Article:
Wray, A., Kellett, S., Bee, C. et al. (2022) The acceptability of cognitive analytic guided self-help in an Improving Access to Psychological Therapies service. Behavioural and Cognitive Psychotherapy, 50 (5). pp. 493-507. ISSN: 1352-4658

https://doi.org/10.1017/s1352465822000194

Behavioural and Cognitive Psychotherapy, 2022, page 1 of 15
doi:10.1017/S1352465822000194

BABCP
www.babcp.com

MAIN

The acceptability of cognitive analytic guided self-help in an Improving Access to Psychological Therapies service

Annie Wray[1], Stephen Kellett[1,2]*, Charlotte Bee[3], Jess Smithies[3], Vikki Aadahl[3], Mel Simmonds-Buckley[1] and Colleen McElhatton[1]

[1]University of Sheffield, Sheffield, UK, [2]Rotherham Doncaster and South Humber NHS Foundation Trust, UK and [3]Pennine Care NHS Foundation Trust, UK
*Corresponding author. Email: s.kellett@sheffield.ac.uk

(Received 3 December 2021; revised 4 February 2022; accepted 17 March 2022)

Abstract

Background: An Improving Access to Psychological Therapies (IAPT) service in England has implemented cognitive analytic therapy guided self-help (CAT-GSH) alongside cognitive behavioural guided self-help (CBT-GSH) in order to support enhanced patient choice. This study sought to explore the acceptability to psychological wellbeing practitioners (PWPs) of delivering CAT-GSH.

Method: This study used a qualitative design with semi-structured interviews and associated thematic analysis (TA). A sample of n=12 PWPs experienced in delivering CAT-GSH were interviewed.

Results: Five over-arching themes (containing 12 subthemes) were identified and conceptually mapped: (a) the past-present focus (made up of working with clients' pasts and the different type of change work), (b) expanding the treatment offer (from the perspective of PWPs and clients), (c) the time and resources required to effectively deliver CAT-GSH (to enable safe and effective delivery for clients and personal/professional development for PWPs), (d) understanding CAT-GSH (made up of confidence, learning new therapeutic language/concepts and appreciating the difference with CBT-GSH) and (e) joint exploration (made up of therapeutic/supervisory relationships and enhanced collaboration).

Conclusion: CAT-GSH appears an acceptable (but challenging) approach for PWPs to deliver in IAPT services. Services should prioritise training and supervision for PWPs to ensure good governance of delivery.

Keywords: CAT; IAPT; low intensity; PWPs

Introduction

Improving Access to Psychological Therapies (IAPT) services have been contributing to the expanding provision of psychological treatment for common mental health problems across England since 2008 (National Health Service, 2019; Mental Health Taskforce, 2016). As recommended by the National Institute for Health and Clinical Excellence (2009, 2011), IAPT services operate within a stepped-care model. A key feature therefore is effective low-intensity interventions being offered at step 2 in the first instance of care (Care Services and Improvement Partnership Choice and Access Team, 2008). These brief, psychoeducational and low-intensity interventions are intended for patients presenting with mild-to-moderate anxiety and depression and are delivered by psychological wellbeing practitioners (PWPs). Whilst clinical guidelines emphasise the importance of offering patients a choice of treatments (Care Services and Improvement Partnership Choice and Access Team, 2008; National Collaborating

Table 1. CAT theoretical concepts, associated definitions and use in the CAT-GSH manual

Theoretical concepts	Description	CAT-GSH usage of the concept and where it appears
Reciprocal role (RR)	An internalised pattern of relating, originating in childhood. This is summarised as an upper (doing/being) role and lower (feeling) role	This was translated into relationship roles and these were named and mapped (session 2)
Target problem	The problematic reciprocal role procedures that are the focus of the therapy	Same (identified in session 2)
Target problem procedure (TPP)	The procedures connecting up the poles of the reciprocal roles	One key anxious reciprocal role and one TPP was written connecting the feeling pole of the RR to the doing pole (session 4)
Zone of proximal development (ZPD)	The client's capability for change in the here and now with the assistance of another	The PWP when adding exits to the SDR were encouraged to consider the client's ZPD and work within it (sessions 4 and 5)
Snag	Self-sabotage pattern	An anxious snag is identified in session 1
Trap	Vicious circle reinforcing beliefs about self, others and the world	An anxious trap is identified at session 1
Dilemma	An either/or false dichotomy (splitting)	A dilemma trap is identified at session 1
Enactment	When the client relates to the therapist in a way that problematic RRs are activated	Thought bubbles are added to the psychoeducational exercises in the manual for the PWP and client to consider whether an enactment was occurring or had occurred
Reformulation, recognition and revision three-phase structure	The structure of CAT (reformulation early sessions, recognition middle sessions and revision later sessions)	The workbook adheres to the three-phase structure. Reformulation (sessions 1–2), recognition (sessions 3–4), revision (sessions 5–6)

Centre for Mental Health, 2018; National Institute for Health and Clinical Excellence, 2009; National Institute for Health and Clinical Excellence, 2011), treatment at step 2 is wholly limited to cognitive behavioural therapy guided self-help (CBT-GSH; Clark, 2011).

