Using **cognitive analytic therapy** in a workplace counselling service

Jill Collins considers how to offer a useful therapeutic experience to clients and their employers, which is ethically sound and within the resources available

Many organisations now provide counselling for their employees. This may be in-house by a counselling service or provided through an external employee assistance programme. Such counselling has a very wide scope, akin to a general practitioner (GP) for mental health, and deals with a full range of emotional and psychological difficulties, as well as issues particular to the context of such a counselling service: stress, bullying, interpersonal difficulties with colleagues, lack of motivation etc. These are all 'personal' difficulties, but also profoundly affect someone's functioning as an employee.

I work in the staff counselling service of a large university which offers time-limited counselling, available free of charge to all staff, for work or personal difficulties. Most of our clients self-refer, sometimes at the suggestion of the human resources department, occupational health, their manager or colleague, or their GP, but rarely through a formal referral route. We see the whole range of staff who work here: academic, researchers, administrative and technical support staff, and manual staff, both men and women, with an age range of 18-65. Sometimes the clients we see are on sick leave but usually they are still at work, albeit in a distressed and troubled state. We work with a wide range of presenting difficulties and client needs. Sometimes these are directly based in the work context, eg stress, bullying, workload and redundancy; but they can also be personal difficulties which are affecting the client's ability to work effectively: relationship difficulties and marital breakdown, anxiety and depression – often severe – eating disorders, self-harm, borderline personality disorders, family difficulties, including eldercare and child protection issues, anger management, sleep disorders and bereavement. We are a team of one full-time counsellor/manager and three half-time staff, and are available to 9,000 employees. We have a variety of approaches within our team: psychodynamic, person-centred, cognitive behavioural therapy (CBT), and cognitive analytic therapy (CAT).

Any workplace counselling service has to find a way to be effective therapeutically with limited resources, which inevitably means working in a time-limited way.

Cognitive analytic therapy has evolved as a brief, focal therapy, usually based on a model of 16 sessions. It is an intervention that can be useful to a very broad range of people suffering mental health problems, and is informed by both cognitive therapy and psychodynamic psychotherapy. It was developed 30 years ago by Dr Anthony Ryle, originally a GP, who was aware of the high proportion of his patients who were suffering emotional problems. His interest was sparked by 'the high prevalence, persistence and personal cost of common neuroses, and of how they were inseparably bound up with the social context and problems of living, for my patients, and with their family structure and personal relationships'[1]. Access to psychotherapy on the NHS was then, as now, limited, with long waiting periods, so was not available to many of the patients he would see in general practice, who, whilst not having acute psychological problems, had lives and health compromised by the emotional difficulties that they experienced. He saw a need for a therapy that was manageable in the NHS but, above all, would be effective for the patients seen.

The aim of CAT is firstly the recognition and then the modification or replacement of the harmful or restrictive ways in which the client is living their life. CAT is structured around the three 'Rs': reformulation, recognition and revision.

Reformulation

Reformulation would usually be the focus of the first four sessions of the therapy. The first task is to build a working relationship; the client will be

