide for the researcher if needed. The interviewer privileged the participant's experiences and followed the direction of conversation that the participant was taking. The main question was 'Can you tell me about your experience of receiving Cognitive Analytic Therapy?' Following this question, the interviewer would further explore what the participant was saying. The remaining questions on the schedule were used as prompts if needed. These typically explored specific techniques in CAT such as thoughts about the therapy in general, CAT tools and techniques, changes due to the therapy, things that were helpful and not helpful, the therapeutic relationship and ending therapy. Although these prompts were sometimes used, the interviews were inductive in nature. The interviewer adopted a position of curiosity and positioned themselves as de-centred. This enabled the participant to guide the direction of the conversations. The interviewer would further explore the participant's experiences to gain a richer description and insight into the experience of receiving CAT. The interviews were audio-recorded and subsequently transcribed verbatim by the interviewer.

Ethics

Before conducting the interview the interviewer provided a brief introduction to the study. They were then provided with the information sheet for the potential participant to read and gave them time to ask questions about the study. Following this, the willingness to take part in the study was confirmed. Written consent was then obtained (Appendix 13) and a demographic information sheet completed by the participant (Appendix 15) before taking part in the interview. The demographic sheet gathered information on gender, ethnicity, the number of CAT sessions received and when the therapy finished. Information regarding diagnoses or difficulties were not recorded as the sample were all included based on having complex mental health difficulties. It was considered that interviews may explore emotive and

sensitive subjects and so the participants were made aware that they could talk to a member of their care team and also signposted to the appropriate agencies or professionals if needed. All participants were open to services which allowed for managing any risks that arose during and after participation. Participants were also given the opportunity to inform the researcher of how they found the process of taking part in the study and were made aware that if they requested to review and comment on the transcript they were able to do so. However, none of the participants requested to review their transcript.

Feedback from Participants

Participants were contacted following the completion of the interview by phone to ask how they found taking part in the study. Participants reported how they were unsure whether they were providing the correct information but also how the interviewer put them at ease.

Data analysis

The data was analysed using Interpretive Phenomenological Analysis (IPA) by following the stages outlined in Smith, Flower and Larkin (2009). This form of analysis is well suited to psychological research as it is concerned with the way humans construct and understand their experiences. IPA enables the exploration of idiographic subjective experience and how individuals make sense of an experience. Therefore, IPA is particularly suited to this study as the aim is to explore individuals experience within a psychological context. Furthermore, this study aimed to understand how individuals have made sense of their experience of CAT. IPA allows the researcher to explore experiences in an inductive 'bottom-up' approach (Smith, Flower & Larkin, 2009). This enabled the researcher's biases and preconceived assumptions regarding therapy and CAT to be acknowledged.

The data was analysed by one researcher so that the epistemological position of the researcher could be fully considered and reflected upon.

However, some themes and subthemes were also cross-checked by a fellow doctorate student and two co-authors. One of which is a service user and carer consultant with lived experience. This also enabled the researcher to consider different ways to most effectively capture the themes by changing the labels of themes or moving some subthemes into other superordinate themes that encapsulated a particular experience more. There is some debate in the literature regarding cross-checking themes in IPA due to the nature of the analysis reflecting a double hermeneutic process (McConnell-Henry, Chapman & Francis, 2011). However, the researcher decided that cross-checking themes enabled the study to be more explicit and open to consideration by others. The researcher believes that a person cannot fully 'bracket off' their perspective and experiences and therefore the researcher instead provides an insight into how the findings developed which is a tenet of IPA (Smith, Flower & Larkin, 2009).

The researcher followed the steps outlined by Smith, Flower and Larkin (2009) to analyse the interview transcripts. The researcher began the process by reading and re-reading the interview transcripts to familiarise themselves with the data and to become immersed in the data. The researcher then went through each transcript and made exploratory comments on the transcript, for example, highlighting things that struck the researcher as important or interesting. Following this, the researcher then began to identify emergent themes and then connections between the emergent themes. This process resulted in the superordinate themes which included several connected sub-themes within each superordinate theme. For example, a section of one transcript was: *'And just sort of stumbling across memories and the way (the therapist) managed to fit them all together to put a sort of pattern together was quite….eye opening really.'* The exploratory comment made was: 'Service user gained insight.' The emergent theme was 'Insight'. This emergent theme was connected to the emergent themes of personal gains, tools to cope and making changes. These connected emergent themes were labelled as 'Changes due to CAT'. Therefore, 'changes due to CAT became a superordinate theme which encapsulated these connected emergent themes and which became the sub-

themes. The researcher changed a theme label based on discussions with the researcher's supervisor, for example, the researcher changed the label of an emergent theme from 'gaining understanding' to 'insight' in order to better encapsulate the experience reported. Furthermore, 'being understood and accepted' was an emergent theme that was moved from 'changes made due to CAT' to the superordinate theme 'the process' as after reflection this was interpreted as a part of the therapy process experienced rather than a change. Further examples of emergent themes and connecting themes are presented alongside a transcript which also includes exploratory comments in appendix 17. A table including the subthemes, themes and quotes is also provided so that the reader can make sense of the researcher's interpretations (Appendix 18).

Researcher position and reflexivity

Research reflexivity is key to being able to fully engage with the participant's experience (Larkin & Thompson, 2012). Therefore, the researcher used a reflective journal to reflect upon their own experiences and assumptions and how those could be influencing the analysis of the data. IPA takes the perspective that the researcher is trying to make sense of how the participant makes sense of the world. This is also known as a double hermeneutic (Smith, Flower & Larkin, 2009). IPA encourages the researcher to document the sense-making process in terms of how the researcher made sense of the participant making sense of their own experiences. The researcher read the transcripts multiple times and during this made notes (Appendix 17). This enabled the researcher to immerse themselves in the data. These initial notes consisted of the researcher's observations, reflections and anything that seemed significant. At this stage, the researcher was focusing on both the content of the interviews but also on personal reflectivity.

The researcher interpreted the data through a critical psychology lens but also as someone who had limited experience and knowledge of CAT. Therefore, the data was interpreted and made sense of through the lens of these perspectives. As a Trainee Clinical Psychologist, the researcher has

previously been familiarised with various psychological models and perspectives. The researcher had some awareness of CAT theory and practice. However, they had never delivered this approach. Before becoming a Trainee Clinical Psychologist, the researcher had been involved in some CAT informed formulations but never used the course of CAT. In addition, the researcher conducted a systematic review of research exploring service user's experience of CAT. The researcher considered how this review of other reading relating to CAT had influenced the emergence of the themes within this study.

The researcher took the perspective of constructivism in which each person makes sense of their experiences in their own way. The epistemological position taken during the analysis process was of Interpretivist whereby the researcher interpreted how the participant made sense of their experience of CAT. Throughout the process, the researcher kept a reflective journal to help consider the views and perspectives of the researcher and how this was influencing the analysis process. The researcher did not attempt to 'bracket off' their own perspectives as described in Smith, Flower & Larkin (2009). This was a conscious decision made by the researcher as they believed that this is not truly possible to do and that the researcher's views and perspective will always influence the analysis process. Therefore, the researcher attempted to document how their perspective influenced the analysis by considering their professional role as a trainee clinical psychologist who is training in delivering therapeutic interventions to service users. Furthermore, how the researcher did not have experience of receiving therapy themselves and how this would impact on the analysis process.

Results

The analysis yielded three superordinate themes with sub-themes within these which were changes due to CAT (Insight, personal gains, tools to cope and making changes), strong emotions (frustrated, scared and upset) and the process (being understood and accepted, ending therapy, therapeutic relationship and therapist attributes and approach). These superordinate themes and interrelated subthemes are detailed in Table 3. The occurrence of each superordinate theme and subtheme across participants can be seen in appendix 18.

Table 3: Superordinate themes and subthemes

Superordinate themes	Subthemes
Changes due to CAT	Insight
	Personal gains
	Tools to cope
	Making changes
Strong emotions	Frustrated
	Scared
	Upset
The process	Being understood and accepted
	Ending therapy
	Therapeutic relationship
	Therapist attributes and approach

These themes represent how the participants of this study perceived and understood their experiences of CAT. Quotes from the transcripts have been used to illustrate the themes and ground them within the participant's

experiences of CAT. Experiences that differ between participants have also been detailed and discussed.

Theme 1: Changes due to CAT

The superordinate theme of 'changes due to CAT' encapsulates several subthemes which relate to service users gaining insight into the difficulties they were experiencing, direct gains post-therapy, learning about different tools that they could use to cope and generally trying to make changes in their lives. All six participants contributed to this superordinate theme.

Insight

Service users reported on the experience of developing an understanding of past events and their relationships but also how these link to current patterns of thoughts and behaviours. Service users also described how they had a better understanding of current triggers to these patterns. All six participants contributed to this subtheme.

"I think it was a lot of the bullying at school but it sort of dug a lot deeper than that just top layer. And you don't realise that that's actually affecting you forty seven years later" **(Stacey).**

"No definitely more independent in that I found that it helped me understand my brain and recognise triggers" **(Claire).**

Personal gains

This subtheme describes the things service users have gained in their lives from receiving CAT. These were things that were described as being a direct result of the therapy. Four participants contributed to this subtheme.

"…..yep…I feel a lot calmer in myself. I feel like before the therapy I was 100 million miles per hour all the time like constantly worrying and

panicking all the time. I do feel like I'm a lot calmer now." **(Jane).**

Tools to cope

This sub-theme consists of how service users reported using specific tools that they learnt from having CAT. It was reported that these tools are being used post-therapy to help service users cope. All six participants contributed to this subtheme.

"Erm but I think that particular model that you you've got to have your own bag of tools to deal with things in your life as well" **(Claire).**

"Then I'd ask myself what would the tools do….I know the importance of talking now….Whereas in the past I wouldn't have addressed id be like well let's get rid of that that's not nice. Now I address and I say right well I need to talk to someone about this so I might talk to one of my friends" **(James).**

Making changes

This sub-theme consists of service user's reports of how they had tried to make changes in their lives during and following CAT. Service users had mixed experiences of being able to make changes with some reporting being able to do things differently. However, some described how translating knowing what they need to change and being able to make these changes were difficult and unachievable. All six participants contributed to this subtheme.

"Erm…it was talked about…erm but again it seems like something that nobody seems to have the answer for. It's like I said to you it's like knowing that that's what you need to do but being able to do it is completely it's completely different" **(Kate).**

"He used to send me messages and I used to think oh god and just press the button. Then we actually spoke at the weekend first time probably for five years reasonably. So and I think it's changed the relationship" **(Stacey).**

Theme 2: Strong emotions

Most service users reported experiencing strong emotions throughout the course of the therapy and particularly during different stages or aspects of CAT. All six participants contributed to this superordinate theme.