Cognitive analytic therapy (CAT; Ryle, 1995) is an integrative therapy which supports clients to understand, recognise and then revise habitual, unhelpful and restrictive patterns of relating to themselves and others (Ryle and Kerr, 2002). CAT is typically delivered in complex clinical populations (Hallam *et al.*, 2021). Calvert and Kellett (2014) specifically suggested the development of a low-intensity version of CAT to enable the delivery of the model with mild-to-moderate common mental health problems. Therefore, Meadows and Kellett (2017) developed a manualised psychoeducational version of cognitive analytic therapy guided self-help (CAT-GSH), designed to be fit-for-purpose for delivery at step 2 of IAPT services. CAT is usually delivered in an 8-, 16- or 24-session (60-minute sessions) contract (Ryle and Kerr, 2002), whereas CAT-GSH is delivered in 6–8 sessions (35-minute sessions) (Meadows and Kellett, 2017). The structure of CAT-GSH follows the established reformulation, recognition and revision approach of the high-intensity version, but the language is adapted to enable ease of understanding (e.g. reciprocal roles being termed relationship roles) and is underpinned by a structured session-by-session workbook. The emphasis during CAT-GSH is on guided self-help, with the PWP supporting the client to work through the structured workbook exercises (Shafran *et al.*, 2021). Table 1 contains a summary of the theoretical concepts of CAT (drawn from Taylor *et al.*, 2017) and whether the theoretical concepts were or were not present in the CAT-GSH. Table 2 contains a summary of the tools of CAT (drawn from Taylor *et al.*, 2017) and whether the tools were or were not present in the CAT-GSH. Although evidence reviews and meta-analyses index the effectiveness and acceptability of CAT, they have also highlighted the need to continue expanding its evidence base in relation to acceptability, effectiveness and efficacy issues (Calvert and Kellett, 2014; Hallam *et al.*, 2021; Ryle *et al.*, 2014).

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

Table 2. CAT tools, descriptions and use or not in the CAT-GSH manual

Tool	Description	Presence in the CAT-GSH manual
Psychotherapy file	A structured, clinical questionnaire asking the client to rate the frequency of reciprocal roles, problem procedures and problematic states	Not included
Narrative reformulation letter	A letter from therapist to client connecting the past and the present, naming potential enactments in the therapeutic relationship, naming TP and TPPs and goals	Not included
Sequential diagrammatic reformulation (SDR)	A visual map of the narrative reformulation, naming key reciprocal roles and TPPs maintaining distress. Exits are added to the SDR during the revision phase	Included – sessions 4 and 5
Monitoring (in and between session)	To facilitate recognition of roles and patterns, clients monitor and record occasions when roles and patterns are activated	Present – each session has recognition homework specified
Goodbye letter	Therapist and client produce and exchange letters at the final session to reflect on the therapy, name exits, identify areas to work on and name relapse signatures and prevention strategies	Not included

Meadows and Kellett's (2017) initial pilot of CAT-GSH reported promising clinical outcomes, including similar effect sizes and smaller drop-out rates compared with CBT-GSH. To assess feasibility, two approaches were adopted. Firstly, three clinical psychologists rated the intervention positively in relation to Cape's (2015) GSH quality criterion: scope, evidence, engagement and promotion of self-efficacy. Secondly, PWPs (n=7) were interviewed about their experience of delivery. Several positive and negative themes related to the content and experience of CAT-GSH emerged from these data: positively, the usefulness of the manual, the treatment as a journey, job role satisfaction and patient engagement; negatively, the increased time demands, the treatment suitability for both clients and PWPs and the time-consuming nature of the 'psychotherapy file' (Association for Cognitive Analytic Therapy, 2007). As a result, relevant modifications to the manual were made and the authors recommended further development, implementation and evaluation of CAT-GSH. A large-scale partially randomised patient preference trial (PRPPT) is subsequently being conducted in an IAPT service to compare the efficacy and clinical durability of CAT-GSH compared with CBT-GSH for anxiety (Kellett *et al.*, 2021). Participants are allocated to 6–8 (35-minute) sessions of CAT-GSH or CBT-GSH based on their preference or randomisation if they do not state a preference. The psychotherapy file has been dropped from the intervention based on the feasibility findings (Meadows and Kellett, 2017).

The importance of valuing the role of a PWP in order to improve retention and reduce potential burnout and stress has been previously recognised (National Collaborating Centre for Mental Health, 2018; Shepherd and Rosairo, 2008). Despite this, there is limited qualitative research exploring the experiences of PWPs themselves in relation to their experience of the feasibility of the brief, guided self-help interventions they are expected to deliver safely and effectively to large caseloads. To fully evaluate the acceptability of implementing CAT-GSH as a step 2 treatment, it is therefore important to consider the experiences of delivery by PWPs. Sekhon *et al.* (2017) defined treatment acceptability as 'a multifaceted construct that reflects the extent to which people delivering or receiving an intervention consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention' (p. 1). Therefore, important aspects of the evaluation of the acceptability of an intervention are practitioners' affective attitudes, the perceived burden of delivery, the coherence of the intervention and the opportunity costs of not delivering another intervention

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

(Sekhon *et al.*, 2017). Interventions with poor acceptability with practitioners are unlikely to be adopted into routine practice. The current project therefore aimed to qualitatively explore the experiences of PWPs delivering CAT-GSH at step 2 in comparison with their experiences of delivering CBT-GSH as treatment as usual. The primary questions of this evaluation were therefore: how did PWPs experience delivering CAT-GSH? How did this experience compare with that of delivering CBT-GSH? How did broader service-level factors influence PWPs' experience of delivering CAT-GSH?

Method

Design and ethics

In line with the exploratory nature of the aims, a qualitative design using semi-structured interviews and associated thematic analysis (TA) was employed. The protocol for the PRPPT has been published and describes the method of the trial and the planned analyses (Kellett *et al.*, 2021). All PWPs in the service treated patients in the trial and there was no selection of trial PWPs. In short, the PRPPT evaluates the clinical outcomes (including 8- and 24-week follow-up) for four groups: (1) allocated to CAT-GSH based on choice, (2) randomly allocated to CAT-GSH, (3) allocated to CBT-GSH based on choice and (4) randomly allocated to CBT-GSH. In terms of a preliminary analysis of outcomes, the IAPT defined moving to recovery rate (i.e. patients whose scores on GAD-7 and/or PHQ-9 were above caseness on either measure before GSH whose scores on both measures were below caseness at end of GSH were as follows: 52.7% for CBT-GSH and 45.6 % for CAT-GSH (χ^2=0.820, p=.365). Therefore, there was no difference between CBT-GSH and CAT-GSH in terms of the moving to recovery rates achieved by each of the low-intensity therapies. Prior to the interviews, participants were asked to read a participant information sheet and were given the chance to ask any questions before providing informed consent to participate. Data were anonymised in full and no personally identifiable information is contained within this report.