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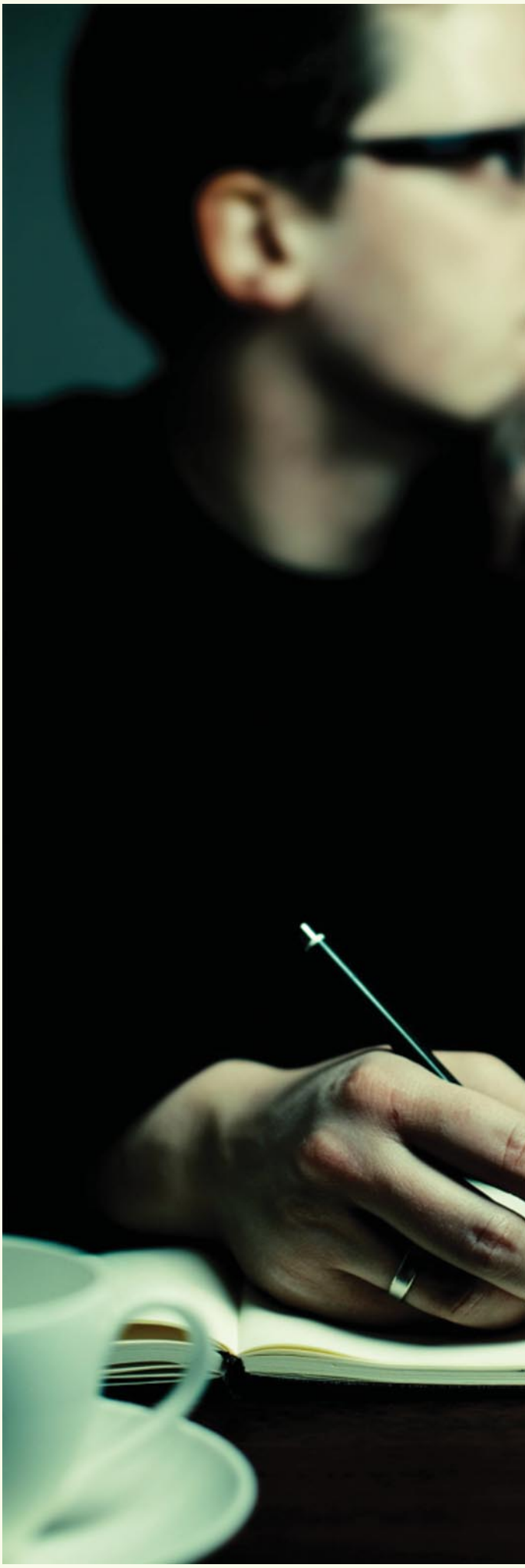
invited to explain what has brought them to therapy and to tell their story. Clients may also be asked to write an account of their life history or to draw a time-line, setting out significant life events. A geneogram may be drawn, covering the past two or three generations of their family. This can be a useful way to document their history, helping to give a context to their difficulty and identify any patterns which might run in the family. After the first session they will be asked to complete a 'psychotherapy file' which asks about typical, common problems or recurring patterns, described as traps, dilemmas and snags. Traps are like a vicious circle, where negative assumptions lead to acts which generate consequences that reinforce the assumption. Dilemmas are where there appears to be only two polarised choices and snags are where appropriate goals are sabotaged. After these exploratory sessions some target problems (TP) are first identified, such as 'I'm not meeting work deadlines', followed by the thoughts and behaviours that perpetuate this difficulty: the target problem procedure (TPP), such as 'I worry that my work won't be good enough and I'll be criticised, I cannot get started, I keep putting it off and miss the deadlines'.

These tasks are all directed to the central task of reformulating the client's difficulties, leading to a reformulation letter, written to the client and read aloud in or around the fourth session. This letter describes what brought the client to therapy, the target problems identified, and summarises the client's history and how the negative patterns learned from their early experiences are now being repeated. A diagram of these patterns, called a sequential diagrammatic reformulation (SDR), or therapy map, is drawn with the client and provides a focus for the middle stage of the therapy.

Recognition

The middle part, the recognition phase, is when the client, using the diagram and the reformulation letter, begins to monitor how these patterns are played out in their daily life, by keeping a diary. Symptoms, mood swings and behaviours are increasingly recognised and understood, and begin to be modified. In the sessions, these will be talked about, with the therapist bringing the client back to the agreed focus by asking, 'Where were you on the diagram/map?' The client begins to develop the ability to recognise the patterns, and in time starts to revise their behaviour and reaction; and alternative ways of responding or coping – exit points – will be drawn. A rating sheet for each TP is completed at each session, which invites the client to evaluate how well they are noticing and revising their behaviour.



