Catalyse | Change in Action

UNMANAGEABLE FEELINGS & RISK TO OTHERS

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5th March 2026

Key Learning Objectives

- Knowledge of the reasons that complex clients are hard to engage and help (restricted, extreme and distorted RR repertoire)and of common but unhelpful responses by staff teams/systems including boundary breaches.
- Knowledge of different ways of working with hard to help clients: applying CAT concepts in direct and indirect working.
- Understanding where the client's starting point is, awareness of their ZPD.
- Building on current knowledge of elicited countertransference and its conceptualisation from a CAT perspective as a RR enactment and that how we respond to clients can affect their ability to engage, enact unhelpful RRs, or create relational exits to damaging RRPs

Key Learning Objectives

- Understanding how we can use elicited countertransference and CAT reformulation (SDR) to provide a richer, relational understanding about a client's risk and management and how we can helpfully respond in the moment as individuals and teammembers.
- Understanding that risk is a relational concept which is not just located in the individual.
- Skills in integrating CAT's relational understanding about risk potential and how this can be integrated within service risk assessment and management plan

AIMS:

- Development and maintenance of a curious, empathic, self-reflective capacity when working with powerful enactments and 'hard to help' clients.
- Development of an openness to sharing the difficult feelings that clients can elicit in us and using this knowledge to inform a psychological rather than personal response to a clients' unhelpful/damaging enactments.

Complexity and Risk To others

10AM	1hr 15 mins	Introduction to managing risk Readiness for CAT and alliance building where there are risks
11.15	15 mins	Break
11.30	1 hr 30	CAT with risky/offending behaviours
13.00	60 mins	Lunch
14.00	60 mins	CAT with risky/offending behaviours cont
15.15	15 mins	Break
15.30	60 mins	CAT and teams working with risk and complexity Reflections and evaluation
16.45 FINISH	-	Finish

SELF CARE TODAY

- We are talking about working with people who pose different kinds of risk of harm to others
- We may be talking about clinical case material where violence and sexual violence have featured
- We are talking about the impact risk has on us as clinicians and within the system
- Please look after yourself and do what you may need to ensure your well being
- We can be available at breaks if you feel this would be helpful

- Today is about managing difficult feelings and relational experiences that can lead to harm for others - so not just about “forensic clients” but about complexity and complex clinical/presentations that requires change

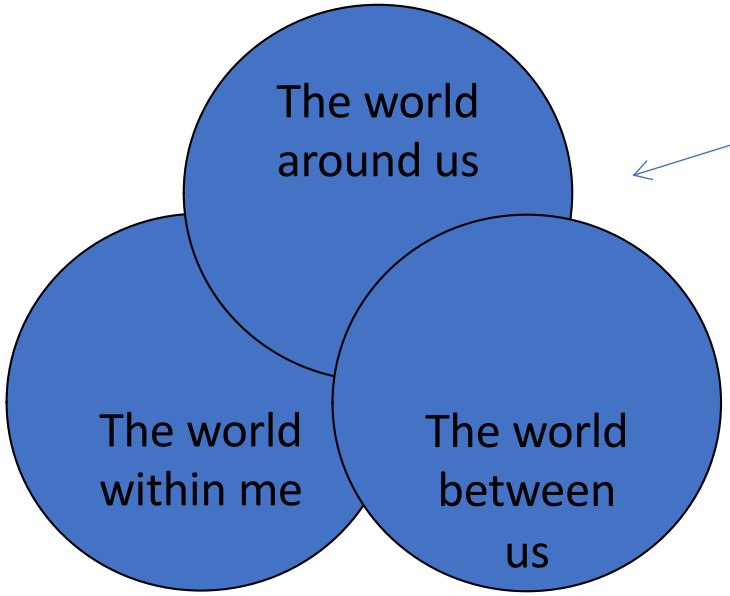
- All contexts may find themselves working with people whose coping may be harmful for others along a continuum of severity and complexity

- So if you don’t work in a forensic context, don’t switch off and stay with us!

Best Practice in Managing Risk

- Philosophy underpinning the framework
  - Positive risk management
  - Collaboration – service users and their carers
  - Importance of recognising and building in service users strengths
  - Organisations role in risk management
- Risk management is everyone's business…….. all services do it, but even those using similar/the same risk assessment and management tools do it differently

THE ONE THIRDS RULE (POTTER 2021)



The wider system – how they view risk – core business vs someone else's business, anxiety, complacency

My relational patterns, my relationship with risk, how the referral came to me

The client – their relational patterns, their experiences of services, how they came to be involved with you

RISK, THREAT AND SAFETY

- *"Security provides the framework within which care and treatment can be safely provided. Patients and staff can't participate positively or purposefully in the activities of the service unless they feel safe."* (Allen, 2015, p4)