Frustrated

Service users reported how they felt frustrated throughout the course of the therapy but mainly during times when service users would know that they needed to stop a pattern but felt unable to do so. Three participants contributed to this subtheme.

"it got me to the point where some weeks frustrated because I kind of knew what the steps where and I kind of let myself……and tried to make everything perfect and almost cross with myself that I didn't recognise it earlier" **(Claire).**

"And it's quite frustrating when I'm identifying that I'm dismissing myself…you know….that's **what I'm doing and then well that's what I do that's how I work and I don't really know a different way" (James).**

Scared

Some service users reported feeling scared during CAT. This was specifically with telling the therapist things about themselves and what they might think of them but also how it was scary the thought of having to make changes. Two participants contributed to this subtheme.

"erm but I think after so many years it's so hard to you know we've not just been together for a couple of years we've been together all my adult life and to suddenly to start changing things now it's really scary and….I don't know.." **(Kate).**

"that's key because your scared this is the first time you've told anyone any of this and it's like oh my god what's she gonna think. What's anyone going to think about this. And then when it's okay it's kind of okay and erm you realise okay well maybe it's not so bad. Maybe these thoughts and feelings are not so terrible." **(James).**

Upset

Service users reported feeling upset during the course of CAT. This was mainly when they would be reading the reformulation letter or sequential diagrammatical reformulation and feeling upset about the unhelpful patterns that had been identified. Five participants contributed to this subtheme.

"Erm I felt sad initially like when I read it I felt if I was reading about someone else I would have felt like god that poor person they feel so rubbish and have had all these things happen" **(Jane).**

"I would say it was quite upsetting actually which sounds really quite stupid erm. I remember getting a bit teary over erm you know some of my themes and that erm. I think it was more admitting to having those feelings erm yeah." **(Becky).**

Theme 3: The process

This superordinate theme encapsulates experiences of the process involved in CAT such as the therapist understanding and accepting service users

through using CAT tools such as the sequential diagrammatical formulation and the relationship with the therapist. All six participants contributed to this superordinate theme.

Being understood and accepted

This subtheme represented how service users described being understood by the therapist and how the therapist accepted them. The sequential diagrammatical formulation showed service users how the therapist had understood and accepted them. All six participants contributed to this subtheme.

"It's nice to have someone say it's not all your fault. There are so many contributing factors to why we are here" **(Jane).**

"They maybe identify the reason and say well maybe you do that because of this and that makes it very nice because you feel like someone's understanding you and accepting you and then helping you which is all part of the process of CAT and what I think is very useful about CAT" **(James).**

Ending therapy

Some service users reported how when coming to the end of CAT they found the goodbye letter helpful in being able to reflect on the progress that they had made and give hope for the future. The follow-up sessions were described as helpful but that there needed to be more. Five participants contributed to this subtheme.

"combined with my letter and thinking about it and realising and then her letter as well I was thinking it did give me a bit of a boost. I was thinking okay I can actually do this I'm going to be okay." **(Becky).**

"I don't know whether I would have liked a few more follow up sessions

even if it was just checking in a couple of times over the next year." **(Claire).**

Therapeutic relationship

Service users reported on the quality of the relationship that they had with the therapist. Many reported on how important it was for them to feel that they could trust them which was something that grew during the course of CAT. All six participants contributed to this subtheme.

"It's very much a relationship, a therapeutic one at that, and it's very much a you know you end up trusting this person because you feel like they understand your thought processes when they analyse them" **(James).**

Therapist attributes and approach

There were differences reported in terms of each therapist's approach and attributes in terms of the delivery of the therapy. Some service users reported the therapist being very non-judgmental and accepting. Some service users reported on varied ways the therapist delivered CAT such as using analogies often which was not reported by other service users. All six participants contributed to this subtheme.

"Yeah no definitely it's really important that she was you know good and none judgmental and accepting and all the good things she did and…" **(James).**

"so we used quite a lot of analogies so one of mine was I felt like I was erm drowning in the sea and there was a boat and I couldn't get into it and she helped me change my mind set so I felt like I had to either get people to pull me into the boat because I was drowning or drown…there was no other way. And then we started to look at….could we…..come round the boat this way and get in." **(Claire).**

Discussion

Key findings

Participant's accounts of their experiences were analysed using IPA. Following this, three superordinate themes emerged which were changes due to CAT, strong emotions and the process. Key findings are now described and discussed with reference to the current literature relating to CAT and psychotherapy. Furthermore, the strengths and limitations of this study are discussed followed by the implications for clinical practice and recommendations for future research.

Changes due to CAT

The findings highlight mixed experiences of change. Individuals in this study described gaining an understanding of their past experiences and current triggers and unhelpful patterns through using CAT tools such as the SDR and during the reformulation phase. These findings are consistent with findings from previous studies exploring service user's experience of CAT (Rayner, Thompson & Walsh, 2011; Shine & Westacott, 2010; Sandhu, Kellett & Hardy, 2017; Taplin, 2015). Shine & Westacott (2010) reported that service users experienced a further understanding of themselves. Sandhu, Kellett & Hardy (2017) also reported that service users had developed an observing self through receiving CAT. However, in the present study, some participants reported that they were unable to make changes both during and after receiving CAT due to there being systemic factors such as difficult family dynamics or lack of support from those around them. Interestingly, there is no evidence of difficulties making changes within the current literature exploring service user's experience of CAT.

This study also identified how service users have been given tools to cope. Some individuals felt that the tools helped them cope better and how they were able to make changes such as trying something different like talking to a friend. This is consistent with the findings from Shine & Westacott (2010)

about how service users found having something tangible to use such as tools to cope was helpful. Sandhu, Kellett & Hardy (2017) also identified how service users described breaking away from old patterns by developing and using new roles and procedures and applying a range of methods to support and maintain change in their lives.

Strong emotions

Service users described experiencing feeling strong emotions during the course of CAT and specifically during the development of the SDR and when trying to make changes in their lives. Participants specifically described feeling frustrated, afraid or upset at these times. Although some service users did report that the strong emotions that they felt were worth it, not all service users reported this. These findings are consistent with some of the available literature on experiences of CAT. Evans & Parry (1996) found that service users reported that the reformulation aspect of CAT was overwhelming and frightening. There have been some studies where the quotes included within the article have indicated strong feelings, for example, *"I was frightened I couldn't do it myself"* (Rayner, Thompson & Walsh, 2011) and *"it was a range of emotions (pause) it was upsetting, it was (pause) as I said it was daunting, it was scary* (Taplin, 2015). Rayner, Thompson and Walsh (2011) also identified negative emotions evoked whilst receiving CAT. The study reported that participants described CAT as being a 'painful emotional process'. Chadwick, Williams, & MacKenzie (2003) reported that service users described a negative emotional reaction when having a formulation shared with them when receiving CAT. However, no further literature can be found regarding any negative effects of CAT. Hardy et al (2019) investigated the factors associated with service user's negative experiences of therapy. They identified that there was a lack of fit between the service user's needs, therapist skills and the structure of the service. This lack of fit could result in problems with containment and power and control. Finally, a meta-synthesis of the negative effects of therapy has been recently reported by Curran, Parry, Hardy, Darling, Mason & Chambers (2019). The meta-synthesis identified negative feelings and feeling worse as

an adverse effect of the therapies reviewed. Negative feelings described by service users were self-blame, hatred, doubt, guilt, and shame. The literature highlighted relationship factors involved whereby the therapist is un-attuned to the service user's emotions. In another study reviewed service users thought that the therapist did not help them to adequately work through feelings that had been evoked during the therapy. Furthermore, negative feelings were caused when the service user's expectations of the therapist were breached.

The process

Participants reported their experience of the processes involved in CAT. Service users found that being understood and accepted by the therapist was particularly helpful which is also reported in other studies. Evans & Parry (1996) highlighted how service users reported how the reformulation showed them that the therapist had listened and understood them. Shine & Westacott (2010) also identified how service users felt accepted by the therapist. Ending CAT was considered difficult with some reporting that they felt that they needed more time. Some service users also described how the goodbye letter was particularly helpful which has also been highlighted by Ruppert (2013) as a method of sharing things that they had not been able to share previously.

The therapeutic relationship was seen as important in terms of being able to trust the therapist. This was seen as important by service users in being able to share their experiences with the therapist. Hamill, Ried & Reynolds (2008) highlighted how service users developed a connection with the therapist based on the development of trust. Ackerman & Hilsenroth (2003) conducted a review of therapist qualities and techniques and therapeutic alliance. The review covered a variety of therapeutic approaches and concluded that therapist characteristics such as being flexible, honest, respectful, trustworthy, confident, warm, interested, and open were found to contribute positively to the alliance. This review indicates that the therapeutic alliance is central to all therapeutic approaches, not just CAT. Therapist attributes and

approach was something that participants reported on and highlighted how different therapists have different personal characteristics and approaches within the framework of CAT. The SDR was experienced as a CAT tool that helped service users feel understood and accepted and the ending letter helped manage the transition process.

Methodological strengths and limitations

These findings are based on a small sample of service users who agreed to be interviewed. Furthermore, this was a predominantly female sample with only one male. Therefore, this study represents the experiences and perspectives of this particular group of people. The findings of this study provide an insight into the service user's experience of CAT rather than findings that can be generalised to other individuals with an experience of CAT. Those that participated in this study had varied experiences of CAT as highlighted within the data. IPA acknowledges ideographic experiences but also that experiences are shared due to being human and how individuals are in similar situations and contexts (Smith, Flower & Larkin, 2009). However, this study may help to identify features of the experience of CAT that are specific to service users with complex mental health difficulties.

The researcher kept a reflective journal and reported on their influence on the data during analysis. Providing the reader with an understanding of the researcher's position and how this may have influenced the findings is a strength of this study. The authors of the present study were not CAT trained and so this is a strength in terms of reducing bias in the conduct of this research. However, it is important to highlight that the researcher was not involved in the identification of the potential participants due to ethical reasons relating to data protection. As a result, the therapists may have identified service users that had a positive experience of CAT. Therefore, selection bias may have influenced this study.

A service user with lived experience was involved at all stages of the research from the development of the study topic, to the interview schedule

and analysis. Validation has been considered a controversial area in IPA research. However, researchers are beginning to integrate methods such as IPA and action research to enable a more community and co-produced focus. Flower and Eatough (2019) are currently researching Depression in young people using IPA and with a high service user involvement in design and feedback.