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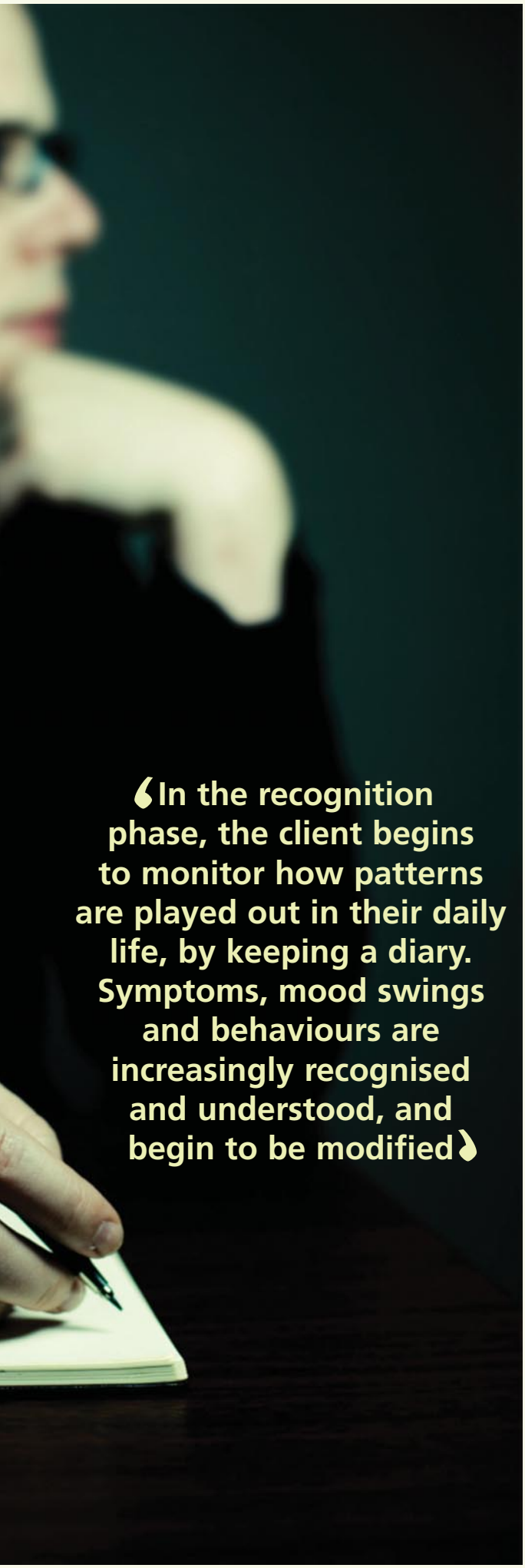

‘In the recognition phase, the client begins to monitor how patterns are played out in their daily life, by keeping a diary. Symptoms, mood swings and behaviours are increasingly recognised and understood, and begin to be modified’

Revision

At the end of the therapy the therapist will write a goodbye letter, summarising what has happened in the therapy, how the problem procedures have, or have not, been modified, and to identify where further work is needed. The letter gives the client a reminder of the therapy and helps to internalise the experience. The client is invited to also write a goodbye letter to the therapist. These letters are often exchanged in the penultimate session so that there is an opportunity in the last session to work with any issues which might have come up from the ending. A follow-up session is arranged for about three months afterwards, at which the effectiveness of the therapy can be reviewed.

Twelve versus 16-session model

After I had completed my CAT practitioner training, I began to think about how I could offer CAT more widely within the constraints of our resources, as the usual 16-session plus follow-up structure, with an assessment session as well, was almost doubling what we could offer if our waiting time was not to become unmanageable. A briefer model of CAT has been thought about. In his first book, Ryle refers to a ‘satisfactory 12-16 session therapy’[1] and in later writing says: ‘The time limit is usually of 16 sessions but this can be extended in treating more disturbed and damaged patients or shortened where the threshold to consultation is low and mildly disturbed patients are seen’[2], which applies to most of our clients who self-refer and are functioning in their lives.