PSYCHOLOGICAL SAFETY

- Within therapy, making changes involves significant interpersonal risk within therapeutic relationships
  - The idea we can speak up, ask for help
  - Try something, make mistakes, fail without interpersonal consequence

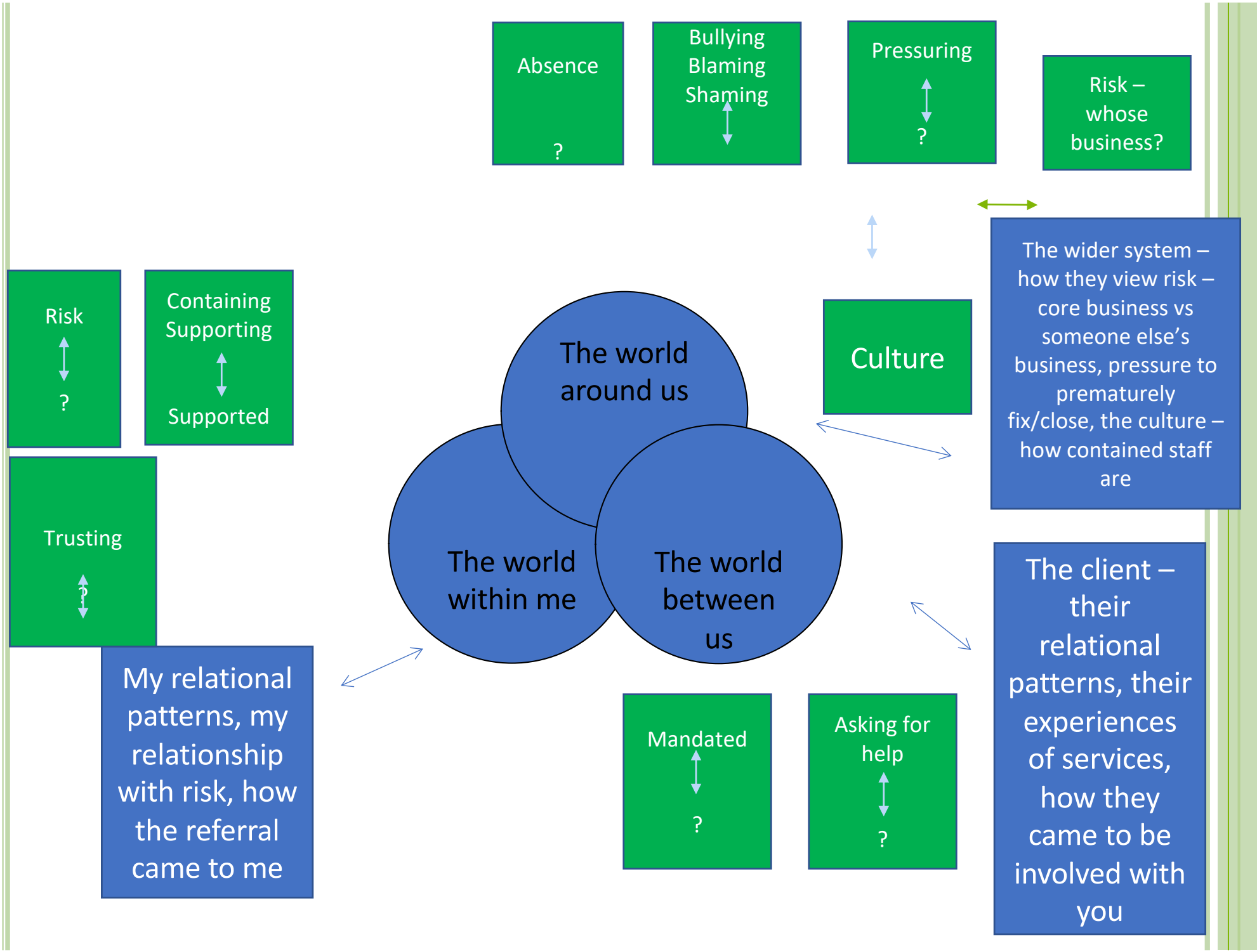
PSYCHOLOGICAL SAFETY

- The need for staff to feel safe and contained
- Major enquiries highlight the importance of culture, role of leaders (DOH, 2012; 2014)
  - "It is a shocking figure that over a third of NHS staff surveyed do not feel safe to speak up about concerns. It is a clear indication that we remain far away from the NHS vision of creating a patient safety culture throughout the health service." (Patient Safety Learning 2022)

PSYCHOLOGICAL SAFETY IN THE WORKPLACE

- Our patterns that we bring – messages we were given
- The workplace patterns – cultural dynamics, specific to teams, to professions
- Workplace procedures and processes which impact on safety

How do we integrate these ideas into our understanding of therapy and risk and what is possible?