Implications for clinical practice

There is evidence that CAT helps enable service users to gain an understanding and awareness of their past experiences and current problems. However, CAT can evoke strong negative emotions in service users. Therefore, therapists need to be highly mindful of the potential for this to occur when delivering CAT and perhaps this needs to be more explicitly discussed with service users at the outset and as part of the consent process. Evoking strong negative feelings in already vulnerable service users could compromise the ethics of the therapy. Service users who may be struggling to regulate their emotions may be encouraged to feel emotions that are too powerful which is potentially leading them to feel unsafe. Alternatively, CAT therapists could manage these negative effects during the session. This is most important when developing and sharing the diagrammatical reformulation or formulation letter with service users or discussing ways of making changes in their lives. CAT therapists could try to be mindful of the potential for shame and frustration linked to difficulties making changes. Perhaps it would be more helpful to normalise these feelings and re-contextualise why change may be difficult whilst also adopting a hopeful position about the potential for achievable change. Therapists could also explore the potential for other agencies to support change if there are more systemic issues and ways to work systemically following receiving CAT. Furthermore, therapists focusing more on containment and safety issues, especially if negative emotions could lead to dissociation for service users who have complex mental health difficulties as a result of trauma could be helpful. It may also be useful for the therapist to explore how much they are part of a reciprocal role when service users are

experiencing negative feelings. This could also perhaps be sensitively explored within the sessions or during supervision. Bradley (2012) highlighted the potentially distressing experience of looking at the sequential diagrammatical reformulation (SDR) in CAT. Bradley, Cox and Scott (2016) further explain how the SDR was developed based on a deficit and disease model of mental health which focuses on symptom reduction rather than building on strengths. To address the potential for service users to become overwhelmed by the SDR, Bradley, Cox and Scott (2016) describe the use of a hopeful diagrammatical reformulation diagram (SDR). A hopeful SDR aims to build on the strengths that a person has by mapping out healthy relationships rather than pathologizing them. It integrates ideas from compassion focused therapy such as attempting to activate a more compassionate emotional regulation system. CAT therapists may be able to minimise strong negative emotions by using a hopeful SDR alongside the traditional SDR.

Finally, therapists need to consider the limitations of CAT in terms of bringing about change in people's lives. This study highlighted how service users find it difficult to make changes despite gaining an understanding and awareness of why and how changes need to happen. Therefore, with people with complex difficulties, it might be that a more systemic approach would be more useful. This could be due to their being potentially toxic environmental factors that are impacting on the service user's ability to make changes. Family members resisting any changes that the service user is trying to make and wanting a service user to stay within a certain reciprocal role was experienced. Combining CAT with systemic approaches may be more helpful to this group or a systemic approach on its own may be more helpful. In situations when service users do not have an understanding of their current difficulties and relational difficulties, individual CAT work may be helpful with this before then moving to more systemic approaches. Combining CAT with systemic working has been detailed by Gray (2006) whereby a service user's partner was also seen by the therapist. The partner had one to one sessions and also sessions with the therapist. He also was given his own reformulation letter, SDR and goodbye letter. Both the service user the

partner would look at their SDRs between sessions and Gray (2006) reports that this seemed to be helpful for both of them. The paper described working with several couples and reported that the couples gained a better understanding of each other and found ways to be happier together.

Future research

Investigating service user's emotional responses to CAT and CAT tools may provide more information on the extent that this is an issue and when and how these emotions are evoked. Furthermore, research interviewing both service user and therapist pairs exploring emotional responses to CAT could provide further insight. Conducting research with service users who have not been able to make changes in their lives following CAT could provide more insight into service user's experience of this and its prevalence. Research investigating therapist's responses to service users experiencing strong emotions could provide insight into what helps with managing service user's emotions. Studies investigating service user's experience of CAT using a more integrative approach by combining systemic, compassion focused therapy and CAT may also provide insight into how service users experience CAT integrated with other approaches. Finally, it is important to note that CAT is a dialogic process and that the experience of therapy for the service user and therapist alongside one another could also be a useful area for future research.

Conclusions

Service users described gaining an understanding of their past and their current problems, experiencing strong negative emotions and having mixed reflections with regards to being able to make changes in their lives. This study emphasises the importance of CAT therapists offering containment, adopting a compassionate stance and considering the impact of systemic factors on the ability for service users to make changes when working with this population.

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Chapter 3: Executive summary of experiences of receiving Cognitive Analytic Therapy: for those with complex secondary care mental health difficulties

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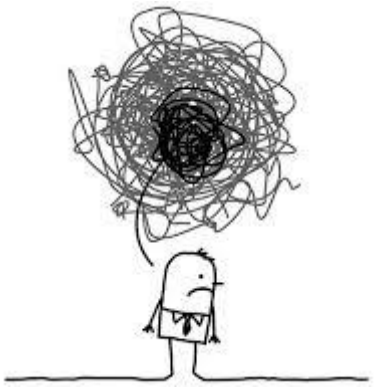
Why the research was done

Cognitive Analytic Therapy

Cognitive Analytic Therapy, also known as CAT for short, is a collaborative psychotherapy approach (Kerr, 2005). It looks at difficulties with relationships with others and yourself and on problematic repeating patterns of thoughts, feelings, actions, events and relationships that are keeping the problem going (Ryle, 1979b).



CAT uses a range of tools to map out a person's problems and these repeating patterns such as a reformulation diagram and letters (Ryle, 2004).

Some research has looked at the service user's experience of Cognitive Analytic Therapy (CAT). Within these studies, service users have reported that the reformulation helped them understand themselves and feel listened to and accepted. However that it was overwhelming, frightening and exposing (Evans & Parry, 1996; Shine & Westacott, 2010; Rayner, Thompson & Walsh, 2011).

The majority of the studies exploring service user's experience of CAT were done by qualified CAT therapists. This may have made the research biased with the researchers trying to look for positive experiences of CAT. Also, none of the studies investigating service user's experience of CAT has been with service users experiencing complex mental health difficulties.

This study aimed to explore the service user's experience of CAT with service users who were experiencing complex mental health difficulties.

What we did

Procedures and sample

Interviews took place with six service users who had experienced complex mental health difficulties. Five service users were female and one was male aged between 25 and 47 years. The average number of sessions of CAT received was 24 sessions. The period between completing a course of CAT and taking part in this study was between 2 months and 11 months ago.

Data analysis

The interviews were analysed using Interpretive Phenomenological Analysis (IPA) (Smith, Flower & Larkin, 2009).

What we found

We found that CAT has the potential to cause strong negative emotions, that CAT tools help generate change, that change for some participants is hard especially if their social network is unsupportive or others need to change too and service users don't have the power to influence this.

Changes due to CAT

Service users talked about developing an understanding of past events and current patterns, experiencing personal gains like feeling different, learning new tools to cope and how they had tried to make changes in their lives but how this was also difficult to achieve for some.

***"I think it was a lot of the bullying at school but it sort of dug a lot deeper than that just top layer. And you don't realise that that's actually affecting you forty seven years later"* (Stacey).**

.

Strong emotions

Service users talked about how they felt frustrated, scared and upset at points during therapy and particularly when putting together the sequential diagrammatical reformulation, otherwise known as the map, or when trying to make changes.

***"And it's quite frustrating when I'm identifying that I'm dismissing myself……that's* what I'm doing and then well that's what I do that's how I work and I don't really know a different way" (James).**

The process

Service users described being understood by the therapist and how the therapist accepted them, finding the goodbye letter helpful, the importance of the relationship with the therapist and commented on the therapist's approach and attributes.

***"It's nice to have someone say it's not all your fault. There are so many contributing factors to why we are here"* (Jane).**

What this means

This study explored the experience of receiving Cognitive Analytic Therapy (CAT) with people who were experiencing complex mental health difficulties. Three themes emerged which were changes due to CAT, strong emotions and the process.

The findings highlight mixed experiences of change. Individuals in this study described gaining an understanding of their past experiences and current triggers and unhelpful patterns by using the map and during the reformulation phase. This study also identified how service users were given tools to cope and also tried to make changes in their lives due to receiving CAT.

Service users described feeling strong emotions during the course of CAT. These emotions tended to be frustrated, scared or upset during the reformulation or when trying to make changes. Some service users did report that the strong emotions that they felt were worth it. However, not all service users reported this. Service users found that being understood and accepted by the therapist as particularly helpful.

Ending CAT was considered difficult with some reporting that they felt that they needed more time. Some reported how the goodbye letter was particularly helpful. The therapeutic relationship was seen as important in terms of being able to trust the therapist which seems common for all therapies but may be enhanced by some of the tools unique to CAT. This was seen as

important by service users in being able to share their experiences with the therapist. Therapist attributes and approach was something that participants reported on and highlighted how different therapists have different personal characteristics and approaches within the framework of CAT.

What next?

- Therapists need to focus on helping contain and normalise feelings and be tentative when sharing formulations and when the service user is trying to make changes.

- Therapists could have a chat, during the consent process, with service users about the potential for them to experience negative emotions during the course of CAT.

- Some service users with complex difficulties might benefit from a more systemic approach due to their being potentially toxic environmental factors that are impacting on the service user's ability to make changes.

- Conducting research with service users who have not been able to make changes in their lives following CAT.

- Conducting research looking at service user's experience of when CAT has been combined with a systemic or compassion-focused approach.

- Conducting research looking at the experience of therapy for the service user and therapist alongside one another could also be a useful area for future research.

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Appendix 1: CASP Qualitative Research Tool Questions

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Appendix 2: CASP for case control design Tool Questions

1. Did the study address a clearly focused issue?
2. Did the authors use an appropriate method to answer their question?
3. Were the cases recruited in an acceptable way?
4. Were the controls selected in an acceptable way?
5. Was the exposure accurately measured to minimise bias?
6. What confounding factors have the authors accounted for? Have the authors taken account of the potential confounding factors in the design and/or in their analysis?
7. What are the results of the study?
8. How precise are the results? Do you believe the results?
9. Can the results be applied to the local population?
10. Do the results of this study fit with other available evidence?

**Note: The term 'exposure' in question 5 refers to a participant engaging in a treatment. In this review this has been taken as the engagement of a service user in Cognitive Analytic Therapy.*

Appendix 3: Results sections converted into qualitative codes for thematic synthesis

Paper	Reason for conversion	Original text	Open coded
Evans & Parry (1996).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	The reading of the prose reformulation appeared to have a considerable emotional impact on all four of the subjects – two used the word 'overwhelming' and two the word frightening to describe the experience.	Hearing the reformulation was overwhelming. Hearing the reformulation was frightening.
		For all four there was material in the reformulation that they recognised they had been trying to blank off from conscious thought, much of the material relating to painful early childhood experiences.	Reformulation helped recognise what they had been blanking off from conscious thoughts.
		All four of them commented that the reformulation had given them a better understanding of their problems.	Reformulation gave a better understanding of problems.

