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Running head: developing exits in CAT for depression

The development of a change model of ‘exits’ during cognitive analytic therapy for the
treatment of depression

Sundeep Kaur Sandhu¹,

Stephen Kellett^{23*}

&

Gillian E. Hardy²

¹Birmingham and Solihull Mental Health NHS Foundation Trust, UK

²Centre for Psychological Therapies Research, University of Sheffield, UK

³Sheffield Health and Social Care NHS Foundation Trust, UK

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Correspondence should be addressed to Stephen Kellett, Clinical Psychology Unit, University
of Sheffield, Cathedral Court, Floor F, 1 Vicar Lane, Sheffield, S1 1HD, UK. E-mail:
s.kellett@sheffield.ac.uk

Objectives: ‘Exits’ in cognitive analytic therapy (CAT) are methods that change unhelpful patterns or roles during the final ‘revision’ phase of the therapy. How exits are conceived and achieved is currently poorly understood. This study therefore focused on the revision stage of CAT to explore and define how change is accomplished.

Methods: Qualitative content analysis studied transcripts of sessions six and seven of a protocol delivered eight-session CAT for the treatment of depression. Eight participants met the study inclusion criteria and therefore sixteen sessions were available for analysis.

Results: The exit model developed contained three distinct (but interacting) phases; (1) developing an observing self via therapist input or client self-reflection, (2) breaking out of old patterns by creating new roles and procedures and (3) utilisation of a range of methods to support and maintain change. Levels of inter-rater reliability for the exit categories making up the model were good.

Conclusions: The revision stage of CAT emerged as a complex and dynamic process involving three interacting stages. Further research is indicated to understand how exits relate to durability of change and whether change processes differ according to presenting problem.

Key Practitioner Messages:

- Exit work in CAT is a dynamic process that requires progression through stages of insight, active change and consolidation.
- Development of an ‘observing self’ is an important foundation stone for change and CAT therapists need to work within the client’s zone of proximal development.
- A number of processes appear important in facilitating change such as attending to the process and feelings of change.

Cognitive analytic therapy (CAT) is an integrative therapy that draws on personal construct (Kelly, 1955) and object relations theory (Ryle, 1985), and is based on the principle that mental representations of self, others and the world are developmentally formed by early interactions with significant others (Ryle & Kerr, 2002). CAT assimilates associated psychoanalytic and cognitive methods to offer a transdiagnostic, time-limited and relational approach to facilitating therapeutic change (Ryle & Kerr, 2002). The model therefore anticipates that the client will relate to the therapist as they did with significant others in their early life, and 'enactments' of these roles will occur within the therapeutic relationship.

Clients' presenting difficulties in CAT are defined as target problems and associated target problem procedures (TPPs). TPPs are patterns of relating to self or others, which involve a sequence of aim, cognition, affect, behaviour and consequences generated from reciprocal roles (Ryle & Kerr, 2002). Reciprocal roles are learnt patterns of relating to one self ('self-to-self') or to others ('self-to-others' and 'others-to-self') that are the product of early interpersonal experiences (Ryle, 1985). Change in CAT is considered to occur on a platform of early, collaborative narrative and diagrammatic reformulation. Narrative reformulation develops a shared understanding of the developmental origins of difficulties, current maintaining processes and names potential unhelpful enactments within the therapeutic relationship (Ryle, 1995). A sequential diagrammatic reformulation (SDR) is constructed to identify the predominant reciprocal roles and associated problem procedures that maintain difficulties, and as a means of managing the 'enactments' of past roles and procedures that occur within the therapeutic relationship (Ryle, 1997).

The structure of CAT follows a reformulation, recognition (increasing relational awareness) and revision (active change) three-phase approach. During the revision stage, client and therapist explore, develop and try out new ways of relating to self and/or others as a way of 'exiting' from their target problems. The revision stage therefore involves clients

engaging in new ways of “experiencing, judging and acting” (Ryle & Kerr, 2002, p.124).

The change methods of CAT are diverse and retain fidelity to the CAT model as long as they are grounded in the SDR and within the client’s zone of proximal development (Kellett, 2012). Change in CAT would mean a client changing long-term roles and associated patterns by relating to themselves differently (a change in ‘self-to-self’ reciprocal roles), relating to others differently (a change in ‘self-to-other’ reciprocal roles) and also changing what they invite from others (a change in ‘other-to-self’ reciprocal roles).