Absence
?
Bullying
Blaming
Shaming
Pressuring
?
Risk – whose business?
Risk
?
Containing
Supporting
Supported
The world around us
Culture
The wider system – how they view risk – core business vs someone else's business, pressure to prematurely fix/close, the culture – how contained staff are
Trusting
?
The world within me
The world between us
My relational patterns, my relationship with risk, how the referral came to me
Mandated
?
Asking for help
?
The client – their relational patterns, their experiences of services, how they came to be involved with you

IMAPCT OF EARLY LIFE ON RISK TO OTHERS 1

- Forensic patients typically present with themes of early, severe deprivation, neglect and physical and sexual abuse
- These are all related to boundaries in early relationships:
  - A violation of boundaries (e.g. Different forms of abuse).
  - Little or no boundaries (e.g. Child neglected, allowed to do what they want)
  - Inconsistency of boundaries, child never knows where they stand, or get mixed messages (e.g. not caring what time they come in one night, being excessively punitive the next; being abused and hurt, then treated as special).
  - Dissociation: shutting off from overwhelming experiences, or where meaning-making not possible.
-

IMAPCT OF EARLY LIFE ON RISK TO OTHERS 2

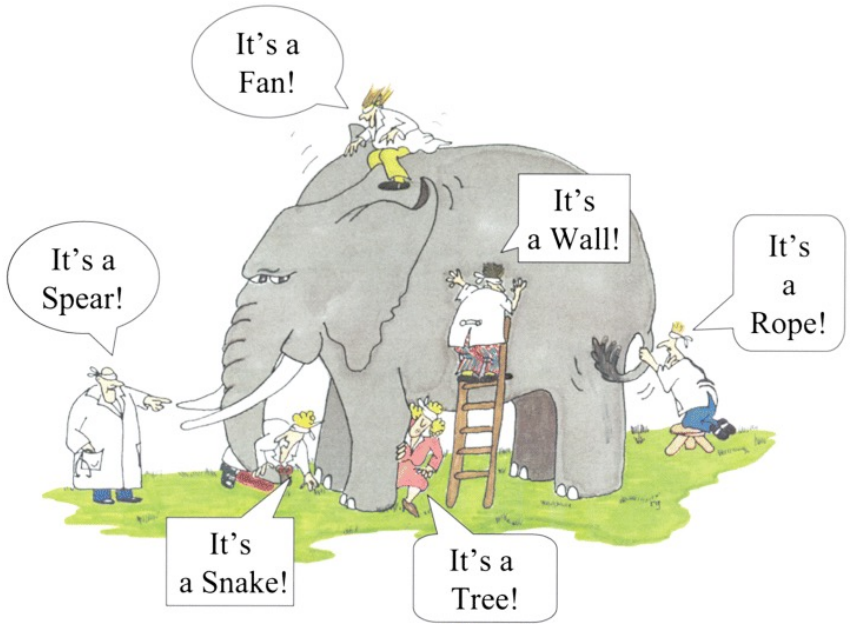
- As a result the reciprocal role repertoire of the client who poses a risk to others is frequently grossly restricted, damaged and damaging
- This restricted role repertoire is seen to contribute and be re-enacted in their risk to other (such as offending behaviour)
- Behaviour that is risky to others (including offending behaviour) is ultimately relational
- Motivation, contributory factors and risk factors are to be understood within the context of these RR repertoires and their relationship to the victim/target of the risky behaviour

Risk to others

- There may be confusing and extreme emotional states with high levels of arousal
- Each state associated with a specific repertoire of thoughts, affect and behaviour
- State shifts may be characterised by varying degrees of dissociation
- Rapid state shifts may occur outside conscious awareness
- Confusing to the individual and confusing to the staff involved
- This can leave staff feeling deskilled, overwhelmed and vulnerable to unhelpful re-enactments

A RELATIONAL UNDERSTANDING

- Developing a shared understanding can assist in meaning making, of state shifts, of inconsistent experiences or fragmented parts of self
- For professionals it can help different experiences be part of meaning making and different perspectives valued and acknowledged as part of the whole picture