Paper	Reason for conversion	Original text	Open coded
Evans & Parry (1996).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	KI commented that the reformulation was "proof that she (therapist) really did know what it felt like. The other doctors listened, but I thought are they taking it all in, do they care. I couldn't trust them but it is different now. At first I felt the same with my therapist but since I've had the reformulation IV HAD 100% trust in her and don't hold anything back now".	(The reformulation was) proof that she (therapist) really did know what it felt like. The other doctors listened, but I thought are they taking it all in, do they care. I couldn't trust them but it is different now. At first I felt the same with my therapist but since I've had the reformulation IV HAD 100% trust in her and don't hold anything back now.
		"Everything is out on the table – you know that you are not going to get distracted by less important things" (RK).	Everything is out on the table – you know that you are not going to get distracted by less important things.
		GC who did not receive the reformulation until the sixth session felt that it was not a major part of therapy.	Felt that the reformulation was not a major part of therapy.

Paper	Reason for conversion	Original text	Open coded
Tzouramanis et al. (2010).	Quantitative data reporting service user's experience of CAT and so coded to be able to include in thematic synthesis.	At the 1-year follow up the patients find more helpful the new understanding, the self-monitoring and the fact that therapy was time limited, compared to the 2-month follow-up.	Compared to scores on the 2 month follow up, at the 1-year follow up the patients found having a new understanding helpful. Compared to scores on the 2 month follow up, at the 1-year follow up the patients found the self-monitoring helpful. Compared to scores on the 2 month follow up, at the 1-year follow up the patients found the therapy being time limited helpful.
		The highest score on both follow-ups is on the question "relationship to the therapist".	At both the follow ups the relationship with therapist was reported as helpful.

Paper	Reason for conversion	Original text	Open coded
Stockton (2012).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation. Quantitative data also used.	HAT ratings suggest earlier sessions tended to be more helpful than later ones.	Earlier sessions were more helpful.
		In relation to CAT tools, the most frequently noted helpful aspect was the use of mapping techniques in the production of the SDR, and its subsequent application throughout therapy.	Mapping techniques were helpful in the SDR.
		Participants also noted the Narrative Reformulation and goodbye letter as helpful.	The goodbye letter is helpful. The Narrative reformulation was helpful.

Paper	Reason for conversion	Original text	Open coded
Stockton (2012).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation. Quantitative data also used.	CAT techniques that were frequently cited included the identification of exits on the SDR and improved pattern recognition.	Identifying exists on the SDR. Improved pattern recognition on the SDR.
		Participants also acknowledged the helpfulness of making links between past and current relationships and associated self-monitoring techniques.	Making links between past and future relationships and associated self-monitoring is helpful.

Paper	Reason for conversion	Original text	Open coded
Stockton (2012).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation. Quantitative data also used.	A number of non-specific therapeutic elements were identified as helpful, most prevalent was gaining a new awareness or understanding (e.g. of one self or ones problems), and the opportunity to verbalise difficulties.	Understanding self and awareness was helpful. Verbalising difficulties was helpful.
		The identification and release of emotions, quality of the therapeutic relationship (e.g. collaborative, understanding, listening, encouraging), and ability of the therapy/therapist to instil hope were also often stated.	Release of emotions was helpful. Quality of the therapeutic relationship was helpful. Therapist instilling hope was helpful.
		Sessional WAI ratings for both arms tended to improve incrementally as therapy progressed.	Working alliance improved as the therapy progressed.

Paper	Reason for conversion	Original text	Open coded
Stockton (2012).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation. Quantitative data also used.	There were no significant differences between groups on WAI scores at reformulation (F(2,22) = .317 p = .579; ES .240) or termination (F(2,22) = .336 p = .568; ES .247) when scores were adjusted using session one WAI scores as a covariate.	There was no difference in the working alliance between those who had the narrative reformulation and those that did not.

Paper	Reason for conversion	Original text	Open coded
Kellett & Hardy (2014).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	As Table 3 summarizes, the patient stated three key changes: 'I see people differently now, I can manage my thoughts and no longer playing the game.' The patient reported being very surprised by the changes and that the changes were unlikely without the help of therapy.	Seeing people differently now. Being able to manage paranoid thoughts. Stopping playing 'the game'.

Paper	Reason for conversion	Original text	Open coded
Kellett & Hardy (2014).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	The patient stated that the graphed time series of the target complaint measures reflected his change process.	The graphed time series of the target complaint measures reflected his change process.
		He did note, however, that his increasingly close relationship with his wife and child did help to support his psychological change. This was a benefit of the exit on the SDR of developing and practicing interpersonal closeness.	His increasingly close relationship with his wife and child did help to support his psychological change due to exists on the SDR.
Kellett, Bennett, Ryle & Thake (2013).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	In terms of specific helpful therapeutic factors, the patient identified the active and open therapeutic style of the therapist and that some direction was provided when requested. The patient noted that it was extremely difficult to manage his paranoia initially in sessions and not surreptitiously play ‘the game’.	Open therapeutic style of the therapist and that some direction was provided when requested was helpful. Difficult to manage paranoia and not play ‘the game’.

Paper	Reason for conversion	Original text	Open coded
Kellett, Bennett, Ryle & Thake (2013).	None or few direct quotes from service users. Only text that states that the service user reported something has been coded so that it is about their experiences and not researchers interpretation.	Ratings of the change interviews recorded a change mean of 1.54 (SD=0.77) indicating that change had taken place, with an attribution to therapy mean of 1.62 (SD=1.13) indicating that patients felt that the CAT provided was the main reason for the changes experienced.	Change had happened due to receiving Cognitive Analytic Therapy.

Appendix 4: Thematic synthesis themes, extracted quotes and original themes

Thematic synthesis	Quote	Theme from original paper
Theme 1: CAT Tools		
Diagrams.	*". . . if I have a big dip, or I feel, I start to feel a bit shaky, I'll go back to [the diagram] and try and 'right, what's this about, what's happening here?'* (Elaine: extracted from Rayner, Thompson & Walsh, 2011).	CAT tools and 'understanding and feeling.
	"No purpose it was just his writing and you know you were just kind of looking at it" suggesting it is the therapist's tool (not the service-user): *"A useful tool for him…an important part of his work"* (Elaine: extracted from Rayner, Thompson & Walsh, 2011).	Emotional outcomes of mapping as a process.
Reformulation letter.	*"The other doctors listened, but I thought are they taking it all in, do they care. I couldn't trust them but it's different now. At first I felt the same with my therapist but since I've had the reformulation IV HAD 100% trust in her and don't hold anything back now"(*KI: extracted from Evans & Parry, 1996).	No theme. Only a summary of quotes provided in the results section.
	"Hearing the reformulation was frightening" (unknown: extracted from Evans & Parry, 1996).	No theme. Only a summary of quotes provided in the results section.

Thematic synthesis	***Quote***	***Theme from original paper***
Goodbye letter.	*"well our goodbye letter is obviously something I will keep for many years so it is very significant and important to me so keep it all as well"* (S: extracted from Ruppert, 2013).	Letters.
The letter.	*"Yeah, in a good way, because it made you feel heard, and that was nice"* (Sarah: extracted from Shine & Westacott, 2010).	Feeling heard.
	"A bit shocking really, because it was all problems, so it was problem had. i(didn't mention the g(H)d parts of my life. It was a summary of the bad parts, and it was a bit shocking. A bit of a jolt really" (Mary: extracted from Shine & Westacott, 2010).	Feeling exposed.
Theme 2: Experienced change		
Learning to trust.	"It's about developing that trust" (Elaine: extracted from Rayner, Thompson & Walsh, 2011).	Being with the therapist.
	"Other treatment I've had in the past I've kind of built up a trust relationship you know… where I can, I feel as if I can tell you these things what are going on in my mind… and I didn't feel that with my therapist, I didn't feel it at all… I felt as if he was the enemy and I was fighting that enemy". (Ben: extracted from Taplin, 2015).	Dynamics within the therapeutic relationship.

Thematic synthesis	***Quote***	***Theme from original paper***
Personal changes.	*"Like reading a very sad book. You have empathy for that person even though that person is actually you"* – Clare: extracted from Rayner, Thompson & Walsh, 2011).	CAT tools and 'understanding and feeling'.
	"*When I realise that, actually, the only reason I am beating myself up about [not being able to achieve something perfectly] is because I demand perfection from myself; and the only reason I demand perfection from myself is because my father always did; then it gives me the chance to say, well, other people aren't perfect. Nobody is perfect, in fact. So why should I be?"* (Client 8: extracted from Fusekova, 2011).	Feeling empowered to make a choice about one's life.
Theme 3: Knowledge and skills		
Learning about patterns.	*"And you know it made me want to get in there and get it sorted because it'd . . . it did recognize what the problems were, it was on a bit of paper, you could break it down and sort it out . . ."* (Maggie: extracted from Hamill, Ried & Reynolds, 2008).	Connecting to the Therapy Process: Patients' Perception of the Structure of Therapy.
Doing things differently.	*"It's like there's, a door is open to give you a model of trying to manage your life if you like."* (Elaine: extracted from Rayner, Thompson & Walsh, 2011).	Understanding and feeling.

Thematic synthesis	***Quote***	***Theme from original paper***
Theme 4: Reflecting on the process		
Endings.	*"I did get to rely on the people too much. I wanted it to go on forever (pause) it's not realistic (pause)" (*D: extracted from Ruppert, 2013).	Endings.
Exits.	"the will to change, in whichever way you decide to change your life, in work, and how you respond to people and communicate - [this] is in effect an exit" (Client 2: extracted from Fusekova, 2011).	One-off exits.
Expectations.	*"thought the group would help me to kind of find an even keel instead of er going in from one extreme to another all the time in my life I thought I'd find a happy medium and.."* (R: extracted from Ruppert, 2013).	Disappointment.
Relationship with therapist.	*"Open therapeutic style of the therapist and that some direction was provided when requested was helpful"* (open coded from Kellett & Hardy, 2014).	No theme provided.
General experience of the therapeutic process.	***"****. . . and that's what I liked about the therapy it wasn't sort of up in the clouds you know, it was real in terms of your day to day activities"* (Sheila: extracted from Rayner, Thompson & Walsh, 2011).	Keeping it real.

Thematic synthesis	***Quote***	***Theme from original paper***
Theme 5: Strong feelings		
	"I was frightened I couldn't do it myself" – Elaine: extracted from Rayner, Thompson & Walsh, 2011).	Being with the therapist.
	"it was a range of emotions (pause) it was upsetting, it was (pause) as I said it was daunting, it was scary. (Scott: extracted from Taplin, 2015).	Emotional outcomes of mapping as a process.
Theme 6: Being in a group		
	"I umm I enjoyed the people that I've met here very much and they put my issues in focus for me" (B: extracted from Ruppert, 2013).	Group process.