There is a small but developing evidence-base for CAT for complex clinical populations (Calvert & Kellett, 2014), with a weighted mean effect size across CAT outcome studies of $d_+ = 0.83$ (Ryle, Kellett, Hepple, & Calvert, 2014). However, how these effect sizes are achieved (i.e. how change is brought about) during CAT is currently poorly understood (Calvert & Kellett, 2014). The evidence base for CAT with depression is mostly made up of practice-based evidence and there is a lack of controlled studies with this population. Two qualitative case reports (Bennett, 1994; Hamill & Mahoney, 2011) reported good outcomes for CAT for depression. CAT has also demonstrated comparable effectiveness to cognitive behavioural therapy (CBT), person centred therapy (PCT) and ‘interpretative therapy’ for clients with depression (Brockman, Poynton, Ryle, & Watson, 1987; Marriott & Kellett, 2009).

Defining the mechanisms of change of a therapy is important in (a) improving treatment outcomes (Johansson & Høglend, 2007), (b) in defining differences between psychotherapies (Ahn & Wampold, 2001) and (c) refining treatments (Warmerdam, van Straten, Jongasma, Twisk, & Cuijpers, 2010). There is single case experimental design evidence that the early reformulatory stages of CAT can help clients change (Kellett, 2005; Kellett & Hardy, 2013). During CAT for borderline personality disorder, personality integration has been observed to take place during the revision phase (Kellett, Bennett, Ryle,

& Thake, 2013). Fusekova (2012) used grounded theory to explore the development of exits from nine therapist-client dyads. The three-stage process model of exit development consisted of ‘opening up of new perspectives,’ then ‘coming up with common sense, yet novel ideas about exits’ and finally ‘working hard and persevering’ with exits. Toye (2009) identified that exits needed to be personally meaningful to clients, and so were therefore often highly idiosyncratic. Exits were identified as either evolving spontaneously during sessions, or through focused discussion and planning between client and therapist (Toye, 2009).

In order to better understand and define the revision stage of CAT, this project sought to study how CAT therapists collaborate on ‘exit’ work with clients in ‘real time’ during treatment of depression. The main aims of the current study were to define the types of exit work completed, provide a tentative exit change model and to provide some initial reliability and validity evidence for the model.

Method

Design and ethics

The study used qualitative content analysis (QCA; Schreier, 2012) to study audio-recorded therapies of CAT provided to clients with depression. Relevant ethical and governance approval was granted for the research (ref: 13/YH/0112).

Participants

The sample included eight clients who are part of an ongoing component analysis study, exploring the impact of narrative reformulation in CAT (Stockton, 2012). All participants were referred to a UK primary care mental health service following a GP consultation that identified depression. A diagnosis of depression was established through a screening interview (conducted using DSM-IV criteria; APA, 1994). Clients were excluded from the study if they: (a) did not meet DSM-IV criteria for depression; (b) had significant

on-going risk issues, a co-morbid anxiety disorder, any previous in-patient admission, a history of overdoses/self-injury, or significant previous contact with mental health services; (c) visual impairment that could result in difficulties in using therapy materials; (d) non-English speaking and finally (e) currently abusing substances. Participants were selected for this study if they additionally had completed all sessions of therapy, if the sessions were audio-recorded and pre-post outcome measures were available. Eight participants (age range 27-55, 7/8 women) met inclusion criteria during the study period and agreed to participate (see Table 1).

Insert Table 1 here please

Therapists

CAT was delivered by five therapists, four of these were women. All therapists were trainee clinical psychologists completing a specialist 3rd year CAT placement. Therapists received two days of training on CAT for depression, in addition to the four days of CAT training they received as part of their clinical programme. Therapists attended a weekly two-hour group supervision conducted by an experienced CAT practitioner and supervisor. The supervision was conducted via the CCAT (Competence in Cognitive Analytic Therapy; Bennett & Parry, 2004).

Treatment and treatment fidelity

Participants received an 8-session CAT. The CAT followed a reformulation (2 sessions), recognition (3 sessions), revision (2 sessions) and endings (1 session) protocol. Narrative reformulations were delivered at session 3 and the diagrammatic reformulation (sequential diagrammatic reformulation; SDR) was completed at session 4. Treatment competency was assessed using the CCAT; one of the authors of the CCAT assessed one

session per client. On average, the delivery of CAT was satisfactory, with an average rating across therapists of 25, and range of 18-40 (see Table 1). In a recent randomised controlled trial of CAT for personality disorder, the mean CCAT competency score was 22 with a range of 13-38 (Clarke, Thomas, & James, 2013).