Setting and recruitment

This research took place in the IAPT service where the PRPPT is being conducted. The PWPs initially attended a 2-day training course on CAT-GSH and continued to receive monthly 2-hour group supervision to support the delivery of CAT-GSH, alongside the required clinical and case management supervision. Supervision was matched for CAT-GSH and CBT-GSH participants. Table 3 provides a session-by-session summary of CAT-GSH, and the workbook can be found here: https://pearlsresearchlab.group.shef.ac.uk/resources.

Twelve PWPs (all female, with an average age of 30.72 years) were recruited via volunteer sampling (i.e. a sample size suitable for small-scale qualitative projects; Braun and Clarke, 2013). The PWP sample had been qualified and practising as PWPs for an average of 4.50± 5.01 years (mean±*SD*). The average number of CAT-GSH participants treated in the trial by an individual PWP was 10.00±7.09 (mean±*SD*) and the average number of CBT-GSH participants treated in the trial by an individual PWP was 3.50±4.34 (mean±*SD*). Adverts were emailed to all PWPs working in the service and further brought to their attention during group supervision and team meetings. PWPs who wished to participate contacted the researcher (A.W.) to arrange a telephone interview. This sampling method was used to give PWPs the opportunity to decide whether they would like to take part or not, thus resulting in participants who were willing to contribute their experiences. To meet inclusion criteria, participants were required to be qualified PWPs with past or present experience of delivering both CAT-GSH and CBT-GSH as step 2 treatments within the PRPPT. To allow for a diverse

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

Table 3. Description of the CAT-GSH workbook

Session	Content	Homework
Session 1	Elicit a description of anxious snag, trap or dilemma (i.e. elicit anxious procedures in the here and now)	Recognise and record snag, trap or dilemma and associated learning Draw a family tree Complete a time line
Session 2	Elicit themes from key past relationships Produce core relationship role	Recognise and record when in top or bottom of the relationship role and associated learning
Session 3	Connecting past to present Produce a problem statement	Recognise and record when there is relationship role activation
Session 4	Produce the roadmap connecting relationship roles to anxious procedures Add exits to the roadmap	Recognising the roadmap (noticing roles and procedures) Practising exits
Session 5	Name strengths and resiliencies Define healthy self Produce positive relationship roles	Practising exits Practising positive relationship roles
Session 6	Acknowledge the ending Defining the change Possible self-sabotage Relapse prevention	Holding onto awareness Holding onto change

Table 4. PWP participant information

Participant number	Age	Gender	Ethnicity	Years working as a qualified PWP	Number of participants seen for CBT-GSH under the PRPPT	Number of participants seen for CAT-GSH under the PRPPT
1	32	Female	Asian Pakistani	6	17	25
2	41	Female	White British	15	3	4
3	25	Female	Unknown	1	0	2
4	29	Female	White British	2	3	11
5	38	Female	Unknown	10	2	7
6	28	Female	Other Asian background (Japanese)	1.5	5	14
7	27	Female	White British	1	3	9
8	27	Female	Unknown	1	4	17
9	37	Female	White British	13	0	14
10	Unknown	Female	Unknown	1	2	1
11	25	Female	White British	0.5	0	1
12	29	Female	British Pakistani	2	3	15

sample of PWPs, no other inclusion or exclusion criteria were applied. Participant information can be found in Table 4.

Data collection

The lead researcher (A.W.; trainee clinical psychologist) conducted all the qualitative interviews using a semi-structured interview schedule (see Supplementary material for the interview schedule). The content of the schedule was decided by the research team via consultation. The final schedule included eight open-ended questions covering three key main topics: (1) PWPs' experiences of delivering CAT-GSH; (2) how these experiences compare with CBT-GSH; and

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

(3) how these experiences were impacted by broader service-level factors. The schedule also included a number of exploratory prompts to elicit full and clear responses (Braun and Clarke, 2013). The average length of the interviews was 47±11 minutes (mean±*SD*). Interviews were audio-recorded and transcribed verbatim by an external transcriber.

Data analysis

The data were analysed using Braun and Clarke's (2006) six-step TA approach. The qualitative data analysis software, NVivo, was used to support the analysis. TA was selected as it facilitates a detailed and meaningful account of qualitative data by capturing patterns within the responses and organising these into prevalent themes (Braun and Clarke, 2006). A trainee clinical psychologist (C.M.) independently coded 25% of transcripts. The findings were checked against the lead researcher's (A.W.) initial codes and preliminary themes to arrive at consensually agreed final themes and sub-themes. Research supervision and peer debriefing were subsequently sought to allow for additional reflection and triangulation of the interpretations (Long and Johnson, 2000). The themes and sub-themes were summarised into a draft conceptual map. Daley (2004) stated that the advantages of conceptual maps of qualitative results are: (1) being able to show the inter-relationships between themes, (2) being able to summarise hierarchical relationships between themes and (3) reducing the volume of data. The conceptual map sought to show the relationships between themes, rather than using a cluster or word frequency approach (Conceicao *et al.*, 2017).