Appendix 5: Sample of transcript and corresponding coding

Transcript of quotes	Codes
"You don't just sit back and let it all happen, you know your therapist isn't going to wave a little magic wand and it's all going to be okay. It's working alongside" (Sheila).	You don't sit back. There is no magic wand. Working alongside therapist.
"It's about developing that trust. I think for me the . . . the testing out was, if I fell apart, could [therapist] bring me back up, because I was frightened I couldn't do it myself" (Elaine).	Developing trust with therapist. Testing out if therapist could bring me back up if fell apart. Frightened I couldn't do it myself.
"There are certain thought patterns, that I have, and what I am doing, is learning to change those thought patterns. Block them when I've discovered that I'm using them" (Margaret).	Learning to change thought patterns. Learn to block thought patterns when know I'm using them.
"I think if you start understanding, how you're functioning, then you can, sort of appreciate how other people are functioning as well" (Margaret).	Understand how you function. Appreciate how other people function.

Transcript of quotes	Codes
“I have no illusions that I’m now cured forever. No way. And I’m sure there’s major crises that are around some corner or other” (Elaine).	No illusions of being cured. There are still crises around the corner.
“[therapy is] not an end in itself. It’s like there’s, a door is open to give you a model of trying to manage your life if you like. But . . . but it’s a process and as you build you’ll move forward” (Elaine).	Therapy is not an end in itself. Gives you a model of managing your life. Therapy is a process to move forward.

Appendix 6: Table summarising what was synthesised from each study

Study	What was synthesised
Tzouramanis et al. (2010).	Quantitative data was converted into qualitative data and then synthesised.
Hamill, Ried & Reynolds (2008).	Direct quotes synthesised.
Evans & Parry (1996).	Results sections coded and then synthesised.
Shine & Westacott (2010).	Direct quotes synthesised.
Kellett, Bennett, Ryle & Thake (2013).	Quantitative data was converted into qualitative data and then synthesised.
Rayner, Thompson & Walsh (2011).	Direct quotes synthesised.
Kellett & Hardy (2014).	Results sections coded and then synthesised.
Fusekova (2011).	Direct quotes synthesised.
Ruppert (2013)	Direct quotes synthesised.
Sandhu, Kellett, & Hardy (2017).	Direct quotes synthesised.
Stockton (2012).	Results sections coded and then synthesised.
Taplin (2015).	Direct quotes synthesised.

Appendix 7: Summary of study characteristics

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Tzouramanis et al. (2010). Country: Greece.	Quantitative (non-randomised). 	128 participants with DSM-IV diagnosis of Panic Disorder.	Community Mental Health centre.	To assess service user's experience of Cognitive-Analytic Therapy (CAT).	The Post-therapy Questionnaire (PtQ) was used at two follow up points after the therapy finished which were at 2 months and 1 year. This PTQ questionnaire investigated service user's experience of receiving CAT.	At the 1-year follow up, service users reported new understanding, self-monitoring and CAT being time limited more helpful when compared to the 2-month follow-up. This was a significant difference. .

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Hamill, Ried & Reynolds (2008). Country: UK.	Qualitative.	Eight service users with Depression only with two diagnosed with Anxiety.	NHS.	To explore service user's perspectives on therapeutic letters in CAT.	Semi structured interviews conducted following the completion of therapy. Thematic analysis was employed with elements of grounded theory.	The themes that emerged were connecting to self, connecting to therapist, connecting to the therapy process and connecting to others.
Evans & Parry (1996). Country: UK.	Mixed methods.	Four clients considered to be 'difficult to help'.	Information not available.	To evaluate the impact of reformulation on clients.	Semi-structured interviews were conducted following the completion of therapy.	Clients reported that the reformulation had considerable impact on them, overwhelming and frightening, gave them a better understanding of themselves and showed the therapist had listened and understood them.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Shine & Westacott (2010). Country: UK.	Mixed methods.	Five clients with an Axis I disorder (this consists of the more common diagnoses such as Anxiety and Depression).	NHS	To explore the client's perspective on reformulation.	Interviews were conducted post reformulation. Template analysis was used to analyse the qualitative data.	Seven themes were identified: feeling heard, understanding patterns, space to talk, feeling accepted, having something tangible, working together, and feeling exposed.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Kellett, Bennett, Ryle & Thake (2013). Country: UK.	Mixed methods.	19 Clients with Borderline Personality Disorder (BPD) diagnosis.	NHS.	To examine the effectiveness of CAT for patients with Borderline Personality Disorder (BPD).	The methodology was small N repeated measures design, with patients interviewed at the third follow-up session using the Change Interview. The data from this interview was reported as quantitative data.	The quantitative data indicated that patients tended to attribute experience of change to the therapy received.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Rayner, Thompson & Walsh (2011). Country: UK.	Qualitative.	Nine clients with various presenting problems (3 with Depression only).	NHS.	To explore client's experience of receiving Cognitive Analytic Therapy (CAT), including specific tools in CAT.	Semi-structured interviews were conducted. Grounded theory was employed to explore client's experience of CAT.	A core theme of 'doing with' the therapist emerged from the analysis. Within this, four subthemes were identified which were being with the therapist, keeping it real, understanding and feeling and CAT tools.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Kellett & Hardy (2014). Country: UK.	Mixed methods.	One client, diagnosed with Paranoid Personality Disorder (PPD).	A secondary care community mental health team, situated in a mental health NHS Trust.	To report the assessment, formulation and treatment of a client using CAT.	Qualitative data was collected via the Change Interview regarding their experience of CAT.	The client reported seeing people differently and being able to manage thoughts due to CAT. Also, that the active and open therapeutic style of the therapist was helpful and how it was difficult to manage feelings of paranoia during the therapy.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Fusekova (2011). Country: UK.	Qualitative (Thesis project).	17 participants; eight therapists and nine clients with different presenting difficulties.	Adult mental health services.	To examine the development of exits in sessions of CAT as a way of investigating change.	Nine therapist-client dyads were interviewed together about how exits developed during CAT. The qualitative data was analysed using grounded theory.	Two main types of exits identified were: “planned exits” and “one-off exits”. Clients also portrayed exits as common sense yet novel. Further themes were opening up new perspectives, discussing and communicating together, developing understanding, feeling empowered, developing a more objective (shared) perspective, coming up with common sense yet novel ideas about exits, working hard and persevering, reaching planned exits and one-off exits.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Ruppert (2013). Country: UK.	Qualitative (Thesis project).	Six service users.	Secondary mental health service.	To investigate service user's experience of a CAT group.	Client experience was gathered via focus groups which were analysed using Template Analysis.	Group members appreciated the letters in CAT but there were differences in their feelings about the diagrams. Using each other's' diagrams within the group was reported as helpful. Lack of direction from the facilitators in recording exits on the diagram was reported as unhelpful.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Sandhu, Kellett & Hardy (2017). Country: UK.	Qualitative.	Eight service users diagnosed with Depression.	UK primary care mental health service.	To explore service user's experience of the revision stage and explore and define change in CAT.	Qualitative content analysis was used to analyse transcripts of sessions 6 and 7 of a protocol delivered 8-session CAT treatment.	The findings identified the following experiences: developing an observing self via therapist input or client self-reflection, breaking out of old patterns by creating new roles and procedures, and utilisation of a range of methods to support and maintain change.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Stockton (2012). Country: UK.	Mixed methods (Thesis project).	36 service users with a diagnosis of Depression.	Improving access for psychological therapies (NHS).	To investigate the efficacy of Narrative reformulation in CAT.	Self- report measures investigated experiences of CAT using the Working Alliance Inventory-Short (WAI-S) and the Helpful Aspects of Therapy (HAT). Content analysis was employed on the HAT.	Service users found that the working alliance improved over time but that the earlier sessions were more helpful. Identified themes were CAT tools, CAT techniques, and non-specific therapeutic elements.

Authors, year and country	Study design	Participants	Setting	Purpose/aims	Methodology	Findings
Taplin (2015). Country: UK.	Qualitative (Thesis Project).	Seven service users.	NHS.	To explore service user's experience of the Sequential Diagrammatical Reformulation (SDR).	Semi structured interviews were conducted after completing a course of CAT. The data was analysed using Interpretive Phenomenological Analysis (IPA).	The findings identified four superordinate themes regarding service user's experience of the SDR were chaos to clarity (a process of meaning making), the change process, relational dynamics and focus on treatment context/options.

Appendix 8: Critical Appraisal Results

Authors, year and country	Study Design	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	QA1	Total score/ Percentage	Quality rating
Hamill, Ried & Reynolds (2008).	Qualitative.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	20 points (95%)	High
Evans & Parry (1996).	Mixed methods.	Y	Y	Y	Y	Y	N	P	N	P	Y	N	14 points (66.6%)	Medium
Shine & Westacott (2010).	Mixed methods.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	20 points (95%)	High
Kellett, Bennett, Ryle & Thake (2013).	Mixed methods (small N design).	Y	Y	Y	Y	Y	Y	Y	Y	P	P	N	18 points (86%)	High

Authors, year and country	Study Design	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	QA1	Total score/ Percentage	Quality rating
Rayner, Thompson & Walsh (2011).	Qualitative.	Y	Y	Y	Y	Y	Y	P	Y	Y	Y	N	19 points (90%)	High
Kellett & Hardy (2014).	Mixed methods (small N design).	Y	Y	Y	Y	Y	N	Y	P	Y	Y	N	17 points (81%)	High
Fusekova (2011).	Qualitative (Thesis project).	Y	Y	Y	Y	Y	Y	P	Y	Y	Y	N	19 points (90%)	High

Authors, year and country	Study Design	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	QA1	Total score/ Percentage	Quality rating
Ruppert (2013).	Qualitative (Thesis project).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	20 points (95%)	High
Sandhu, Kellett, & Hardy (2017).	Qualitative.	Y	Y	Y	Y	Y	Y	P	P	Y	Y	N	18 points (86%)	High
Tzouramanis et al. (2010).	Non-randomised Quantitative.	Y	Y	Y	Y	Y	Y	Y	P	P	Y	N	18 points (86%)	High

Authors, year and country	Study Design	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	QA1	Total score/ Percentage	Quality rating
Stockton (2012).	Mixed methods (Thesis project) Qualitative aspect.	Y	Y	Y	Y	Y	P	Y	P	P	Y	N	17 points (81%)	High
	Mixed methods (Thesis project) Quantitative aspect.	Y	Y	P	P	Y	Y	P	P	P	Y	N	15 points (71.4%)	High
Taplin (2015).	Qualitative (Thesis project).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	21 points (100%)	High

Note: The CASP for Qualitative Research was used to assess the quality of all of the studies except for the (Tzouramanis, et al, 2010) study whereby the CASP case control study tool was used. Furthermore, the (Stockton, 2012) study used the CASP for Qualitative Research to assess the qualitative aspect of the study and the CASP case control study tool was used to assess the quantitative aspect of the study.