Outcome measure

The Patient Health Questionnaire-9 (PHQ-9; Spitzer, Kroenke & Williams, 1999) is a valid and reliable screening measure of depression (Martin, Rief, Klaiberg, & Braehler, 2006), which is sensitive to treatment outcome (Löwe, Unützer, Callahan, Perkins, & Kroenke, 2004). Assessment categories are 0-4 (none-minimal), 5-9 (mild), 10-14 (moderate), 15-19 (moderate to severe) and 20-27 (severe depression). 'Caseness' on the PHQ-9 is a score ≥ 10 (Arroll et al., 2010). Participants were categorised into PHQ-9 outcome categories to ensure a spread of outcomes were available for the QCA. Jacobson and Truax's (1991) metric calculated reliable and clinically significant change rates on the pre-post PHQ-9 outcome data. To achieve a reliable reduction in depression, participants had to have a pre-post PHQ-9 reduction ≥ 6 ; for this change to be clinically significant the post-therapy score needed to be < 10 . Two participants were categorised as 'recovered' (reliable improvement and shift from clinical to non-clinical category), three as 'improved' (reliable improvement, but remained in the clinical range) and three were in 'stasis' (neither reliable improvement nor deterioration). No participant met the criteria for reliable deterioration (see Table 1).

Procedure

The audio-recordings of the revision sessions, six and seven, were transcribed. The transcripts were then analysed using Qualitative Content Analysis (QCA; Schreier, 2012). To prevent experimenter bias, coders were 'blind' to both outcome and competency.

The first pilot-coding phase was conducted on six randomly selected sessions from the sample (both session 6 and 7 from participants 1, 3 and 6), the second iteration of the pilot-coding was conducted on two additional randomly selected sessions from remaining sessions (participant 7 session 6 and participant 8 session 7). The final coding was conducted on the remaining six sessions (both session 6 and 7 from participants 2, 4 and 5). All coding regardless of stage of model development was subject to inter-rater reliability analysis (see Table 2) via Cohen's Kappa (Cohen, 1960). Kappa levels were interpreted as follows: <0 no agreement, 0–0.20 slight, 0.21–0.40 fair, 0.41–0.60 moderate, 0.61–0.80 substantial and 0.81–0.99 perfect agreement (Landis & Koch, 1977).

The QCA process was as follows:

a) Selecting the material. Sessions 6 and 7 were selected, as the study protocol identified these as the revision phase of the 8-session CAT (i.e. where exits were likely to be evident). Sections of the transcripts from session 6 and 7 deemed irrelevant were marked as 'not relevant' (e.g. setting up the session, scheduling the next appointment and discussion of difficulties with no reference to reciprocal roles, problem procedures or change processes).

b) Building the coding frame. This stage involved structuring the code frame and this was achieved through generating dimensions and subcategories for dimensions. A combination of concept-driven (using what is known about CAT) and data-driven (what emerged from the transcripts) strategies was employed. The concept-driven strategy drew on (a) the CAT evidence base and (b) consultations with five expert CAT therapists (all completed CAT practitioner training, CAT supervision training and with a minimum of 10-years CAT practice, post qualification). The data-driven strategy used to extend the concept-driven categories utilised the process of 'subsumption', as described by Mayring (as cited in Schreier, 2012). This involved analysis of relevant passages for evidence of significant change concepts and deciding whether these were novel or not. When novel, these data were

developed into a category. This strategy was used, as it is appropriate when the main dimension (i.e. the notion of a revision phase in CAT) has already been fully or partially determined (Ryle & Kerr, 2002). The novel categories identified needed to be mutually exclusive and to also contain residual categories. Residual/miscellaneous categories capture any unanticipated information, which is relevant to the research but does not fit into any of the main categories. Residual categories are also important when working with a data-driven coding frame as some information is likely to be only mentioned once in the material. The method for defining a category followed the Schreier (2012) four-stage process: (i) concisely name the category, (ii) provide an adequate description of the category via the use of typical indicators, (iii) provide typical anonymous examples of the category from the transcripts and finally (iv) where conceptual overlap existed between categories, a decision rule was used to assign data to the appropriate category. Once all categories had been through the four-stage process and the coding frame drafted, the coding frame was revisited and refined. This was in order to ensure sharp distinctions between categories where possible, and when significant overlaps existed, categories were collapsed.

c) Sectioning the material into units of coding. The material was divided into smaller units of coding using a thematic criterion. Therefore, change in a theme/topic during a session indicated the ending of one unit and the beginning of another. These were numbered consecutively. This was in order take into account that each unit (i.e. a piece of discussion from the session) should fit into a single subcategory only.

d) Testing the coding frame through double coding. This stage involved reviewing the data, and raters discussing how each unit of coding could be classified into the coding frame and the reasons why. This provided another iteration phase of the coding frame. Transcripts from sessions from each outcome category were randomly selected and coded independently with the new coding frame. Coders assigned each segment of the session transcript to a sub-

category. Where there was disagreement, the coders met to discuss the interpretation of units. Where relevant, adjustments were made to the coding frame, the units of coding or the procedure. As many amendments were made, a second trial coding took place with a single transcript randomly selected from two of the outcome categories. It is inappropriate to change the coding frame during the main analysis. Using differing sessions across the outcome categories from the first run of double coding, the double coding was again repeated.

e) Evaluating and modifying the coding frame. Adapting and matching the code to the material throughout the analysis served as a validity check to ensure that the coding adequately represented constructs of interest and the data itself. The coders worked separately when analysing units of conversation using the final coding frame. The CAT experts (N=5) also checked that the categories and the final coding frame accurately represented CAT theory and practice.

f) Conducting the main analysis using the final coding frame. All original session transcripts were revisited and sectioned into units of coding using the revised and final coding frame. The first author coded all of the transcripts. The second coder coded the transcripts from the three clients not chosen in any of the randomisation procedure to date, independently using the new coding frame. Finally, the coders came together to discuss any units of coding they coded differently, in order to negotiate a final code.