A RELATIONAL UNDERSTANDING

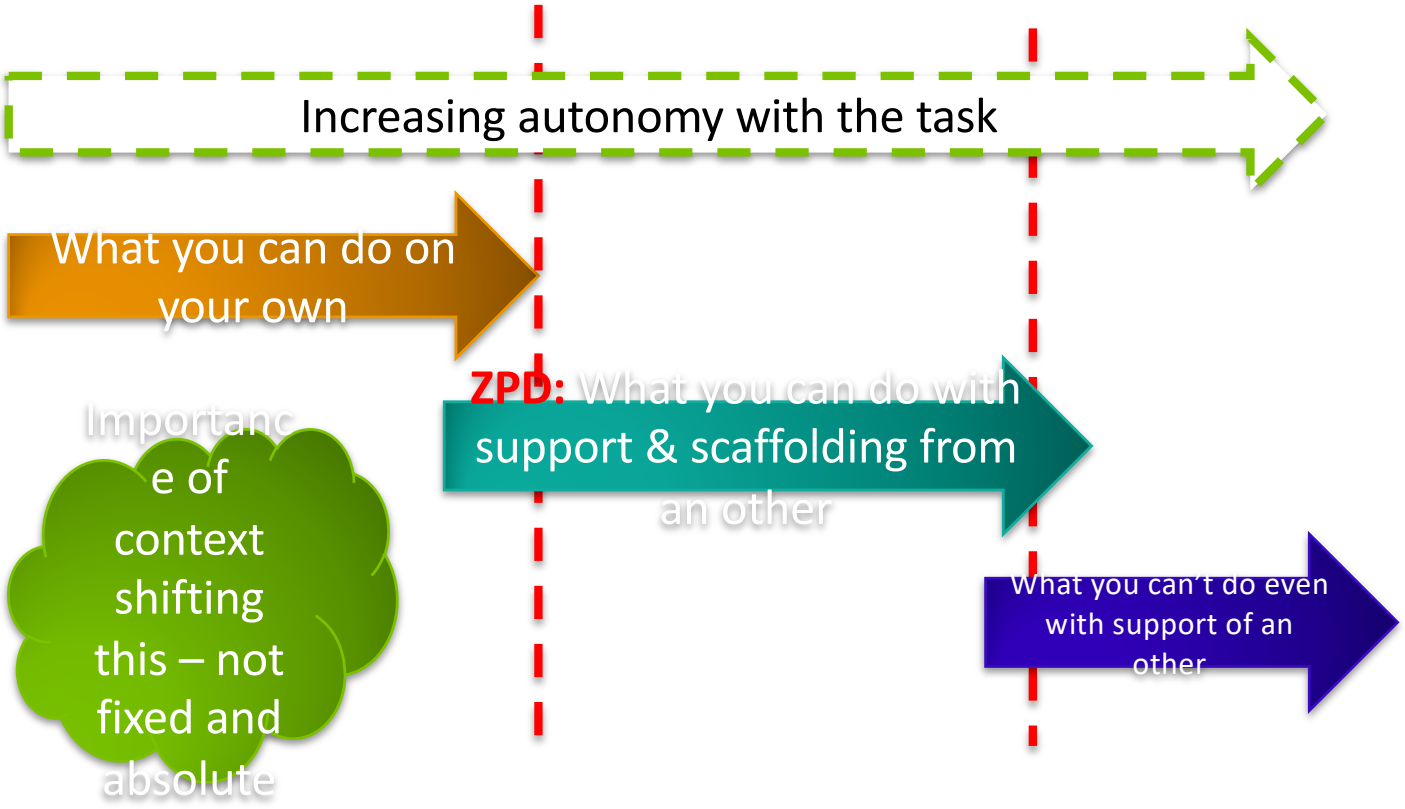
- Diagrammatic reformulation can help provide an integrated understanding of risk and unmanageable feeling states – it's easier with a map
- Harmful behaviours or risk to others can be reconceptualised as Target Problem Procedures
- This can help staff empathise and consider alternative responses (exits)

Where there is risk to others or for those in a forensic setting…

- Therapy may have been mandated directly (judge, parole board, MDT, social workers….) or implicitly (if you don't engage in therapy, we can't give you leave)
- Given the complexity, nature and degree of trauma and adversity, any kind of relationship can be perceived or experienced as frightening, threatening etc – difficulty in receiving care – issues arise in the relationship not in the client per se
- Given the nature of issues (harm to others) then there can be powerful emotions (and so enactments) around in all parties

- So, the client may not want to or be very ambivalent about engagement and the system may be making this worse through inadvertent enactments
- Clients often labelled as "unmotivated" or "not ready for therapy"
  - (Other clinical contexts with similar scenarios?)

Zone of proximal development



Offering therapy/help

?

Talking about change

?

"Offender readiness model"

Ward, Day, Howells and Birgden , 2004; McMurran, 2014

Readiness is the presence of characteristics within either the client or therapeutic situation, which are likely to promote engagement and likely to enhance therapeutic change.