Appraisal scoring system

- **Y** is short for Yes: this is when the paper fully meets the CASP criteria. The score allocated is 2 points
- **P** is short for Partial: this is when a paper partially meets the CASP criteria. The score allocated is 1 point
- **N** is short for No: this is when a paper does not meet the CASP criteria. The score allocated is 0 points.
- N for **A1** will receive 0 points and a Y will receive 1 point.
- The maximum number of points that can be allocated is **21 points**.
- **Quality rating**: (0%-33%) =low quality, (34%-66%) =medium quality, (67%-100%) =high quality.

Appendix 9: Journal author guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper. If you need more information about submitting your manuscript for publication, please email Vicki Pang, Editorial Assistant at papt@wiley.com or phone +44 (0) 1243 770 410.

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

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• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).

• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

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Further information about the process of peer review and production can be found in this document. What happens to my paper? Appeals are handled according to the procedure recommended by COPE.

Appendix 10: Invitation letter

(Contact details of the NHS service)

DATE

Dear

You have been invited to take part in a research study exploring service user's experience of the Cognitive Analytic Therapy they have received. This would involve taking part in an interview about your experiences of this therapy. It is important for therapists in the future to have an understanding of what it is like to receive Cognitive Analytic Therapy so that they can best meet the needs of service users in the future.

The researcher is Nadia Rose and she is a Trainee Clinical Psychologist. She would be grateful to hear about your experience. If you are interested in taking part please can you complete and send her the attached form in the envelope provided.

You are under no obligation to take part in this study and it is completely voluntary. The NHS or private treatment that you receive will not be affected by taking part in this study or deciding not to.

Kind regards,
Recruiting therapist's name

Appendix 11: Participant information sheet

RESEARCH INFORMATION SHEET

Study Title: Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties.

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Researcher: Nadia Rose, Trainee Clinical Psychologist, Staffordshire University, College Road, Stoke on Trent, Staffordshire, ST4 2DE.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if anything is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

To find out more about what it is like to receive Cognitive Analytic Therapy (CAT) and to gain a better understanding of service user's experience of CAT. CAT also uses some unique therapeutic tools such as letters and diagrams. The study will also look at what service users thought of these and how they were used in therapy. There have been limited studies in this area and I believe it is important for future psychologists and therapists to hear client's experiences so we can learn from them.

Why have I been chosen?

You have been chosen as you have recently completed a number of sessions of Cognitive Analytic Therapy with a psychologist, psychiatrist or therapist within South Staffordshire and Shropshire Health Care NHS

Foundation Trust or privately. In total I am hoping to interview about six to eight people, all who have received CAT in the last 18 months.

Do I have to take part?

No, your participation is completely voluntary and it is up to you to decide if you wish to take part. If you do decide to take part then you can keep a copy of this sheet and the consent form you will be asked to sign. However, you can choose to withdraw from the study at any point up to one month after taking part in the interview, without giving any reason. You can also withdraw your data up to one month after taking part in the interview, without giving any reason. Whether you choose to take part or not won't affect any NHS or private treatment you are receiving now or in the future.

What is involved in taking part?

Spending some time talking to me in a tape recorded interview. I am mostly interested in your experiences, views and understanding of the therapy you have received. This interview should take about an hour and will take place at the NHS or private service where you received therapy. We can arrange a time and day that suits you. After each interview is completed, the tapes will be transcribed by myself and I will begin to look for common themes in what people have said. You will be able to withdraw your data up to one month after taking part in the interview. I will also call you on the telephone to say thank you for taking part in the study and to ask how you found the process of taking part. Deciding to take part, declining to take part or withdrawing will in no way affect any present or future treatment that you receive.

Will my taking part in this study be kept confidential?

Those involved in you care, including your GP, will be informed that you are involved in this study. However, what you talk about in the interview will not be fed back to your therapist, your care team or GP. Due to us talking about things that are private to you, the tape recording of our interview will be kept

confidential. There are limits to confidentiality which is that if you disclosed that you are at risk of harm or others are then I will need to pass this information onto the health care professional you are involved with. You will be issued with a code number and the tape recording will not have your name on it, just this code number. Any personal details you give me will be kept away from the tape recordings and the tapes of our interview will be kept safe, locked in a filing cabinet when I am not using them. Personal details will also be kept in a locked cabinet. Personal information and the tapes will be destroyed following the completion of the project, in line with the University policy and procedure. When I am writing up the research project all names and other details will be changed so no one can identify you or your therapist. There are certain circumstances however in which confidentiality may be broken. Such circumstances might be, for example, if you disclosed intent to harm yourself or others. If this did occur in the interview I would openly discuss this with you and inform you of the action I would need to take as appropriate.

What are the Potential benefits of taking part?

You can have the opportunity to talk about your experiences of receiving Cognitive Analytic Therapy so that therapists can better understand what it is like to receive this therapy. This study may also be able to inform other therapist's clinical practice in the future.

What are the potential disadvantages or risks of taking part?

Some people find talking about their experiences helpful, but others might find that this upsets them. You have the choice to refuse to answer any questions asked in the interview or withdraw your consent to take part in the interviews at any time. If you do become upset during or after the interview you will be able to talk to someone from your care team or if that person is not available you can talk to the member of the team that works within the service that you access. If you would prefer you might also want to contact

your GP or the Samaritans on 01785 243333 (Stafford) or 01743 369696 (Shropshire), or care co-ordinator afterwards.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study then please contact myself in the first instance on 01782 294007 or at the School Of Psychology, Sport and Exercise, Faculty of Health Sciences, Staffordshire University, Sciences Centre, Leek Road, Stoke on Trent, ST4 2DF. If you feel that your complaint still has not been resolved to your satisfaction then please contact the research project supervisors, Professor Helen Dent on 01782 294007 or at School of Psychology, Sport and Exercise, Faculty of Health Sciences, Staffordshire University, Sciences Centre, Leek Road, Stoke on Trent, ST4 2DF or Dr Christopher John on 01543 431580 or at Park House, 12 Park Road, Cannock, Staffs, WS11 1J. If you still feel that your complaint still has not been dealt with satisfactorily then you can contact the Sponsor of the study which is Dr Elizabeth Boath, on 01782 294000 or at Staffordshire University, College Road, Stoke-on-Trent, Staffordshire ST4 2DE. If you have contacted the Sponsor and still feel that your complaint has not been dealt with satisfactorily then you can use the normal NHS complaints procedure by contacting the NHS Trust's complaints department on 01785 783026. PALS is also a useful source of advice within the NHS. The contact details can be found on the South Staffordshire and Shropshire NHS Foundation Trust website.

What will happen to the research when it is done?

I aim to write up the research for my thesis that will contribute to my Doctoral qualification in Clinical Psychology. This means that the thesis will be

available within the Staffordshire University library. I also hope to have the research published in an academic journal, in order that your experiences can be understood better by psychologists and other therapists who deliver Cognitive Analytic Therapy.

What next?

If you would like to take part you will be provided with a consent form to complete before taking part.

Thank you for reading this information.

Appendix 12: Opt in slip

Consent form to be contacted about the research project entitled (opt in slip):

Study title: Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties.

Name:

Address:

*Home Telephone Number:

*Mobile Telephone Number:

*E mail Address:

*You do not need to complete all of these fields if you do not wish but I will need at least one contact number. Please underline your preferred method of contact.

I agree to be contacted by Nadia Rose to talk more about taking part in this study

Signature:

Date:

Please complete this form and return in the envelope provided. Thank you

Appendix 13: Consent form

CONSENT FORM

Title of Project: Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties.

Name of Researcher: Nadia Rose, Trainee Clinical Psychologist, Staffordshire University

Please initial box:

1. I confirm that I have read and understood the information sheet …… ☐
2. I have had the opportunity to ask questions and these have been adequately answered…… ☐
3. I understand that the interview will be tape recorded…… ☐
4. I understand that I am free to withdraw from the study at any point up to one month after taking part in the interview, without giving any reason…… ☐
5. I understand that my care team and GP will be notified of my involvement in this study…….. ☐
6. If I choose to read through the transcripts I consent to a copy of the interview transcript to be sent to my home address…….. ☐
7. I understand that I can withdraw my data up to one month after taking part in the interview, without giving any reason…… ☐

8. I agree to be called on the telephone after the interview to be asked how I found the process of taking part in this study……..… ☐
9. I agree to take part in the above study…….…… ☐

Name of Participant……. Date…….

Participant Signature……

Name of Researcher……. Date…….

Researcher Signature……

Appendix 14: Interview schedule

INTERVIEW SCHEDULE

Can you tell me about your experience of receiving Cognitive Analytic Therapy?

Prompts to be used if necessary:

- *Can you tell me about how you came into therapy?*
- *Tell me about what happened during therapy. Could you describe what you thought about it?*
- *How did you feel therapy went?*
- *Did your therapist use any letters or diagrams in therapy?, if so how did you find them?*
- *How did you find the diagrams? How did they make you feel? What did you think?*
- *Did coming to see your therapist make a difference to you in anyway?*
- *Are there specific moments where you noticed a change in how you felt*
- *Were there points in therapy when you felt stuck?*
- *What hasn't changed?*
- *Did you want those things to change?*
- *Why do you think they didn't change?*
- *Was there anything in therapy which was difficult for you?*
- *How did you get on with the therapist?*
- *Were there moments when you didn't get on? If so why?*
- *Were these moments resolved? If so how?*
- *What did you do near the end of therapy?*
- *Was there anything that helped finishing therapy?*
- *Anything that didn't help?*
- *Is there anything you wish to add about your experience of the therapy which hasn't been covered?*

Appendix 15: Demographic information sheet

Demographic information

Date……

Name……..

Date of birth……..

Gender……

Ethnicity…….

No of Cognitive Analytic Therapy sessions……

***Date completed Cognitive Analytic Therapy……**

**** If full date unknown then please put the month and year completed***

Appendix 16: Accuracy of transcript form

Accuracy of transcript

Dear

Thank you for taking part in this study. Please indicate if the attached interview transcript is an accurate record of the interview that you took part in. If not then please describe why below and what you would like to change.

Yes this is an accurate record of the interview……..☐

No the interview transcript is not an accurate record of the interview……☐

If not please provide a description for why and what you would like to be changed:

Please return this form in the prepaid envelope provided within the next two weeks.

Thank you for your time.