Results

The results are presented in three sections: (a) reliability and validity evidence, (b) description of the main exit categories and associated sub-categories and (c) presentation of the final three-stage exit model. The main categories of exit work were; (1) development of an observing self (i.e. clients' increasing awareness of depressive roles and associated

problem procedures), (2) change in procedures and roles (i.e. clients trying out new ways of relating, thinking, feeling and behaving to change their depression), and (3) support and maintenance of change (i.e. therapists helping clients to consider how to nurture change over time).

The face validity of the coding frame was supported, as only 3% of the total categories coded were assigned a residual category (self-care other, self to self; other or self to other; other). In addition, CAT experts were consulted about the coding frame. This prompted change to the labelling of categories within the ‘observing self’ main category, as this did not originally differentiate between therapist-facilitated and client-facilitated recognition of problem procedures and/or reciprocal roles. Results from the inter-rater reliability analysis are reported in Table 2, in the order that the transcripts were coded. The main coding showed substantial levels of inter-rater consistency ($\Rightarrow 0.61$) indicating that the final coding frame produced was reliable. Individual exit categories related to ‘changes in procedures and roles’ occurred most often outside of the session - the most frequent categories included improvements to ‘self-care’ and ‘being more assertive regarding meeting own needs/wants’, which were exits that were identified by 7 out of the 8 participants. The exits that most commonly occurred within sessions were ‘self-compassion’ and ‘motivating and encouraging oneself’, as they were identified by 4 out of the 8 participants (see table 3). Considering the large number of categories within the ‘change to procedures/roles’ theme, only these 4 exits will be described further, as they were the most frequently identified across the clients. As individual categories within the ‘observing self’ and ‘support and maintenance of change’ themes were present in the majority of cases, all categories are detailed.

Insert Table 2 here please

In Table 3 for each sub-category within a main category the total number of cases, percentage of cases for which the exit category was present, range of total number of units per client and average number of units where a category was present is reported. All three themes were present in all cases and change in procedures/roles and support/maintenance of change were present in the majority of cases (range 6-8). The most common exit categories included: ‘therapist facilitated recognition – out of session’ (mean 8 units per case, range 3-17 units), ‘planning change through scaffolding’ (mean 10 units per case, range 3-15) and ‘client and therapist attending to the process of change’ (mean 8 units per case, range 2-13). The prevalence of the ‘change in procedures and roles’ exit categories varied across cases, with a range of 9-80 units coded per client and an average of 38 units coded per client. Individual exit categories related to ‘changes in procedures and roles’ referred most commonly to events outside of the session - the most frequent categories included improvements to self-care (88% of cases) and being more assertive regarding meeting own needs/wants (88% of cases). The exits that most commonly occurred within sessions were self-compassion (50%) and motivating and encouraging oneself (50%). As individual categories within the ‘observing self’ and ‘support and maintenance of change’ themes were present in the majority of cases, all categories are detailed. Considering the large number of categories within the ‘change to procedures/roles’ theme, only the most common ‘self-to-self’ and ‘self-to-other’ categories are described.

In the following short sections, each main exit category and associated sub-categories are presented, with sub-categories grounded in the original data from the transcripts of the therapy session.

Insert Table 3 here please

Developing an observing self

This theme reflected the process by which clients increased their capacity for self-reflection regarding the factors maintaining their depression. Specifically in terms of CAT, clients reported being able to better recognise ‘depressive roles and procedures’. Two factors enabled the development of a more effective observing self; feedback from the therapist and client self-recognition. Therapists used both ‘in session’ (when there was an ‘enactment’ of a role or a procedure within the therapeutic relationship) and ‘out of session’ material (when the client was in a depressive procedure or occupied a depressive role in their general life) to facilitate better client self-awareness.