Epistemological position and reflexivity

This research was completed within a critical realism framework, recognising that there is a reality to the PWPs' experiences, whilst also critically reflecting on the context in which this reality has been constructed within. Each PWP is assumed to have their own unique experiences and meanings attached to delivering CAT-GSH, and this is interpreted by the researcher to construct a collective narrative of the experience of delivering CAT-GSH. To that end, it is important to acknowledge the context, experiences and perspectives of the participants and researchers. For example, the participants and the researchers work within NHS psychological services and will therefore be aware of the challenges people can face in accessing psychological therapy and also making an informed choice about the style or type of therapy they wished to receive. As such, the participants and researchers may have been drawn towards more favourable and positive narratives around CAT-GSH, due to the assumption that offering this form of GSH improved choice and better supported patient preference. Swift *et al.* (2021) highlighted that accommodating patient preferences was ethically correct and this may have therefore influenced how PWPs saw the CAT-GSH intervention. Although the lead researcher (A.W.) was not directly involved in the initial development of CAT-GSH, the PRPPT or the supervision of the PWPs, she did work within a team of researchers very closely involved in all these processes, and this may have influenced the reporting of positive themes around CAT-GSH. The lead researcher had a positive attitude towards CAT and some clinical experience of the model, but had not formally trained in the model. Efforts were made to remain reflexive throughout the research process. For example, the lead researcher (A.W.) kept a diary to log reflections, thoughts, feelings and key decisions regarding the data collection and analysis (Long and Johnson, 2000). Supervision and peer debriefing also encouraged the critical reflection of the different ways that the data may be understood (Long and Johnson, 2000).

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

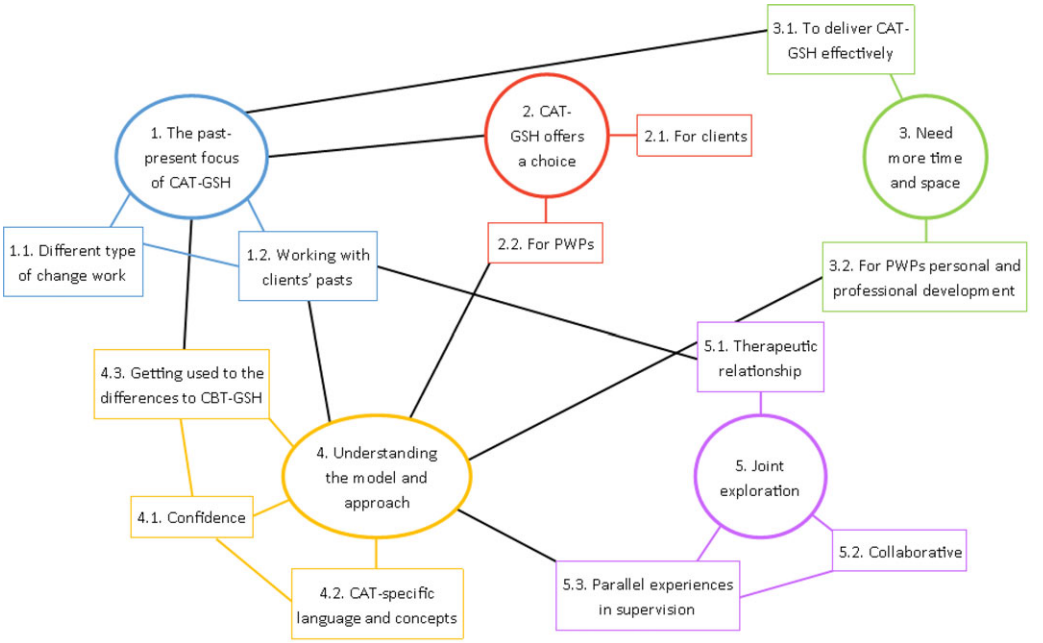

Figure 1. Thematic map illustrating the five over-arching themes and twelve sub-themes.

Results

Five over-arching themes and 12 sub-themes were identified to elucidate the PWPs' experiences of the acceptability of delivering CAT-GSH. These themes are conceptually presented in Fig. 1 and with supporting verbatim quotations below. Using a thematic map (Daley, 2004), Fig. 1 illustrates how different elements of the PWPs' experiences were inter-related and interdependent. As represented by the connecting links, certain experiences of delivering CAT-GSH described by the PWPs are assumed to be dependent on (i.e. have a hierarchical relationship with) their understanding and experiences of other elements of CAT-GSH. For example, without an understanding of the past-present focus of CAT-GSH (and the associated need for working with clients' pasts using the approach), the PWPs' understanding of the CAT model and approach would have been experienced differently. This would also have significant implications for both offering treatment choice to clients and also the personal and professional development of PWPs that CAT-GSH was perceived to offer them as IAPT low-intensity practitioners.

Theme 1 The past-present focus of CAT-GSH

All of the PWPs talked about the past-present focus of CAT-GSH and how this affected their experiences of delivering CAT-GSH.

1.1. Different type of change work

The PWPs explained that their experiences of clients making positive therapeutic changes during CAT-GSH differed from that in CBT-GSH in terms of timing and content, something which many of them attributed to the past-present focus of the CAT-GSH approach. For example, six PWPs reflected that the early reformulatory focus of CAT-GSH meant that change work

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

particularly occurred later on in treatment (i.e. during the revision stage). This seemed to lead to some frustrations for some of the PWPs: '*One of the frustrations I always had in the beginning was that I found with CAT it felt like it was dragging its feet, you spent four sessions going over the past … I felt like I was holding people back*' [participant (P) 8].

Whilst there was a consensus that the more concrete changes were observed later on in CAT-GSH as is consistent with the reformulation, recognition and revision structure, most PWPs talked about their experiences of clients making different types of change during CAT-GSH particularly due to its past-present focus and approach. These changes were often proceeded by insight. For example, five PWPs talked about a '*light bulb moment*' occurring (P1, P2, P3, P10, P11) when clients suddenly developed insight and awareness into their problematic patterns during early reformulatory sessions: '*I've noticed it* [the light bulb moment] *the most after session two, where you start to talk about relationship roles and identify where that pattern might have-have come from, clients seem to really click with that*' (P1). It seemed that once PWPs had adjusted their expectations of client change to be based more on insight and awareness, that this was a '*rewarding*' (P10) experience for them as practitioners.