So we need to be thinking about…

- Level of support and encouragement: Availability of individuals who wish the client well and would like to see him/her succeed
- Appropriate institutional culture
- Positive or negative atmosphere
- Therapeutic alliance
- Required conditions for engagement
- Adequately skilled, supported and motivated staff
- Previous treatment experiences

- Interrelated social, psychological and contextual factors

STARTING WHERE THE CLIENT IS AT…IMPORTANCE OF ZPD

- Before we even think about psychotherapy files, 16 or 24 sessions, early life experiences and RF letters…
- Consider what might help or hinder getting to changed based on the possible enactments from the outset
- "Pre-CAT work" (Shannon, 2018)
  - Time limited and contracted session to explore client engagement and 'motivation'
  - Use CAT tools and skills flexibly and based on client's needs and wants
  - May include mapping here and now
  - Chance for client to 'try out' working with you
  - Focus not on change, but engagement and connection to avoid powerful enactments of immediate focus on 'change' or 'risk'
  - May be to spark curiosity in client or sense of achievement and positive engagement and co-production of a tolerable map

POSSIBLE PRE-CAT CONVERSATIONS

- The importance of naming the power dynamics within the system and the background to the proposed therapy
- The opportunity to think about these dynamics and acknowledge where we sit as therapists as part of this system

POSSIBLE PRE-CAT CONVERSATIONS

- Does the client know why they are in the assessment with you? Do they know what a therapist/psychologist even is?
- Explore client's opinion and perspective – what do they want to get out of this?
- Explore with client his/her opinion on other people's perspectives – esp. in relation to risk?
- Ask what the client wants to change, if anything?
- What have previous experiences of therapy/psychology been like? Good and bad? How come?
- What has felt easier and/or more difficult for the client to talk about with other professionals? (e.g. risk, offence etc)
- Maps current important topics for client (e.g. not getting leave, frustrated with peers etc.)

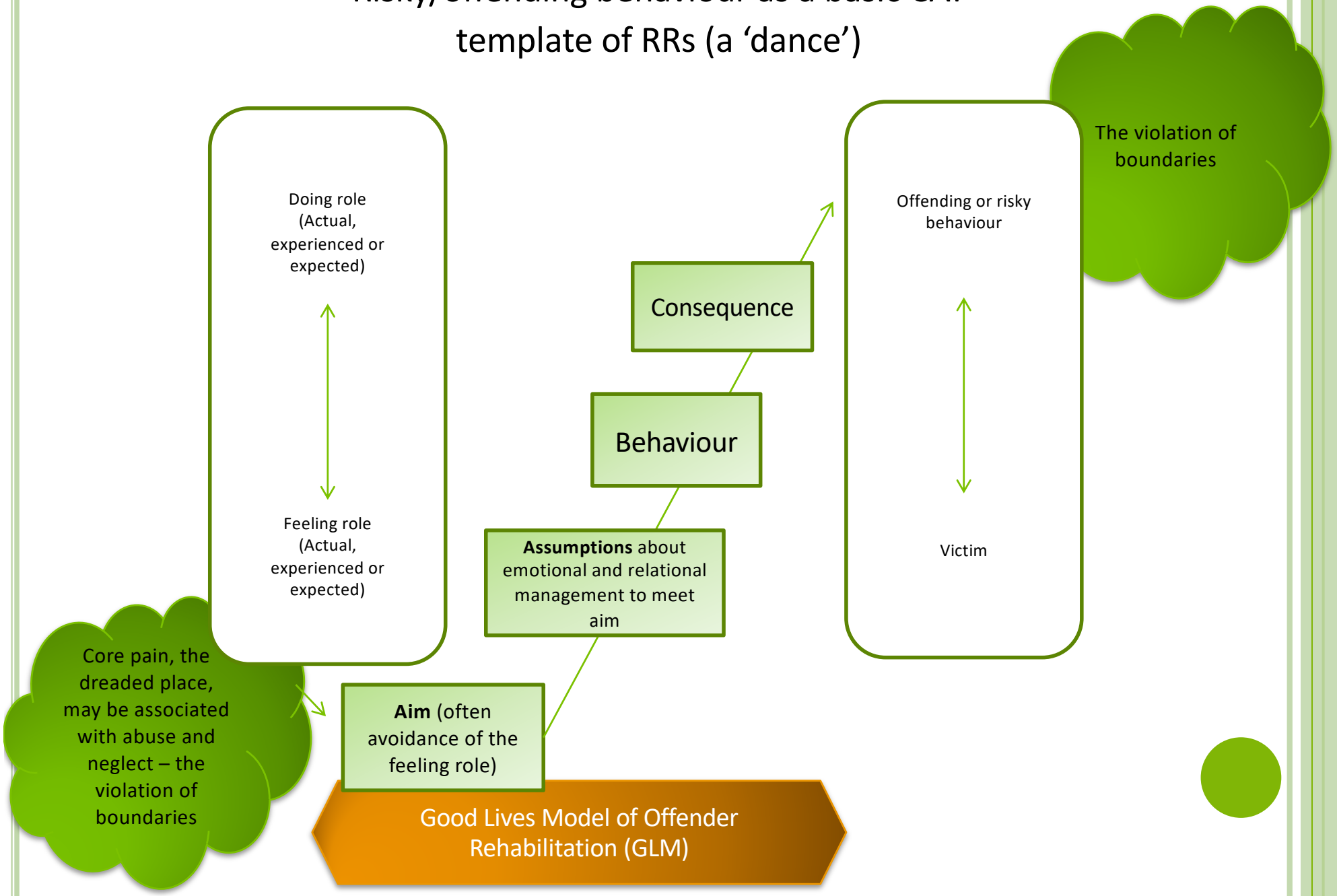
EXERCISE – ROLEPLAY 1

- Is this person ready for CAT? Why? Why not? how might you think about the relational dynamics impacting on readiness?
- Applying to your own cases – think of a case where you are uncertain about readiness. How might you think about the readiness model for your client?