Therapist-facilitated recognition. Here the therapist facilitated the development of an observing self, by making tentative statements linking re-enactments of old patterns in current relationships:

‘It strikes me that he does a lot of this in this relationship, very much in control of the relationship ... so you're doing this kind of trying to keep him happy by not pushing him and not giving him an ultimatum. Not putting your own needs first. So you're giving in to kind of what he wants, he comes round when he wants and it puts you back in this position’ (Jess’ therapist)

Client-facilitated recognition. Some clients demonstrated an increasing ability to recognise patterns and roles themselves in their general life during sessions, thus also supporting the development of an observing self. One participant highlighted the importance of this:

'You've got me aware, it's awareness and if you're not aware of the patterns, you can't do anything about it. It's like anything; if you don't know what you're up against, you can't solve it' (Alex)

In session or out of session. Development of the 'observing self' took place in relation to events outside of the session, and also in relation to enactments within the therapeutic relationship. This was when therapists were aware of, named and began to use re-enactments of reciprocal role procedures within the therapeutic relationship. This activity was always therapist-led and was initiated by the therapist. There was no evidence of clients taking the lead on naming patterns and roles within the therapeutic relationship themselves:

Therapist I'm wondering in our sessions if there's a tendency to, where I've noticed it, that there's a feeling in me almost wants to take control fully in sessions. *I'm wondering whether that's something about when you're feeling muddled or don't understand, it's easy for others to take control and others oblige'.*

Client *'... that's quite interesting that you feel that you have to take control and I'm wondering if that's how I come across to relationships'* (Sam)

Change in procedures and roles

This stage involved clients developing and trying out new repertoires of self-to-self and self-to-other roles and procedures, reengaging with previously discarded repertoires of roles and procedures, and becoming both more self-focused and more assertive.

Self-care. Participants described planning a range of behavioural activities identified to improve their depression through being more caring of themselves. Exits that came under

this category included attending routine medical appointments, not applying for a promotion that would result in further stress, reading depression self-help books, planned relaxation, booking holidays and various activities regarding improving diet/exercise:

'I've never had me time before; when I was single, when I was married. There has never been enough hours in the day for me to think: I want to do things for me, or I want to, instead of having a quick bath I want to have a soak' (Gail)

Being assertive – *meeting one's own needs/wants*. Being more assertive as an exit was evident across many cases. Exits that came specifically under the category of 'meeting one's own needs and wants' involved participants moving from a position of thinking that other people's needs were more important than theirs, to compromising and balancing their own needs with the needs of others. For example:

'I were having everybody up for Sunday lunch, so I just rang everybody up and said I'm not doing it until teatime because I didn't feel I could function ... normally I'd have, dinner would have been at two, I'd have been rushing to get it done, I would have been stressed and I'd have been ... meeting everybody's needs, meeting another nine people's needs so I met my needs' (Ann)

Self-compassion. This involved clients being more compassionate towards themselves, through self-acceptance, self-valuing, and self-care. Clients were resisting and challenging old patterns of being self-critical and self-blaming, and engaging in more positive nurturing self-talk:

'All these things that my dad said in the past and my ex-husband said in the past, I'm not them things, I'm me and I, I'll help anybody I can if I can and I, I'm a nice person and a decent person, I'm hard-working and everything else and I've got all this love to give and by listening to them then I'm not showing me.' (Gail)

Motivating and encouraging oneself. This represented strategies (usually in the form of self-talk), employed by clients to motivate themselves. This was demonstrated at times of low motivation, as well as at times of heightened self-efficacy. Strategies included using a diary, reflecting on successes with exits tried to date, considering the potential benefits of engaging in the exit and motivating self-talk. For example:

'I just think, I've got to take better care of myself, I've got to because I've got to, if I don't, I can't change all these things. Although I want them changed, it's not going to happen overnight' (Ann)

Support and maintenance of change

Support and maintenance of change was enabled by therapists scaffolding around the changes identified and proposed, working within participant's zone of proximal development, and using the SDR to illustrate where and how the proposed changes might work. Therapists were also attending to what change felt like for clients, recognising positive change when it occurred and discussing how change could be maintained over time.

Planning exits through scaffolding. This reflected collaborative discussions on how to use an exit in an appropriate and paced manner. Therapists checked and encouraged employment of exits within the participant's zone of proximal development (Ryle & Kerr, 2002; Wood,

Bruner, & Ross, 1976). This meant that the hierarchical approach adopted was likely to be effective, as clients were not over stretching themselves. Therapists therefore provided ‘bespoke’ scaffolding for change at a level dependent on each individual’s needs:

Therapist: ‘Okay, so would, shall we, shall we put these as things to try, kind of taking a definite break where you're not sat at your laptop. You're, I don't know, what, what would you do, what would you do if you were going to have a proper break?’

Client: ‘... *We've got a little garden, garden shed in the corner ... which is quite nice to sit in even on cold days., No, there's no excuse then, and I haven't sat in it for a long time*’ (Toni)

Therapists continually assessed clients’ capacity to change, exploring previous experiences of engaging in exits, exploring barriers and ways to address these as the first step in ‘scaffolding’ to enable change. Potential exits were discussed and planned in detail, which involved identifying a back-up plan.