1.2. Working with clients' pasts

Most PWPs reflected that the past-present focus of CAT-GSH contributed to more disclosures from clients. This was mostly experienced as anxiety-provoking and emotional by PWPs, particularly if the disclosures were related to early trauma or abuse: '*that* [past-present focus] *kind of invites, erm, maybe things into treatment sessions that we're not used to necessarily having to deal with, so I think it's been quite upsetting, you know, for clinicians*' (P2). PWPs talked about feeling worried with regard to how to respond appropriately to disclosures, something that was heightened by the brief nature of CAT-GSH. As such, there was an emphasis on ensuring clients are suitable for step 2, rather than allocating clients based on service needs or limitations:

> '*I think it's* [CAT-GSH] *really suitable as long as it's used correctly by services … it could become quite overwhelming for the clients who are unpacking some quite difficult traumas, erm, in quite a small amount of time in a low number of sessions, which can be quite unsafe and quite unsafe for step two practitioners too.*' (P4)

Some PWPs did, however, reflect that these disclosures were sometimes helpful facilitators of the light bulb moments discussed above, as well as contributing to strong therapeutic relationships (see theme 5).

Theme 2 CAT-GSH offers choice

All of the PWPs talked about what CAT-GSH brings to the step 2 offer, both for clients and practitioners.

2.1. For clients

Nine PWPs talked about how CAT-GSH offers clients an important alternative to CBT-GSH at step 2, particularly for those who have already tried CBT-GSH: '*people are choosing CAT because they've tried CBT and maybe didn't click with it*' (P1). Some PWPs talked about how they enjoyed being able to offer this choice, reflecting that they previously felt as though they were pressuring clients into doing CBT-GSH. These PWPs emphasised that they would like to continue being able to offer a choice of treatment at step two: '*it's something that I would love to be able to continue in the service; to be able to give people preference*' (P7).

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

2.2. For PWPs

PWPs also highlighted the value of learning and delivering another therapy model for themselves, both personally and professionally. For example, all PWPs talked about finding the process enjoyable and/or interesting for them. One emphasis seemed to be on how the process helped PWPs feel more valued, equipped and capable as practitioners: '*it's just nice to have a different kind of tool on your belt if you like … just like to learn a different model as clinicians and have a different take on things and be able to deliver something different*' (P2).

Two PWPs also talked about how this process has inspired their continued professional development going forward: '*it opened up another avenue for sort of my own development … it's something that I'm looking sort of more into sort of being involved with in my work*' (P3).

Theme 3 Need for time and space

There was a consistent theme concerning needing more time and resources to deliver CAT-GSH effectively, particularly in the context of existing pressures of working in the step 2 service.

3.1. To deliver CAT-GSH effectively

Eight PWPs spoke about how CAT-GSH was hard to deliver within the specified 6–8 session (35-minute) time frame and suggested that more or longer sessions were needed at times. Most attributed this to the content of the first theme, speaking about needing more time to explore clients' histories: '*trying to stick to that 30 minutes was, was really difficult at certain sessions … when you were exploring more about the past*' (P5). Some PWPs talked about how this left them feeling anxious, under pressure, frustrated or like they were doing a bad job: '*sometimes it makes me feel like "why can't I fit it all in"*' (P12). Despite this, several PWPs acknowledged that, over time, they had learnt or expect to learn how to adapt their practice so that they can deliver CAT-GSH within the specified timeframe. One PWP also had a contrasting view that CAT-GSH could be delivered within 6–8 sessions without any issues, something which they attributed in part to the workbook:

> '*Its* [the workbook] *set out in a way that it can be completed in six-eight sessions … it can be completed in the sort of 30 minutes, the actual amount of content in each session to cover is appropriate to complete in a time limited, erm, therapy.*' (P7).

3.2. For PWPs personal and professional development

Eight PWPs talked about how delivering CAT-GSH added to the existing pressures on them within the wider service context, particularly when it pushed the limits of step 2: '*Unfortunately, our sessions are back-to-back and between back-to-back we're doing the notes, typing the notes up between sessions as well, as you can imagine having those extra* [time] *stressors was making it quite difficult*' (P10). Although two PWPs talked about these additional pressures as '*part and parcel*' (P4) of being a step 2 practitioner, others felt it warranted more time for self-care, reflection and training. Specifically, several PWPs said that they would have liked more frequent supervision for CAT-GSH: '*I think it's a shame that its* [supervision] *only once a month … it's a shame that erm I suppose it's kind of restricted in like times*' (P11). Several PWPs did acknowledge, however, the benefits of the additional *ad hoc* one-to-one sessions with a senior clinician that they could attend if they needed additional support related to CAT-GSH in between supervisions.

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

Theme 4 Understanding the model and the approach

All PWPs talked about their experiences of developing an understanding of CAT-GSH, particularly in relation to how it took them some time to get used to the theoretical and applied differences to CBT-GSH.

4.1. Confidence

Most PWPs talked about an initial lack of confidence in their understanding and subsequent delivery of CAT-GSH. For example, several PWPs talked about their uncertainty as to whether they are delivering CAT-GSH in the right way: '*I'm constantly thinking did I do something right*' (P6). Most PWPs, however, reflected that their confidence grew with time and practice. Some PWPs viewed this growth of confidence as a natural process, similar to their experiences following their initial CBT-GSH training: '*you only realise you know, erm, how to do the CAT, you know how to do an intervention once you start doing it don't you, and you know the confidence in doing it as well*' (P12). The PWPs spoke about how shadowing and hearing other PWPs' experiences of delivering CAT-GSH, as well as the workbook, helped them develop their confidence.