Every crime is a window onto the offender's internal world and represents the relational, interpersonal expression of these inner processes as external manifestations…something inside the offender is translated into relational actions

Pollock, 2004

Risky/offending behaviour as a basic CAT template of RRs (a 'dance')



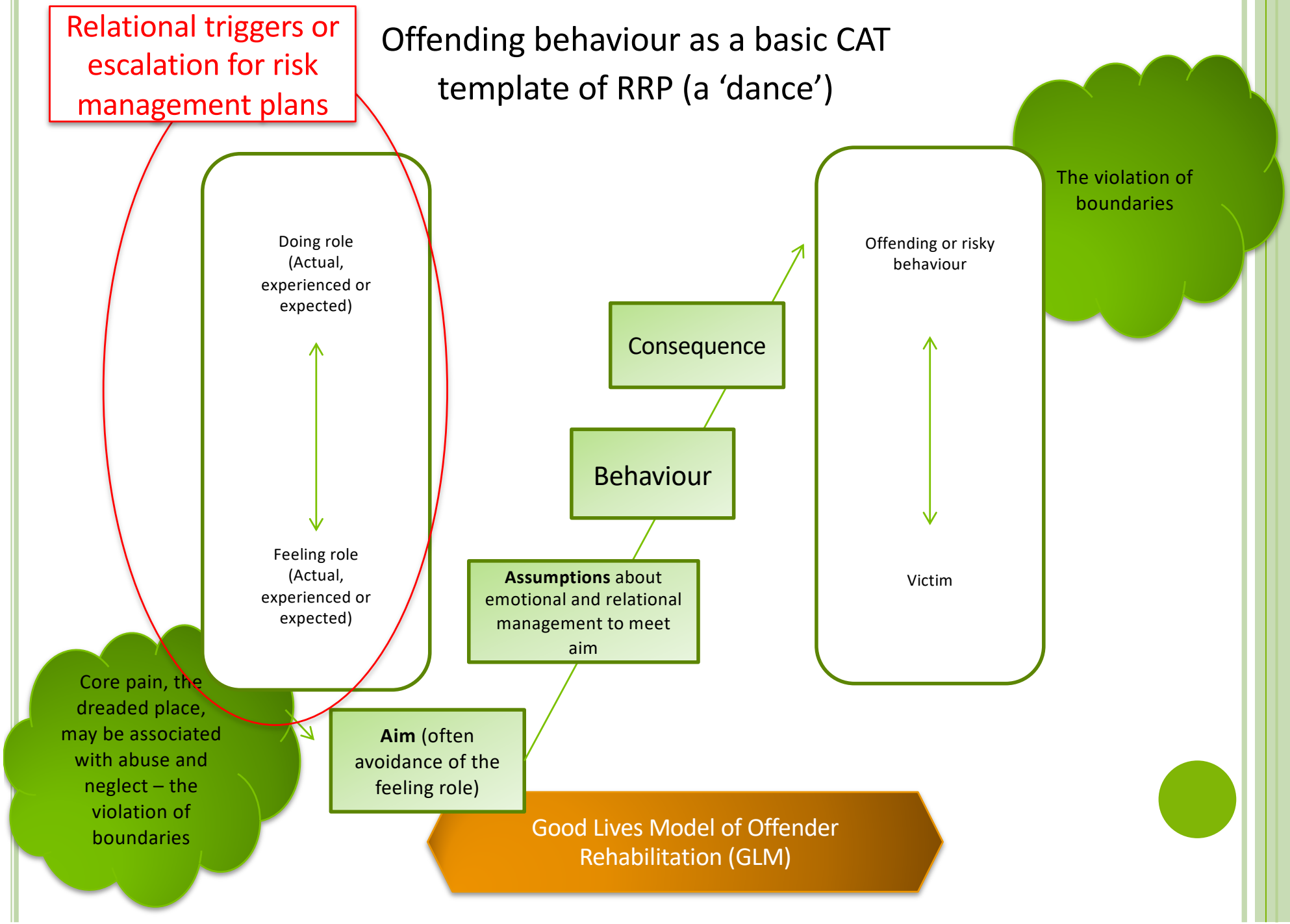
RISK BEHAVIOURS SERVE A PURPOSE

- In CAT terms, procedures involved aim-directed activity
- Good Lives Model of Offender Rehabilitation (GLM) (can help inform aims in CAT maps)
- We all value certain states of mind, personal characteristics and experiences. So we can see "aims" as:

1.Life	including healthy living and functioning
2.Knowledge	feeling well informed about things that are important to us
3.Excellence in play	hobbies and recreational pursuits
4.Excellence in work	including mastery experiences
5.Excellence in agency	autonomy, power and self-directedness
6.Inner peace	freedom from emotional turmoil and stress
7.Relatedness	including intimate, romantic, and familial relationships
8.Community	connection to wider social groups
9.Spirituality	**i**n the broad sense of finding meaning and purpose in life
10.Pleasure	feeling good in the here and now
11.Creativity	expressing oneself through alternative forms

Ward and Brown (2004)

Offending behaviour as a basic CAT template of RRP (a 'dance')



MATE: Four possible procedural pathways (Ramm & Shannon, 2024)

- Move: When an individual attempts to obtain a desired RR position through using a behavioural procedure – moving to a 'better relational position'
- Accept and endure: When an individual finds themselves in a powerless RR position feel unable to move into a preferred role because they lack the opportunity or skills or fear the consequences of trying. They therefore have to 'accept' the position of victim and can do little except endure it or try to placate their abuser
- Turn the tables: involve a person inverting the RR that is being enacted – can be sudden or build up over time if 'move' has not worked
- Escape: involve those in a negative RR position using avoidance behaviours to temporarily avoid the negative feelings of being in that position. The individual may simply psychologically shut o□ or use substances to cope.

KEY POINTS IN GETTING RISK ON THE MAP

- Attend to what the process might bring up
  - What might be present in the map that might be intensified by considering risk
  - Is risk something which is admired 'top dog', something to be proud of
  - Is risk likely to trigger more painful positions, a shamed position or humiliated
- Taking into account offender readiness model and zone of proximal development
  - How aware is the person and how slowly do you need to take this?
  - Can it be thought about together or is this reflective practice for the team?
  - What do you need to do to enable or work towards a more collaborative way of understanding risk?

Key points in getting risk on the map

- Might taking it too fast or working outside of readiness or ZPD increase risk?

- Attend to system dynamics
  - How does the system think about risk? How safe is it to talk about risk within the system? What messages are given about this?
  - What can different views about risk within the system add to our understanding of risk?

ROLEPLAY EXERCISE 2

- How might you use the GLM to make sense of risk in this scenario?
- Using your own example, consider what the GLM could add to your understanding.

Multiple self states simplified and risk/safety (Harvey, 2024)

- The CAT model sees the self as multiple.
- This means we all have different parts or sides to us that make up our overall sense of self or personality.
- When using the MSSM model the focus of the reformulation process is slightly different compared to a standard CAT.
- With the MSSM one of the early tasks is to identify the different parts and map them out on paper. This can be scaffolded by two CAT tools: The Personality Structure Questionnaire (Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001) and the list of 'Different States' at the back CAT psychotherapy file.

Multiple self states simplified and risk/safety (Harvey, 2024)

Level of the Multiple Self State Model	Level 1: Difficulty with rigid and fixed relational patterns	Level 2: Difficulty with fragmented experiences of myself (or others)	Level 3: Difficulty with reflection and self-awareness
Key CAT concept	Limited and restricted reciprocal role repertoire	Self-states and metaprocedures	Reflective eye
	It is hard to relate to myself (or others) in new or flexible ways Finding it hard to respond in new ways or ways that are flexible depending on the situation Tending to feel as if there are very few ways of relating to myself and other people	**It is hard to hold in mind the different parts of me (or others) at the same time** Experiencing myself (or others) 'in different parts' Finding it hard to take time to weigh up the options of how to respond to a situation	**It is hard to notice and understand feelings and patterns of behaviours** Difficulties with noticing, naming and understanding feelings and behaviours Strong, sudden emotions - as if they take over my perspectives and behaviours
	Possible aims Notice and expect rigid or limited ways of relating and plan accordingly If possible side step responses that would make things worse Aim for sense of psychological safety to increase capacity to try new and flexible ways of relating	**Possible aims** Avoid relating at any time to only one aspect or part of a person Describe all key self-states (and procedures) and reflect this in safety plans Hold all 'parts' in mind when considering ways to respond and manage risk	**Possible aims** Help build up a more sustainable capacity to notice and describe feelings, thoughts and behaviours in relationship with others and self Help the client describe patterns that may indicate risk escalation and practice noticing and responding new, flexible ways

CAVEATS TO USING MSSM WITH RISK…

- Any form of psychological intervention can destabilize – agree an approach in the person's ZPD and with the available support from others professionals and team
- See Carradice (2013) & Shannon (2016) for CAT-informed approaches there the person is not yet ready for standard one to one therapy.
- As with many models, the MSSM tends to focus on difficulties and problems and although it can incorporate the strengths or the healthy parts of clients and their relationship, this is not the focus today (for more on this see Bradley, Cox & Scott, 2016)

Level 1 - Difficulty with rigid and fixed relational patterns: It is hard to relate to myself and others is new or flexible ways

Abuse, threat and neglect in childhood = less scope to feel safe enough to engage in play, spontaneity, imagination and creativity = limited learning about how to flex and learn in relationships.