Using the sequential diagrammatic reformulation (SDR). The SDR is a diagrammatic reformulation tool in CAT that maps and so integrates analytic (via reciprocal roles) and cognitive (via procedures) concepts (Ryle & Kerr, 2002). Therapists consistently identified exits using the SDR and encouraged clients to explicitly detail and label exits on the SDR. This helped to diagrammatically illustrate to clients how the proposed exit could break unhelpful patterns or change extant roles. Clients often described in sessions, how these exits labelled on the SDR were useful to refer back to:

'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 or whatever. Whether I'm feeling, if I'm in this situation here then my choice now isn't just that way, it's that way' (Toni)

Attending to the process and feelings of change. This involved therapists and clients jointly reflecting on and attending to the feelings, consequences and learning that took place from engaging in exits, both positive and negative. For example:

Therapist: *'So you're kind of, you're then like this aren't you, the more trusting you get, the more vulnerable you feel but it sounds like it's changed a little bit, I don't know, do you, do you feel more, more vulnerable for not checking his phone or'*

Client: *'Less'*

Therapist: *'... What do you think about that? ...'*

Client: *'Mm, it shows that it probably will help to be a bit more trustworthy'*

(Jen)

Recognition from the therapist. This category specifically reflected the positive feedback that therapists provided, that acknowledged and encouraged client's on-going efforts to change.

For example:

'You did an amazing job you know, you've not given in to him and he is being very threatening and really nasty to your son and things, and so in some ways it would be

really easy to give in, but you know you are doing absolutely brilliantly, being able to *stay out of that*' (Ash's therapist)

Maintaining exits via the goodbye letter. This involved therapists exploring ways in which any change achieved could be maintained post-treatment. This specifically often involved asking clients to think about maintenance of change in their 'goodbye letter.' In CAT, both client and therapist write and share goodbye letters in the final session to enable processing of the ending of the therapy, plan relapse prevention and name key change mechanisms (Ryle & Kerr, 2002). In order to maintain positive change, there was recognition from clients that they needed to continue with the exits developed following the ending of the therapy:

'I now accept that this is something I am going to *have to work on all my life ... in the past, I mean I were never, I've been positive for any length of time, and then I've stopped doing the things what made me feel good, err cos I don't feel I need them. Which is ridiculously stupid cos you don't stop putting petrol in your car do you, cos it stops*' (Alex)

The final model of the exit work completed during brief CAT for depression is presented in Figure 1. The model developed suggests a stage process whereby exits are created through movement through 'stage one – developing an observing self' to 'stage two – change in procedures and roles.' These stages took place alongside a range of processes during stage three, which were focussed on '*supporting and maintaining change.*' It is worth noting that exit work was typically not a smooth/linear process and therapist-client dyads were observed to cycle within the sections of the model.

Insert Figure 1 here please

Discussion

This study sought to analyse exit work during CAT. The method and context for achieving this was to utilise QCA (Schreier, 2012) to intensively study the interactions between clients and therapists during CAT for depression. Despite 'exit work' being discussed in CAT texts (see Ryle, 1997, for an example specific to the treatment of borderline personality disorder), there has been a lack of study on how CAT therapists enable change during clinical practice. The process through which exits were created were therefore analysed as they occurred in real time across selected therapy sessions within the 'revision stage' of CAT. This prevented the possibility of any recall bias effects regarding change work occurring (from both therapists and clients), as has previously been the case (Fusekova, 2012). The sample also included clients with a diverse range of outcomes, in order to increase the generalisability of the model developed. The model of exit work completed identified three interconnecting phases of reflection, action and consolidation. The final two stages of the model share similarities with the Fusekova (2012) concepts of 'common sense but novel ideas' and 'working hard' on exits. The initial reliability results for the current model were encouraging. Higher levels of agreement would be difficult to achieve due to the large number of individual categories in the coding frame (Brenner & Klietsch, 1996; Schreier, 2012).

The foundation of exit development was based on clients 'developing an observing self' (Stage 1). This involved clients developing or enhancing skills in self-reflection and more specifically in noticing target problem procedures and reciprocal roles related to their depression. During Stage 2, clients changed these habitual patterns/roles through establishing a new repertoire of self-to-self (e.g. caring for oneself), self-to-other (e.g. being more

trusting) and other-to-self (e.g. being assertive with others) patterns and roles, and this is consistent with CAT theory (Ryle, 1995). The stability of changes in procedures and roles were facilitated by a range of methods at Stage 3, aimed at supporting and maintaining change. The model in action was not a smooth linear process and therapeutic dyads were observed to circulate between identified stages. For example, attending to the process and feelings of change could lead to further enhancement of an ‘observing self.’