4.2. CAT-specific language and concepts

Eight PWPs talked about how it took them time to acclimatise to CAT-specific language and concepts, with one PWP describing it feeling like '*a new language*' (P8) to begin with. Some PWPs spoke about how the workbook helped with this by providing clear explanations and examples: '*the fact that it* [examples] *sits in the back of the book helps the client and the therapist*' (P11). One PWP in particular talked about how they found the language '*jargony*' and not '*user-friendly*' (P10), suggesting further service-user involvement in the ongoing development of CAT-GSH to ensure the language and concepts are accessible: '*I personally feel there should have been more service user involvement, you know what, "what did you find difficult to understand" you know in the beginning really*' (P10).

4.3. Getting used to the differences to CBT-GSH

All PWPs compared and contrasted their experiences of delivering CAT-GSH with CBT-GSH. The differences between the two models seemed to be one of the main obstacles to initially understanding and delivering CAT-GSH.

> '*So in the beginning when you're learning obviously it's really, really confusing to kind of get to grips with . . . it was really difficult to get your head round the fact that it was so conflicting with what we'd already learnt with CBT.*' (P8)

It was evident in the PWPs' narratives that they felt more confident in their understanding and delivery of CBT-GSH compared with CAT-GSH, as they have been doing it for longer. For example, some of the words the PWPs chose to describe CBT-GSH included: '*comfortable*' (P2, P9), '*familiar*' (P2) and '*confidence*' (P6).

Theme 5 Joint exploration

There was an emphasis within the PWPs' narratives about going through the process of learning and delivering CAT-GSH with others, whether this be through working collaboratively with clients, or through learning and developing alongside their colleagues in the supervision group.

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

5.1. Therapeutic relationship

Seven PWPs talked about how CAT-GSH helped them develop strong therapeutic relationships, with several reflecting that they felt more connected to their clients in CAT-GSH compared with CBT-GSH. Most attributed this to the content of theme 1, getting to know their CAT-GSH clients better through exploring their past experiences:

> '*I do find that, with CAT, the relationship that I have with my clients feels much more comfortable and stronger than that of the other sessions that I had outside of CAT . . . that comes back to obviously knowing more and feeling like you get to know them more.*' (P8)

Three PWPs also talked about how they reflected and paid more attention to the therapeutic relationship in CAT-GSH, as it also acts as a mechanism of change during delivery.

5.2. Collaborative

Nine PWPs described the process of delivering CAT-GSH as very collaborative. For example, some PWPs described CAT-GSH as client-led, talking about how they felt able to take a step back from the usual '*teachery*' psychoeducational role (P4) that they often occupied during CBT-GSH: '*for me it's about . . . giving the clients the tool to make the change for themselves . . . as opposed to feeling like you're giving the client like the answers, or telling them what they should do*' (P9). Five PWPs also acknowledged that they felt as though they had more freedom and agency in CAT-GSH, with one PWP talking about how they felt able to be '*cheekier*' (P8) and make more suggestions to clients in CAT-GSH.

5.3. Parallel experiences in supervision

Nine PWPs placed similar value on the relational aspects of group supervision. For example, they talked about how they found it helpful for their own learning and clinical practice to hear other PWPs' experiences in supervision. PWPs seemed to place particular value on the collaborative nature of supervision, with one PWP talking about how it helps that the support and advice often comes from one PWP to another, rather than this primarily coming from the supervisor: '*it helps me when I'm listening to other practitioners rather than, rather than it coming from the supervisor. I think I'd struggle to retain the information when it's a supervisor*' (P12). Four PWPs also described experiencing supervision as a positive experience to go through as a team, as it provided them the space to support and reassure one another, to be there for each other's struggles, and celebrate each other's successes:

> '*It just really joined us together as a group, you know, like we laughed about it, we cried together, and we were in it together . . . I felt so much more bonded to the other PWPs as a team after CAT supervision than I ever did after a step two CBT supervision.*' (P4)

Discussion

This research was conducted with the aim of evaluating the acceptability of CAT-GSH through exploring PWPs' experience of delivering the psychoeducational self-help intervention, particularly in relation to how this compared with their experiences of delivering CBT-GSH and how broader service-level factors impacted their perceptions of acceptability. The TA conducted identified five prevailing themes suggesting elements of CAT-GSH acceptability, but also with some elements needing further consideration. CAT-GSH emerged as a low-intensity intervention that was distinct from CBT-GSH in terms of approach, pace and content and that this form of GSH was challenging initially to learn and deliver. Nevertheless,

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

deeper therapeutic relationships were enabled (also a theme in Meadows and Kellett, 2017), with the slower pace of change being in line with the reformulation, recognition and revision structure of the approach (Ryle and Kerr, 2002). The ability to fit the intervention into the extant time frame for a step 2 intervention (also a theme in Meadows and Kellett, 2017) and the emotional impact of hearing more about troubled pasts were the more burdensome aspects of the intervention. In terms of the treatment acceptability criteria of Sekhon *et al.* (2017), the PWPs had generally positive affective attitudes, believed the CAT-GSH particularly supported patient choice and was a theoretically coherent low-intensity approach, but also found the approach as imposing a high burden of delivery due to its explicit past-present focus. Strategies were employed throughout this evaluation to help maintain a critically reflexive stance (e.g. all 15 criteria for a 'good' TA were considered as fulfilled, reinforcing the rigour and credibility of the qualitative analysis; Braun and Clarke, 2006).