Appendix 17: Transcript extract to illustrate analytic process

Connecting themes	Emergent themes	Transcript extract	Exploratory comments
Connected with personal gains, tools to cope and making changes.	Gaining understanding	*I: And just sort of stumbling across memories and the way (the therapist) managed to fit them all together to put a sort of pattern together was quite….eye opening really.*	Service user gained insight.
		It was quite interesting because she managed to make links that I would never have thought of and then it did very quickly start to form a	Therapist making links that service user would not have.
Connected with personal gains, tools to cope and	Gaining understanding	*recognisable pattern erm and I'm still amazed now how she managed to put all this together just by things that I had said erm… that I*	Service user recognised patterns.

making changes		*hadn't paid any attention to and didn't think they were of any significance and were just random off the cuff remarks*	Therapist focused on things the service user had not previously. Has the therapist been driven by a hypothesis that the service user doesn't agree with?
This was connected with ending therapy, the therapeutic relationship and therapist's attributes and approach.	Being understood	*and then all of a sudden that's linked into that and that's linked into that and erm its quite extraordinary really how these things can be linked without you even realising it and then you suddenly look at your whole personality and your whole being laid out on a piece of paper and you think is that me? Erm you know. Is that really the way I behave or the way I am or the way I'm treated and the way I*	Therapist made links between events. Questions the formulation.
Connected to gaining understanding	Difficulties making changes	*allow other people to treat me or I treat other people erm….and all that information was gathered just by general conversation. It was*	Your told things in the sessions and nobody else know so they don't understand why you are changing.

, personal gains, tools to cope and making changes.		*quite interesting.*	It's difficult to make changes. because of resistance from those in the person's life. Seemed annoyed that she tried to make the changes and it was difficult.
Connected with personal gains, tools to cope and making changes.	Gaining understanding	*Me: So it all kind of came together on this piece of paper sort of thing?* *I: Yeah yes on this big map which she sort of did and that I have now and still refer to now erm and its…it changed for me erm quite a bit in the way that I respond to other people so it did have quite an impact at home for me because one of the things that did come out of it was how other people treat and it was sort of discussed that you know you don't deserve to be treated that way and you shouldn't allow yourself to be treated that way erm and maybe it's time to stop being treated in the way that I was…erm ..but of course me*	Suddenly told that what has been happening is wrong. Becoming aware of unhelpful relationships and reciprocal roles? Becoming aware means you can never be unaware again. The therapist helps you realise

		sitting in therapy having that said to me and	unhelpful relationship patterns.
Connected with personal gains, tools to cope and making changes.	Gaining understanding	*then going home and confronting…well not confronting. Being round these people at home who have no idea what's gone on and what's been said for me to then suddenly start to change my behaviour and they are going well hang on a minute where did that come*	Becoming aware of unhelpful reciprocal roles in current relationships? Beginning to gain insight into unhelpful reciprocal roles?
Connected with personal gains, tools to cope and making changes.	Gaining understanding	*from and it sort of made life a little bit difficult sometimes…at home. And the way I viewed people as well changed which I find quite hard to deal with….because I suppose it's like once you've seen something you can't then unseen it. So once you've seen that a person is being negative towards you or aggressive and I don't mean physically violent or aggressive or*	Once you have gained awareness you can't not go back.
Connected with personal gains, tools to cope and making changes.	Gaining understanding	*anything like that but just in their in their mannerisms and in their language and things like that you know… you spend years and years in your life paying no attention to it and*	Others in their life don't understand

Connected to insight, personal gains, tools to cope and making changes. Connected to insight, personal gains, tools to cope and making changes. Connected to insight, personal gains, tools to cope and making changes.	Difficult to make changes Gaining understanding Difficult to make changes	*just accepting it and you know that's the status quo and that the way things are then all of a sudden someone says to you that's not acceptable and then all of a sudden you start thinking that's not acceptable and they don't understand why and so I found that part quite challenging. So its all very well sitting in a room over here and saying all this and having someone one to one that understands and that can explain it to you but then you go back into the real world and your dealing with real people who have not been in that room with you and have no idea where it has all come from and they are suddenly noticing changes and its difficult.*	why changing so it's challenging. Were they provided with enough guidance and support in making these changes? Or were they just told to change but then left to deal with the consequences on their own? Starting to see people differently. Awareness of relationships. People around them have a lack of understanding. The real world is different to the therapy room. People around you start to notice the attempts in changing the reciprocal roles? Maybe moving from one role that has been occupied with family members to another which is difficult to

			achieve.

Appendix 18: Count of recurrent themes across participants

Superordinate theme	Participant(s) contributing to the theme	Sub-themes	Participant(s) contributing to sub-theme	Illustrative quotes
Change due to CAT.	Jane, James, Becky, Stacey, Claire, Kate.	Insight.	Jane, James, Becky, Stacey, Claire, Kate.	*"I think it was a lot of the bullying at school but it sort of dug a lot deeper than that just top layer. And you don't realise that that's actually affecting you forty seven years later"* (Stacey). *"No definitely more independent in that I found that it helped me understand my brain and recognise triggers"* (Claire).

Superordinate theme	Participant(s) contributing to the theme	Sub-themes	Participant(s) contributing to sub-theme	Illustrative quotes
Change due to CAT.	Jane, James, Becky, Stacey, Claire, Kate.	Making changes.	Jane, James, Becky, Stacey, Kate, Claire.	*"Erm…it was talked about…erm but again it seems like something that nobody seems to have the answer for. It's like I said to you it's like knowing that that's what you need to do but being able to do it is completely it's completely different"* (Kate). *"Erm and it was very frustrating for a time because I was like I said identifying them is one thing but doing something is completely different"* (James). *"He used to send me messages and I used to think oh god and just press the button. Then we actually spoke at the weekend first time probably for five years reasonably. So and I think it's changed the relationship"* (Stacey).
		Personal gains.	James, Becky, Claire, Jane.	*"…..yep…I feel a lot calmer in myself. I feel like before the therapy I was 100 million miles per hour all the time like constantly worrying and panicking all the time. I do feel like I'm a lot calmer now."* (Jane).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
Change due to CAT.	Jane, James, Becky, Stacey, Claire, Kate.	Tools to cope.	James, Claire, Stacey Jane, Becky, Kate.	*"Erm but I think that particular model that you you've got to have your own bag of tools to deal with things in your life as well" (Claire).* *"Then I'd ask myself what would the tools do….I know the importance of talking now and so if I'm in a really bad way or if I've got something going on that I'm really worried about that's really distressing iv now identified well that's not great it's not great to be like that and it's important to address that. Whereas in the past I wouldn't have addressed id be like well let's get rid of that that's not nice. Now I address and I say right well I need to talk to someone about this so I might talk to one of my friends" (James).*

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
Strong emotions.	James, Claire, Stacey, Kate, Becky, Jane.	Frustrated.	James, Claire, Stacey.	*"And then using that to then did I then go on and ended up and it got me to the point where some weeks frustrated because I kind of knew what the steps where and I kind of let myself just gone on and tried to make everything perfect and almost cross with myself that I didn't recognise it earlier"* (Claire). *"And it's quite frustrating when I'm identifying that I'm dismissing myself you know that's* what I'm doing and then well that's what I do that's how I work and I don't really know a different way" (James).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
Strong emotions.	James, Claire, Stacey, Kate, Becky, Jane.	Scared.	James, Kate.	*"I think after so many years it's so hard to you know we have not just been together for a couple of years we have been together all my adult life and to suddenly to start changing things now it's really scary and I don't know.."* (Kate). *"That's key because your scared this is the first time you've told anyone any of this and its like oh my god what's she going to think. What's anyone going to think about this and then when it's okay it's kind of okay and erm you realise okay well maybe it's not so bad. Maybe these thoughts and feelings are not so terrible."* (James).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
Strong emotions.	James, Claire, Stacey, Kate, Becky, Jane.	Upset.	Becky, Jane, Claire, Kate, Stacey.	*"Erm I felt sad initially like when I read it I felt If I was reading about someone else I would have felt like god that poor person they feel so rubbish and have had all these things happen. I just I do feel sad because like…that's me...I was that sad person. It just felt like I didn't have any reason and then I felt happy like but this person gets it this person is helping me. This person was going to help me."* (Jane). *"I would say it was quite upsetting actually which sounds really quite stupid erm. I remember getting a bit teary over erm you know some of my themes and that erm. I think it was more admitting to having those feelings erm yeah."* (Becky).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
The process.	James, Becky, Jane, Stacey, Claire, Kate.	Being understood and accepted.	Claire, Kate, Jane, Stacey, James, Becky.	*"It's nice to have someone say it's not all your fault. There is so many contributing factors to why we are here"* (Jane). *"They maybe identify the reason and say well maybe you do that because of this and that makes it very nice because you feel like someone's understanding you and accepting you and then helping you which is all part of the process of CAT and what I think is very useful about CAT"* (James). *"I looked at it and I was thinking there's no wonder I was constantly tired and emotional and just sad all the time. If all that was going on in my head there's no wonder."* (Jane). *"And that was the first step of that diagram would be in my head when I was having thoughts that weren't making me feel so good id think to the diagram and think right where am I now, what am I doing now? Am I on the diagram and the moment? And often I was and then that was the first step of identifying it"* (James).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
The process.	James, Becky, Jane, Stacey, Claire, Kate.	Ending therapy.	James, Becky, Jane, Stacey, Claire.	*"Yeah so yeah it was good from that point of view. So all together it did make me realise how far I had come and I was chuffed to bits I really was and doing the letters although it was emotionally and like I said it was a mixed thing, combined with my letter and thinking about it and realising and then her letter as well I was thinking it did give me aa bit of a boost I was thinking okay I can actually do this I'm going to be okay. It did give me a boost to think that I could do it. It's a little bit you know but more thinking I can do this I'm going to be okay"* (Becky). *"And it was scary I'm all aware of the not needing you know even I said whilst I was very anxious about the sessions finish I said to the therapist I wouldn't want you on the end of the phone all of the time because that potentially not me being independent and then stand on my own two feet but I don't know whether I would have liked a few more follow up sessions even if it was just checking in a couple of times over the next year. We had a we had a session maybe six weeks after it finished and then that was it whereas I think maybe..*

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
The process.	James, Becky, Jane, Stacey, Claire, Kate.	Ending therapy.	James, Becky, Jane, Stacey, Claire.	*……you can't do it forever can you I'm totally aware of that but maybe you know a couple over a year you know if you did one six months sorry six weeks and then you did one at three months and then one again six months later." (Claire).*
		Therapeutic relationship.	James, Jane, Stacey, Becky, Kate, Claire.	*"It's very much a relationship, a therapeutic one at that, and its very much a you know you end up trusting this person because you feel like they understand your thought processes when they analyse them"* (James).