CAT therapists were observed to make use of the therapeutic relationship (alongside clients bringing material from relationships outside of therapy) as a context within which habitual patterns and roles could be analysed as a means of developing an observing self. This ‘observing eye’ work is a key aspect of CAT theory and emphasises that the therapeutic relationship provides a context in which the client will relate to the therapist in a manner consistent with which they related to early care givers (Ryle, 1995). CAT therapists were observed to therefore make use of ‘enactments’ in the therapeutic relationship as a means of naming and drawing attention to problematic patterns and roles to increase relational awareness (Ryle & Kerr, 2002). The development of the ‘observing eye’ in CAT is similar to the concepts of insight and self-understanding, which have been linked to positive outcomes in dynamic psychotherapies (Gibbons et al., 2009) and was identified as one of a range of core helpful events in a qualitative meta-analysis of helpful events during psychotherapy (Timulak, 2007). Krause et al. (2007) used a similar design to the present research, to find that the most common in-session change process across therapies was ‘establishment of new connections among aspects of self, aspects of self and the environment, aspects of self and biographical elements.’ Therefore, clients ‘noticing’ patterns in the way they relate to self and others during CAT appears to map onto and mirror a common change process across differing psychotherapies.

Work during Stage 2 of the model involved clients revising their idiosyncratic self-to-self, self-to-other and other-to-self procedures and roles, and developing new ways of relating to self and others. The wide range of categories at the second stage of the model shows that CAT therapists collaborate with clients to develop idiosyncratic exits and work within the client's zone of proximal development (Toye, 2009). Two common aspects at this stage of the model were being more self-focussed and also more compassionate towards self. Feely, Sines and Long (2007) emphasised the role that 'people-pleasing' can often play in depression and the risk of being 'other-focused' at the expense of necessary self-care when depressed. Exits during CAT appear to place a premium on being more self-focussed and therefore clients discussed a wide range of self-care activities. This would mean the creation of a caring-to-nurtured self-to-self reciprocal role, mirroring Kellett's (2012) theoretical depiction of positive reciprocal roles developed during the revision stage of CAT.

Exits during the second phase of the model also contained aspects of compassion. Self-criticism plays a key role in responsivity to depression treatment (Marshall, Zuroff, McBride, & Bagby, 2008) and CAT therapists were observed to help clients create a more compassionate stance. This would mean change in self-to-self relating with the client being less criticising of self and feeling less criticised as a result, and the creation of a more encouraging-to-motivated reciprocal role (Kellett, 2012). The role of developing assertiveness was also emphasised during the second stage of the model. Rutten et al. (2015) noted that autonomy-connectedness reflected the capacity for being self-directed whilst simultaneously retaining interpersonal relationships with others.

There is support in both CAT and psychotherapy research in general for the categories evidenced during Stage 3 of the exit model developed. For example, the importance of therapists scaffolding around nascent change has been previously highlighted across both CBT and psychodynamic psychotherapy (Göstas, Wiberg, Neander, & Kjellin, 2012). Crowe

et al. (2012) have emphasised that clients need to reformulate their depression in order to be able to change and in the current study the SDR grounded the exits in the client's formulation. Explicitly labelling exits on the SDR was key therapeutic activity and research on planning clinically effective between-session work has emphasised the utility of writing change strategies down (Helbig & Fehm, 2004). Feedback via recognition from the therapist concerning efforts to change and any successes experienced, are evidence of CAT therapists rewarding client change, and so reinforcing continued usage of the exit. The importance of maintaining exits via use of the goodbye letter in CAT has been previously identified as a modality specific approach (Rayner, Thompson & Walsh, 2011).

In terms of study limitations, whilst the relatively small sample size limits the generalisability of the findings, the sample size was sufficient for the QCA (Schreier, 2012). In addition, findings may be specific to this form of brief 8-session CAT and so may not extend to the established 16 and 24 CAT session contracts (Ryle & Kerr, 2002). The sample was specific to depression, and that was useful in terms of the specificity of an early exploratory study, but the findings may not generalise to other diagnoses or increased levels of complexity or co-morbidity. Asking participants to comment on the final model would have been a valuable addition to the reliability checks conducted.

The model of exits devised in this study provides some initial guidance to CAT therapists on possible ways in which to work with exits with clients who are depressed. The model of exits developed could usefully supplement clinical supervision of CAT work with depressed clients. Future research is needed to examine the utility of the model in other client populations. The next step in this research is to increase the sample size of studies and include analyses of how exits relate to outcomes at end of treatment and at follow-up. To conclude, this study suggests a tentative three-phase exit model of CAT work with depression

consisting of therapist activity that helps clients to develop an observing self, experiment with new roles/procedures and then to maintain their progress.