In line with guidance that suggests services should be offering a choice of low-intensity psychological treatments for anxiety and depression (Care Services and Improvement Partnership Choice and Access Team, 2008; National Collaborating Centre for Mental Health, 2018; National Institute for Health and Clinical Excellence, 2009; 2011), PWPs were very supportive of expanding treatment options at step 2. Whilst therapies offered at step 3 of IAPT have usefully diversified (Wakefield *et al.*, 2020), this diversification has frustratingly not been mirrored at step 2. Participants therefore highlighted the positive and empowering impact expansion of choice creates for both clients and practitioners. In general, PWPs thought that CAT-GSH could offer this choice. The exploratory and relational aspects of CAT (Ryle, 1995; Ryle and Kerr, 2002) were discussed as facilitators of strong therapeutic relationships and mechanisms of important change. The highly collaborative nature of CAT (Ryle, 1995; Ryle and Kerr, 2002) was also recognised in positive accounts of working alongside clients. This was also mirrored in relationships with colleagues in the supervision group. Previous research has similarly highlighted how the development of a 'shared CAT language' with colleagues can help to create a sense of professional collaboration and understanding (Thompson *et al.*, 2008).

The more exploratory style of CAT-GSH, requiring PWPs to facilitate discussions around clients' histories, seemed to particularly differ from their experiences of CBT-GSH, with its explicit here and now focus (Worrell *et al.*, 2018). This appeared to initially contribute to some experiences of anxiety and uncertainty among the PWPs, but also facilitated sudden and key moments of insight for clients. Furthermore, the psychoeducation resource of the highly structured client workbook seemed to help to scaffold and contain PWPs' initial anxieties. Such anxieties may have been understandable due to the training of PWPs strongly emphasising adherence to the 'here and now' focus of the low-intensity CBT approach (University College London, 2015). The early reformulatory sessions in CAT-GSH clearly invited disclosures which could also be upsetting and anxiety-provoking for the PWPs to hear and manage. This experience seemed to be intensified by the existing constraints, dilemmas and pressures of working as a PWP in the fast paced, low-contact and high-volume step 2 approach of IAPT services (Shepherd and Rosairo, 2008; Westwood *et al.*, 2017). It may have been the case that some of these reported challenges of providing CAT-GSH may have also been a reflection of the context being a clinical trial. Despite these challenges, many PWPs acknowledged that their understanding of, and confidence in delivering CAT-GSH developed with time, practice and support. Worrell *et al.* (2018) noted the challenges and advantages of helping IAPT CBT therapists to appreciate the contribution made by approaches other than CBT. Clearly, broader service-level factors such as the facilitation of collaborative group supervision, enabled the sharing of good practice, the validation of difficult experiences and access to peer support also influenced the perception of the acceptability of the intervention.

In terms of limitations, the following are of note. As the PWPs included in this research were mostly female and were recruited using volunteer sampling methods from one IAPT service, their

https://doi.org/10.1017/S1352465822000194 Published online by Cambridge University Press

experiences of learning and delivering CAT-GSH may not be representative of all PWPs working across different IAPT services. The sample size could have been larger and is doubtful whether a sample of n=12 is sufficient to achieve data saturation. Moreover, the study could have adopted a more mixed methods approach and been supplemented with a questionnaire measure of acceptability (Sekhon *et al*., 2017). For example, the Treatment Acceptability Questionnaire (Hunsley, 1992). There was a risk of sampling bias as the PWPs may have volunteered to take part because of particular motivations to contribute their views. The semi-structured interview protocol enabled the PWPs to talk about their experience of CAT-GSH, but there were no direct questions as to what they believed their patients' experience of the GSH were. Also, in relation to the schedule no piloting occurred and neither was there any updating of the topic guide on the basis of early interviews. The research team were not aware at the time of conducting the study that Braun and Clarke (2006) qualitative guidance had been recently updated (Braun and Clarke, 2021). The conceptual map (Daley, 2004) was not shared with the participants to check the validity of the inter-relationships that were conceptualised.

To conclude, this study sought to explore the acceptability of CAT-GSH by understanding the views of the PWPs delivering this low-intensity intervention in IAPT in regard to whether it was possible, how they felt about it and what the impediments to delivery were. CAT-GSH is clearly different to deliver than CBT-GSH, despite the similarity of psychoeducational purpose, approach and delivery method (Shafran *et al*., 2021). Generally, CAT-GSH emerged as an acceptable low-intensity approach, as PWPs felt that it offered choice, enabled the therapeutic relationship and was a highly collaborative therapeutic endeavour. Challenges included the past-present focus of CAT-GSH, as well as the time taken to implement the intervention in the context of busy clinical services and the PWP role. Final recommendations are contingent on the final and full reporting of outcomes from the PRPPT. Services and researchers need to continue to collaborate to expand and evaluate patient preferences.

Supplementary material. To view supplementary material for this article, please visit: https://doi.org/10.1017/S1352465822000194

Data availability statement. The authors do not intend to make the data publicly available as this would compromise the confidentiality and informed consent of participants.

Acknowledgements. With thanks all participating PWPs.

Author contributions. **Annabel Wray:** Conceptualization (lead), Data curation (lead), Formal analysis (lead), Writing – original draft (lead); **Stephen Kellett:** Supervision (lead), Writing – review & editing (lead); **Charlotte Bee:** Data curation (supporting), Project administration (supporting), Writing – review & editing (supporting); **Jess Smithies:** Data curation (equal), Project administration (equal); **Vikki Aadahl:** Project administration (lead), Writing – review & editing (supporting); **Mel Simmonds-Buckley:** Formal analysis (supporting); **Colleen McElhatton:** Formal analysis (supporting).

Financial support. The clinical trial in which this qualitative study is nested is funded by the Association of Cognitive Analytic Therapists (ACAT) and the Catalyse charity.

Conflicts of interest. The authors declare none.

Ethical standards. The project was registered as a service evaluation with the Trust (ref. no. 981.19) and was also housed within the PRPPT that had ethical approval (ref. no. 240751) and was registered as a clinical trial (NCT03730532). The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

References

Association for Cognitive Analytic Therapy (2007). *The Psychotherapy File: An Aid to Understanding Ourselves Better*. https://internationalcat.org/pdf/ThePsychotherapyFile-inwords.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. London, UK: Sage Publications.