Superordinate theme	**Participant(s) contributing to the theme**	**Sub-themes**	**Participant(s) contributing to sub-theme**	***Illustrative quotes***
The process.	James, Becky, Jane, Stacey, Claire, Kate.	Therapist attributes and approach.	Claire, Stacey, James, Kate, Becky, Jane.	*"Yeah no definitely it's really important that she was you know good and none judgmental and accepting and all the good things she did and…"* (James). *"so we used quite a lot of analogies so one of mine was I felt like I was erm drowning in the sea and there was a boat and I couldn't get into it and she helped me change my mind set so I felt like I had to either get people to pull me into the boat because I was drowning or drown there was no other way. And then we started to look at well what could we do actually someone could you could swim and someone could say look come round the boat this way and get in. So those sorts of visual things really worked for me."* (Claire).

Appendix 19: HRA approval letter

NHS
Health Research Authority

Miss Nadia Rose
Trainee Clinical Psychologist
South Staffordshire and Shropshire Healthcare NHS
Foundation Trust
Staffordshire University
Professional Doctorate in Clinical Psychology
Stoke on Trent
ST4 2DF

Email: hra.approval@nhs.net

05 April 2017

Dear Miss Rose

Letter of HRA Approval

Study title:	**Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties.**
IRAS project ID:	**225217**
REC reference:	**17/WA/0084**
Sponsor	**Staffordshire University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

IRAS project ID	225217

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **225217**. Please quote this on all correspondence.

Yours sincerely

Miss Helen Penistone
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Audrey Bright,*
South Staffordshire and Shropshire Health Care NHS Foundation Trust

Appendix 20: NHS REC approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

Pwyllgor Moeseg Ymchwil Cymru 5
Wales Research Ethics Committee 5
Bangor

Clinical Academic Office
Ysbyty Gwynedd Hospital
Betsi Cadwaladr University Health Board
Bangor, Gwynedd
LL57 2PW

Telephone/ Facsimile: 01248 - 384.877
Email: rossela.roberts@wales.nhs.uk

Please note:
This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

31 March 2017

Miss Nadia Rose
Trainee Clinical Psychologist
Staffordshire University
Stoke on Trent
ST4 2DF R027202F@student.staffs.ac.uk

Dear Miss Rose

Study title:	**Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties.**
REC reference:	**17/WA/0084**
IRAS project ID:	**225217**

Thank you for your letter of 24 March 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair. We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise). Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
IRAS Application Form [IRAS_Form_03032017]		03 March 2017
Response to Request for Further Information	1	24 March 2017
Other [Thesis Proposal]	4	24 March 2017
Letters of invitation to participant [Invitation letter]	3	01 March 2017
Other [Consent form]	4	24 March 2017
Other [Participant Information Sheet]	4	24 March 2017
Interview schedules or topic guides for participants [Interview schedule]	3	01 March 2017
Summary CV for Chief Investigator (CI) [Chief investigator CV]	-	01 March 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor letter for insurence]	-	03 March 2017
Other [Insurence document]	-	01 August 2016
Other [Public liability]	-	16 July 2016
Other [Proffesional negligence insurence]	-	16 July 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/WA/0084	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Rossela Roberts

Dr Philip Wayman White, MBChB, MRSM
Chair

E-mail: rossela.roberts@wales.nhs.uk

Enclosures: *"After ethical review – guidance for researchers"*

SL-AR2 After ethical review - research oth

Copy:	Academic Supervisor:	Professor Helen Dent Staffordshire University H.R.Dent@staffs.ac.uk
	R&D Office:	Ms Audrey Bright South Staffordshire and Shropshire Health Care NHS Foundation Trust audrey.bright@sssft.nhs.uk
	Sponsor:	Elizabeth Boath Staffordshire University e.boath@staffs.ac.uk

Appendix 21: University approval letter

Faculty of Health Sciences

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Nadia ROSE
Title of Study	Experiences of receiving Cognitive Analytical Therapy: for those with complex secondary care mental health difficulties
Award Pathway	DClinPsy

Status of approval: **Approved**

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply to the Local NHS Research Ethics Committee (LREC) for approval to conduct your study. You must not commence the study without this second approval.

Please forward a copy of the letter you receive from the LREC to Deb Edwards at Blackheath Lane as soon as possible after you have received approval.

Once you have received LREC approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the Faculty Ethics Committee an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

Signed: Dr Peter Kevern **Date**: 7.2.17
Chair of the Faculty of Health Sciences Ethics Panel

Appendix 22: R & D approval letter

NHS
Health Research Authority

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

From: South Staffordshire and Shropshire Healthcare NHS Foundation Trust

To: Nadia Rose, r027202@student.staffs.ac.uk

Cc: Rachel Lucas, Director of Psychological Services, Rachel.lucas@sssft.nhs.uk

Subject: Confirmation of Capacity and Capability at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Attachment: Agreed statement of activities.

Date: 11 May 2017

Dear Nadia

RE: IRAS No 225217

Confirmation of Capacity and Capability at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Full Study Title: Experiences of receiving Cognitive Analytic Therapy, for those with complex secondary care mental health difficulties.

This email confirms that **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **11 May 2017,** If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Ruth Lambley Burke,

Head of Research and Innovation

Block 7, St George's Hospital, Corporation Street, Stafford ST16 3AG

Appendix 23: University amendment letter

Partner Organisations:
Health Research Authority, England
NHS Research Scotland
HSC Research & Development, Public Health Agency, Northern Ireland
NIHR Clinical Research Network, England
NISCHR Permissions Co-ordinating Unit, Wales

Notification of Non-Substantial/Minor Amendments(s) for NHS Studies

This template **must only** be used to notify NHS/HSC R&D office(s) of amendments, which are **NOT** categorised as Substantial Amendments.
If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

Instructions for using this template

- For guidance on amendments refer to http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/
- This template should be completed by the CI and optionally authorised by Sponsor, if required by sponsor guidelines.
- This form should be submitted according to the instructions provided for NHS/HSC R&D at http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/which-review-bodies-need-to-approve-or-be-notified-of-which-types-of-amendments/ . If you do not submit your notification in accordance with these instructions then processing of your submission may be significantly delayed.

1. Study Information

Full title of study:	Experiences of receiving Cognitive Analytic Therapy; for those with complex secondary care mental health difficulties
IRAS Project ID:	IRAS 225217
Sponsor Amendment Notification number:	1
Sponsor Amendment Notification date:	12/06/2018
Details of Chief Investigator:	
Name [first name and surname]	Nadia Rose
Address:	1 Bryn Teg terrace, Ponciau, Wrexham,
Postcode:	LL14 1HN
Contact telephone number:	07930166762
Email address:	R027202F@student.staffs.ac.uk
Details of Lead Sponsor:	
Name:	Professor Nachi Chockalingham
Contact email address:	N.chockalingham@staffs.ac.uk
Details of Lead Nation:	
Name of lead nation *delete as appropriate*	England
If England led is the study going through CSP? *delete as appropriate*	No
Name of lead R&D office:	South Staffordshire and Shropshire Health Care NHS Foundation Trust

Partner Organisations:
Health Research Authority, England
NIHR Clinical Research Network, England
NHS Research Scotland
NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

Partner Organisations:
Health Research Authority, England
NHS Research Scotland
HSC Research & Development, Public Health Agency, Northern Ireland
NIHR Clinical Research Network, England
NISCHR Permissions Co-ordinating Unit, Wales

2. Summary of amendment(s)

This template **must only** be used to notify NHS/HSC R&D office(s) of amendments, which are **NOT** categorised as Substantial Amendments.
If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

No.	Brief description of amendment *(please enter each separate amendment in a new row)*	Amendment applies to *(delete/ list as appropriate)*		List relevant supporting document(s), including version numbers *(please ensure all referenced supporting documents are submitted with this form)*		R&D category of amendment *(category A, B, C) For office use only*
		Nation	Sites	Document	Version	
1	Recruiting participants through the ACAT organisation which is a registered charity	England	All sites or list affected sites	Thesis proposal Invitation letter Participant information sheet	5 4 5	
		Wales	All sites or list affected sites			
2						
3						
4						
5						

[Add further rows as required]

3. Declaration(s)

Declaration by Chief Investigator

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendment(s) to be implemented.

Signature of Chief Investigator: .....N.Rose.....

Print name: .....NADIA ROSE

Date: 12/06/18

Optional Declaration by the Sponsor's Representative (as per Sponsor Guidelines)

The sponsor of an approved study is responsible for all amendments made during its conduct.

The person authorising the declaration should be authorised to do so. There is no requirement for a particular level of seniority; the sponsor's rules on delegated authority should be adhered to.

- I confirm the sponsor's support for the amendment(s) in this notification.

Signature of sponsor's representative: .....

Print name:.....

Post: .....

Organisation:.....

Date:.....

Appendix 24: Study inclusion and exclusion criteria

Inclusion Criteria:

- Service users who have experienced a course of CAT.
- Presenting with complex mental health difficulties and therefore presenting with both of the following:

1) Multiple mental health difficulties (more than one mental health difficulty or diagnosis such as anxiety and depression)
2) That these mental health difficulties, for example anxiety and depression are profound, serious, enduring or intense.

- Service users who have completed the therapy within the last 18 months.
- Aged 18 years and above.
- Good understanding of the English language.
- Service users must have capacity to consent to take part in this study.
- Service users are currently accessing secondary care mental health services within the Trust.

Exclusion Criteria

- Those who are under the age of 18.
- Have a diagnosis of an organic condition or a learning disability.
- Those who do not present with complex secondary care mental health difficulties as described in the inclusion criteria.
- Service users who do not have capacity to consent to take part in this study.
- Those who are not currently accessing mental health services within the Trust.

Participants will not be excluded on ethnic background or gender.

Appendix 25: Review inclusion and exclusion criteria

. ***Inclusion criteria: Phase 1 (for title screening): Must be present***

- Only include titles that have any of the following words present: Intervention, therapy, therapies, formulation, therapeutic, psychotherapy, psychotherapeutic, treatment, treating, cognitive analytic, Cognitive Analytic Therapy or CAT.

Inclusion criteria: Phase 2 (for abstract screening): All must be present

- Must include the following words: cognitive analytic therapy, CAT or cognitive analytic
- Can either be individual or group delivered CAT
- Must be from the service user's perspective
- Must be investigating the experience of receiving CAT only.

Exclusion criteria: Phase 2 (abstract screening): Must not be present

- Does not include service user's perspective (i.e. professionals perspective)
- Does not include service user's experience of receiving CAT
- Service users receive a combination of CAT with another therapy (e.g. CAT and CBT).
- Only reports symptom reduction outcome measures