I wanted to continue to offer CAT and thought it an excellent therapy for my work setting, but I had to find a way to offer it in fewer sessions. As everywhere else, there is a greater demand on the service than we have therapist time available, so we usually work within eight to 12 sessions, our average session time being 7.5 sessions per client. I started working with an eight-session therapy, but found eight sessions too rushed and cramped, with not enough time to develop and introduce the various CAT tools – the two letters, the psychotherapy file, the SDR, the rating sheets etc. To me, it felt too mechanistic and as if I was losing the therapeutic essence of CAT. So I settled on 12 sessions as the outer limit of what is possible in my service.

However, time was not the only criterion. There were other reasons why a brief CAT would be helpful for this client group. We see the ‘walking wounded’, exactly the group for whom Ryle originally developed CAT. The CAT emphasis on client participation, self-monitoring and self-help is very relevant to this population. Our clients usually attend during their working day (though we do offer some appointments after work until 7.30pm) and are

mindful of not making a commitment for too long a period. They are busy people working in a demanding and pressurised environment and are, on the whole, very motivated to engage in counselling. Most clients have sought out information about the service in advance, usually from the website, and may have thought about coming for some time before committing to seek counselling. Word of mouth is effective, and colleagues who have had a positive experience of counselling can help to encourage others to try the service.

Our clients will have completed a pre-counselling form to register their counselling request and waited on average six to eight weeks to begin. As a population who work here in the university, they are self-directed people, perhaps more than average. Therapy is often new to them and few will have had previous engagement with NHS mental health services. The fact that the employer offers workplace counselling provides a positive endorsement for the service and the familiar setting of work seems to further reduce the stigma for seeking help.

When clients begin counselling they often request a structure to the work because they are familiar with structures relating to teaching plans, deadlines and work routine and so they expect us to provide this as a way to analyse their difficulty. CAT provides this structure and, more importantly, also offers a way for clients to begin to think about underlying relational difficulties. Some of our clients need to learn how to feel (to access their emotions), others need help learning how to think, but for all of them CAT offers a way to understand the relationship between their early experience, their present difficulties, and their understanding of how they relate to other people. As the CAT saying goes, 'From an eye, an I can grow'. Consequently, they come to see the impact of their beliefs, attitudes and behaviours on their daily lives, relationships and approach to work in a very different way.

Our clients meet us with no therapeutic history; we rarely have referral letters from doctors or mental health practitioners; there are no medical files, or assessment records from another therapist, so we are starting with a clean slate. All we have is a pre-counselling form that the client completed and returned to us when they registered. This form collects basic contact and statistical information and invites the client to write as much or as little as they want to about their difficulty, why they are seeking help now, previous help they have had with it, if any, and how it affects them in their daily lives. It asks about what they think might be the origins of their distress, how they are currently coping, questions about risky behaviours or self-harm and about their expectations of counselling. The collaboration with and involvement of the client in their therapy has already begun before they meet a counsellor. Most report in our evaluation that completing the form has been thought-provoking, therapeutic or even cathartic in itself even if it has been difficult to complete. If, for any reason, someone is unable to complete the form (or if it is inappropriate) we offer a pre-counselling session instead.

I used supervision to consider how to structure the 12 sessions I had available to work with. I wanted to extend therapy over as long a period as possible to allow enough time for reflection and change but also wanted a concentrated period at the start of the therapy to enable a good working therapeutic relationship to be established and for the client to become actively engaged in the task of reformulation. This led me to consider spacing sessions at longer than weekly intervals. I considered which CAT tools could be used and specifically how the time-intensive but therapeutically essential letters could be adapted.

The structure I decided on for 12 sessions was to have six weekly sessions and the remainder at fortnightly intervals with a three-month follow-up. Perhaps inevitably, this was skewed slightly because of holidays, work commitments, illness etc, just like any other therapeutic encounter is. However, this was the plan and for the most part it did actually go along these lines. The six weekly sessions involved the reformulation phase, where the usual tasks are completed, ie a personal history taken, a psychotherapy file completed, a diary kept, target problems, and target problem procedures formulated. A reformulation letter is written for session four or five, and an SDR that has been

developing, is finalised enough to be a working tool by the end of session six.