Braun, V., & Clarke, V. (2021). *Thematic Analysis; A Practical Guide*. London, UK: Sage Publications.

Calvert, R., & Kellett, S. (2014). Cognitive analytic therapy: a review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*, 253–277. https://doi.org/10.1111/papt.12020

Care Services and Improvement Partnership Choice and Access Team (2008). *Improving Access to Psychological Therapies Commissioning Toolkit*. https://www.england.nhs.uk/wp-content/uploads/2020/05/iapt-manual-v4.pdf

Cape, J. (2015). *Guide to Evaluating Self-Help Guidance Materials for Anxiety Disorders and Depression*. https://www.ucl.ac.uk/pals/sites/pals/files/7_guide_to_evaluating_self-help_materials.pdf

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, *23*, 318–327. https://doi.org/10.3109/09540261.2011.606803

Conceicao, S. C. O., Samuel, A., & Yelich Biniecki, S. M. (2017). Using conceptual mapping as a tool for conducting research: an analysis of three approaches. *Cogent Social Sciences*, *3*. doi: 1080/23312886.2017.1404753

Daley, B. J. (2004). Using conceptual maps in qualitative research. *Proceedings of the First International Conference on Conceptual Mapping*. Pamplona, Spain.

Hallam, C., Simmonds-Buckley, M., Kellett, S., Greenhill, B., & Jones, A. (2021). The acceptability, effectiveness, and durability of cognitive analytic therapy: systematic review and meta-analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 8–35. https://doi.org/10.1111/papt.12286

Hunsley, J. (1992). Development of the Treatment Acceptability Questionnaire. *Journal of Psychopathology and Behavioural Assessment*, *14*, 55–64. https://doi.org/10.1007/BF00960091

Kellett, S., Bee, C., Aadahl, V., Headley, E., & Delgadillo, J. (2021). A pragmatic patient preference trial of cognitive behavioural versus cognitive analytic guided self-help for anxiety disorders. *Behavioural and Cognitive Psychotherapy*, *49*, 104–111. https://doi.org/10.1017/S1352465820000442

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, *4*, 30–37. https://doi.org/10.1054/cein.2000.0106

Meadows, J., & Kellett, S. (2017). Development and evaluation of cognitive analytic guided self-help for use in IAPT Services. *Behavioural and Cognitive Psychotherapy*, *45*, 266–284. https://doi.org/10.1017/S1352465816000485

Mental Health Taskforce (2016). *The Five Year Forward View for Mental Health*. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

National Health Service (2019). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

National Institute for Health and Care Excellence (2009). *Depression in Adults: Recognition and Management* (NICE Clinical Guideline 90). https://www.nice.org.uk/guidance/cg90

National Institute for Health and Care Excellence (2011). *Generalised Anxiety Disorder and Panic Disorder in Adults: Management* (NICE Clinical Guideline 113). https://www.nice.org.uk/guidance/cg113

National Collaborating Centre for Mental Health (2018). *The Improving Access to Psychological Therapies Manual*. https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf

Ryle, A. (ed) (1995). *Cognitive Analytic Therapy: Developments in Theory and Practice*. John Wiley & Sons.

Ryle, A., Kellett, S., Hepple, J., & Calvert, R. (2014). Cognitive analytic therapy at 30. *Advances in Psychiatric Treatment*, *20*, 258–268. https://doi.org/10.1192/apt.bp.113.011817

Ryle, A., & Kerr, I. B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*. John Wiley & Sons. https://doi.org/10.1002/9780470713587

Sekhon, M., Cartwright, M., & Frances, J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC Health Services Research*, *17*. https://doi: 10.1186/s12913-017-2031-8

Shepherd, M., & Rosairo, M. (2008). Low-intensity workers: lessons learned from supervising primary care mental health workers and dilemmas associated with such roles. *Mental Health in Family Medicine*, *5*, 237.

Shafran, R., Myles-Hooton, P., Bennett, S., & Öst, L. G. (2021). The concept and definition of low intensity cognitive behaviour therapy. *Behaviour Research and Therapy*, *138*, 103803. doi: 10.1016/j.brat.2021.103803

Swift, J. K., Mullins, R. H., Penix, E. A., Roth, K. L., & Trusty, W. T. (2021). The importance of listening to patient preferences when making mental health care decisions. *World Psychiatry*, *20*, 316–317. doi: 10.1002/wps.20912

Taylor, P. J., Jones, S., Huntley, C. D. & Seddon, C. (2017). What are the key elements of cognitive analytic therapy for psychosis? A Delphi study. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*, 511–529. doi: 10.111/papt.12119

Thompson, A., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J., & Kerr, I. B. (2008). Multidisciplinary community mental health team staff's experience of skill level training in cognitive analytic therapy. *International Journal of Mental Health Nursing*, *17*, 131–137. https://doi: 10.1111/j.1447-0349.2008.00521.x

University College London (2015). *National Curriculum for the Education of Psychological Wellbeing Practitioners*. https://www.ucl.ac.uk/pals/sites/pals/files/pwp_review_-_final_report.pdf

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2020). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: a systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, *60*, 1–37. https://doi.org/10.1111/bjc.12259

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health*, *26*, 172–179. https://doi.org/10.1080/09638237.2016.1276540

Worrell, M., Samuels, R. & Woo, R. (2018). Training high intensity CBT therapists in other modalities of therapy: can we change their minds? *Journal of Psychological Therapies*, *3*, 9–16.

Cite this article: Wray A, Kellett S, Bee C, Smithies J, Aadahl V, Simmonds-Buckley M, and McElhatton C. The acceptability of cognitive analytic guided self-help in an Improving Access to Psychological Therapies service. *Behavioural and Cognitive Psychotherapy*. https://doi.org/10.1017/S1352465822000194