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Table 1. Client demographics and outcomes

Participant number	Pseudonym	PHQ-9 pre	Category	PHQ-9 post	Category	Outcome	CCAT
1	Ann	9	Mild	3	Minimal	Improved	18
2	Jen	18	Moderately severe	0	Minimal	Recovered	20
3	Alex	21	Severe	2	Minimal	Recovered	29
4	Jess	18	Moderately severe	10	Moderate	Improved	18
5	Ash	21	Severe	17	Moderately severe	Stasis	19
6	Sam	17	Moderately severe	15	Moderately severe	Stasis	40
7	Toni	17	Moderately severe	11	Moderate	Improved	18
8	Gail	3	Minimal	0	Minimal	Stasis	36

Note. PHQ-9= Patient Health Questionnaire-9. CCAT = Competency in Cognitive Analytic Therapy

Table 2. Inter-rater reliability of coding

Coding phase	Participant No.	Session	Percentage agreement (%)	Cohen's kappa coefficient	Level of agreement*
Pilot coding 1	6	6	54	0.44	Moderate
		7	43	0.39	Fair
	1	6	45	0.42	Moderate
		7	24	0.21	Fair
	3	6	47	0.44	Moderate
		7	35	0.33	Fair
Pilot coding 2	7	6	75	0.70	Substantial
	8	7	62	0.60	Moderate
Main coding	2	6	74	0.72	Substantial
		7	77	0.75	Substantial
	4	6	67	0.63	Substantial
		7	84	0.80	Substantial
	5	6	69	0.62	Substantial
		7	85	0.83	Almost perfect

Note. *Level of agreement on Cohen's kappa coefficient is categorised as follows <0 no agreement, 0–0.20 slight, 0.21–0.40 fair, 0.41–0.60 moderate, 0.61–0.80 substantial and 0.81–0.99 almost perfect agreement

Table 3. Exit categories during CAT for depression

Categories	Rated as present per client			
	Total (n=8)	%	No. of units coded per client (range)	Mean
Category 1 – Developing an observing self (total)	8	100	6-20	11
Therapist facilitated recognition-IS	3	38	0-1	0
Therapist facilitated recognition-OOS	8	100	3-17	8
Client self-recognition-IS	0	0	0-0	0
Client self-recognition-OOS	6	75	0-5	2
Category 2 – Change in procedures and roles (total)	8	100	9-80	38
Self-compassion-OOS	4	50	0-11	4
Self-compassion-IS	4	50	0-2	1
Self-care healthy diet-OOS	3	38	0-2	1
Self-care exercise-OOS	2	25	0-1	0
Self-care sleep hygiene-OOS	1	13	0-4	1
Self-care taking care of appearance-OOS	4	50	0-2	1
Self-care taking care of appearance-IS	1	13	0-1	0
Self-care other-OOS	7	88	0-5	2
Pacing self-OOS	4	50	0-5	1
Reducing/abstaining from drugs/alcohol-OOS	2	25	0-1	0
Being active-OOS	5	63	0-4	2
Problem solving-OOS	2	25	0-6	1
Spiritual practice-OOS	1	13	0-4	1
Challenging thinking-OOS	4	50	0-3	1
Positive focusing or reframing-OOS	3	38	0-5	1
Positive focusing or reframing-IS	1	13	0-2	0
Being mindful/present to the moment-OOS	2	25	0-3	1
Motivating and encouraging oneself-OOS	6	75	0-11	3
Motivating and encouraging oneself-IS	4	50	0-2	1
Externalising the problem-OOS	1	13	0-3	0
Emotional regulation-OOS	5	63	0-7	2
Emotional regulation-IS	2	25	0-1	0
Compassion towards others-OOS	2	25	0-5	1
Assertive-meeting one's own needs/wants-OOS	7	88	0-9	3
Assertive-meeting one's own needs/wants-IS	1	13	0-1	0
Assertive-Asserting own feelings/opinions-OOS	2	25	0-2	1
Assertive-Asserting own feelings/opinions-IS	2	25	0-2	0
Assertive-Not taking responsibility for others-OOS	2	25	0-6	1
Assertive-Accepting help from others-OOS	3	38	0-3	1
Assertive-Accepting help from others-IS	1	13	0-1	0
Being more open and trusting-OOS	2	25	0-6	1
Being more open and trusting-IS	2	25	0-3	1
Connecting with others-OOS	6	75	0-10	3
Acceptance-OOS	3	38	0-7	2
Acceptance-IS	1	13	0-1	0
Releasing distressing feelings-OOS	3	38	0-4	1
Releasing distressing feelings-IS	2	25	0-1	0
Self to other - other	1	13	0-1	0
Category 3 - Support and maintenance of change (total)	8	100	13-39	29
Planning exits through scaffolding	8	100	3-15	10
Exits on the SDR	8	100	1-5	3
Client and therapist attending to the process of change	8	100	2-13	8
Recognition from the therapist	7	88	0-8	5
Maintaining exits and the goodbye letter	8	100	1-10	5

Note. IS = 'in session' and OOS = 'out of session'