The next block of sessions was spaced fortnightly to allow more time for the client to develop an understanding of their difficulties by recognising the TPPs and providing time to revise them. A diary was kept during this period to provide a focus for the work in each session and a rating sheet for each TP was completed at each session. Rating sheets are the part of CAT which I have always struggled with, and I don't think I'm alone with this. I have no difficulty with the other CAT tools, which I feel very at ease with, but coming from a psychodynamic background, I have always felt uneasy when using the rating scales, finding them a mechanistic intrusion into the therapy. I do, however, appreciate their value in recording change and recognise how clients find it useful to see their progress measured. I now use an adaptation, which has columns for sessions six to 12 and follow-up, rather than the standard one with spaces for sessions four to 16 and follow-up, as the unused columns for the 'missing' sessions seemed to indicate what was being offered was a lesser version of a 'real' therapy. I have also found clients sometimes find the terms 'recognising and revising' and 'stopping' a bit confusing, so I have renamed them 'noticing' and 'changing', and find this easier to work with.

My original plan was that the two final sessions would be weekly, with the goodbye letter in the penultimate session, as in a 16-session therapy, but I have revised this as I have gone along. It often felt that session 11, the penultimate session, came too soon in the therapy to review. After a couple of cases where unplanned events, such as client illness or work commitments, meant the goodbye letter was read in the final session, I realised this worked better, and provided more time for reflection. So now, in session 11, I have a discussion with the client to review our work, to establish what the ending meant, evaluate change and identify areas for further work. Verbally, this covers the tasks of the therapist's goodbye letter. I invite the client to write the goodbye letter for session 12, the final session, balancing the reformulation letter I have written earlier, and all clients so far have done this with much willingness and thought. I now also call this a review letter, rather than a goodbye letter, which always felt a bit contradictory when we would then meet for a final session the next week and a follow-up session a few months later. I do not write one myself, partly because of time pressure. With a usual caseload of 18 clients, as well as managing the service and team, I would not have been able to use CAT if I had to write two letters for each client. I also felt two letters from me in a brief therapy might have felt a bit unbalanced. I aimed to provide my input into the review in the discussion we had in the penultimate session.

The follow-up session has been very important in the sequence of sessions which, once therapy has ended, provides a helpful containment. I have been encouraged that, at follow-up, a revision of procedures has been maintained and often continued to improve.

Recent financial pressures and staffing reductions meant that our waiting list increased to between two and three months, longer than normal for us. In some settings, this might be regarded as acceptable; but in ours, expectations from clients and management require us to respond quickly when work is being affected. As a result, I began to use a four-session model with diagram and two monthly follow-ups. This was helpful to the clients but really did not feel adequate, as there was not enough time to monitor and revise a client's difficulties. I'm now trying it with four follow-ups at fortnightly intervals but something seems lost from the therapy without the reformulation letter. It is interesting that Ryle, writing about CAT in primary care and the effectiveness of CAT with frequently attending patients, suggests that six sessions are not sufficient to effect change: 'This suggests that a full course of CAT may be necessary to achieve clinically significant and lasting results in many patients … raises important questions about the widespread practice … of restricting therapists or counsellors to delivering such a limited number of sessions only'[2].

This highlights the tension between being a therapist and the manager of a service, with a provider to answer to in an increasingly tight financial climate.

All services are grappling with this. Perhaps the challenge, to some extent, remains how to offer a genuinely useful therapeutic experience and encounter to clients, which is ethically sound, within the resources available, and which satisfies the motivation of the employers to provide and continue to fund such a service. ■

References

1 Ryle A. Cognitive-analytic therapy: active participation in change. Chichester: Wiley; 1991.

2 Ryle A, Kerr I. Introducing cognitive analytic therapy: principles and practice. Chichester: Wiley; 2002.

For further information on CAT, visit: www.acat.me.org

In a future issue of Counselling at Work *we hope to publish a follow-up article that demonstrates cognitive analytic therapy in action, using case study examples.*