Experiences of very limited and rigid relationship patterns from care givers = rigid and few RRs are experienced and so internalized.

So harder to occupy the complex, fluid and nuanced roles that are required for safe and good-enough adult relationships. Instead, there is a pull to rigid and limited ways of relating with self and others, as if there were very few options

- What is the relevance for understating and planning to manage risk of harm to others?

Level 2 - Difficulty with fragmented experiences of self (and others): It is hard to hold the different parts of me (and others) in mind at the same time

- Imagine child whose parent switched suddenly between:
  - neglecting, overlooking (e.g. ignoring him when he cried, not providing food, leaving him overnight when he was very young, taking no action when he truanted) and at other times was:
  - rageful, cruel, critical, aggressive (e.g. being physically abusive in fits of rage, belittling him in front of others, implementing a grueling and sadistic regime of 'discipline' in the home).
- What would the experiences of the bottom roles be? And the coherent sense of self across both bottom roles?

- These different parts that feel unconnected and fragil. When the child grows up he and so as a grown up may experience very distinct perspectives and emotions that appear to change with little warning and so be very confusing and unsettling.

- What is the relevance for understating and planning to manage risk of harm to others?
- Which self states get warded off, by whom and to what purpose?

Level 3 - Difficulty with reflection and self-awareness: It is hard to notice and understand my feelings and patterns of behaviour

- Related to conscious self-awareness and 'reflective capacity'.
- Ability to notice, describe and understand our own feelings, behaviours, motivations, and intentions
  - In the moment
  - Over time, which help us build up an idea of how we tend to respond and mange emotions and relationships (which is the basis of our sense of self and identity)
- Ability to notice and hypothesize about the feelings, behaviours, motivations, and intentions in other people - through CAT we see this as the *expected or perceived reciprocal roles* in interpersonal reactions.

- If a care giver offers limited attention, vocabulary and commentary about the child's feelings and experiences in relation to relationships and the links between the internal and external world, then the language to understand these links will also be limited as an adult
- a lot of physical or psychological threat, it may mean that survival is prioritised over experiences that help a child come to understand their own feelings with increasing autonomy and exploration
- sexual abuse or physical violence), they may cope through dissociation in those moments. This will lead to a discontinuity of memories and narrative of what happened. It will be fragmented or partial in their mind and over time impact on their sense of self

Working with risk and the system

- In trying to manage risk and safely rehabilitate, at the heart is the therapeutic relationship
- But for those who have experienced trauma/rejection, particularly by powerful others supposed to care and protect, forming the therapeutic relationship and feeling safe is especially difficult
- Often staff with the least training have the most contact walking the tightrope of care/treatment and risk management
- If staff navigate this, they hear the hurt or risk potential/caused to others and experienced by them
- Holding both perspectives, victim and perpetrator requires the holding of multiple positions
- Can lead to team conflict and splits if only identifying with one part of the picture/story

We **will** end up on the map

- Given the restricted repertoire of **reciprocal** roles of the client – there will be pressures/pulls for us to repeat what the client knows. In a sense, the client has no/limited other ways of relating.
- Services often repeat the problematic relational patterns of clients
- Experienced therapists report getting caught in negative interaction cycles where they respond to patient hostility with their own counter-hostility (Henry et al 1986).
- Our own Reciprocal Roles may make us more prone to parts of the client's patterns, eg Many of us have a tendency towards "ideal carers/rescuers" – which often brought us into the caring professions.
- Organisational dynamics eg. Pressure to "rescue" (minimise risk), eg pressure to "control" (detaining function of ward), eg pressure to reject (BPD refused treatment as not "genuine mental illness" – this is no longer acceptable – NIHME documents, NICE Guidelines)

Re-enactments and Services contribution to escalation

- Traditionally risk tends to be seen as solely located within the individual, rather than it being relational i.e. between the worker and client, team and client or system and client and society and client.

- Consider the contribution of the system/staff in increasing risk through re-enactment of damaging RRP's (e.g for the client who "ups the ante" in order to be seen within a service, *doing to* the client)

MAKING SENSE OF UNHELPFUL ENACTMENTS

- Enactments can be examples of offence paralleling behaviours
- Use CT to help identify boundary breaches which can be indicators of parrallelling offending behaviours/risky RRp's and increased risk.
- Reformulate to increase recognition and develop exits.

EXERCISE 3

- Group roleplay of a team scenario

USING THE SDR TO IDENTIFY RISK

The sequential diagram provides a model for:

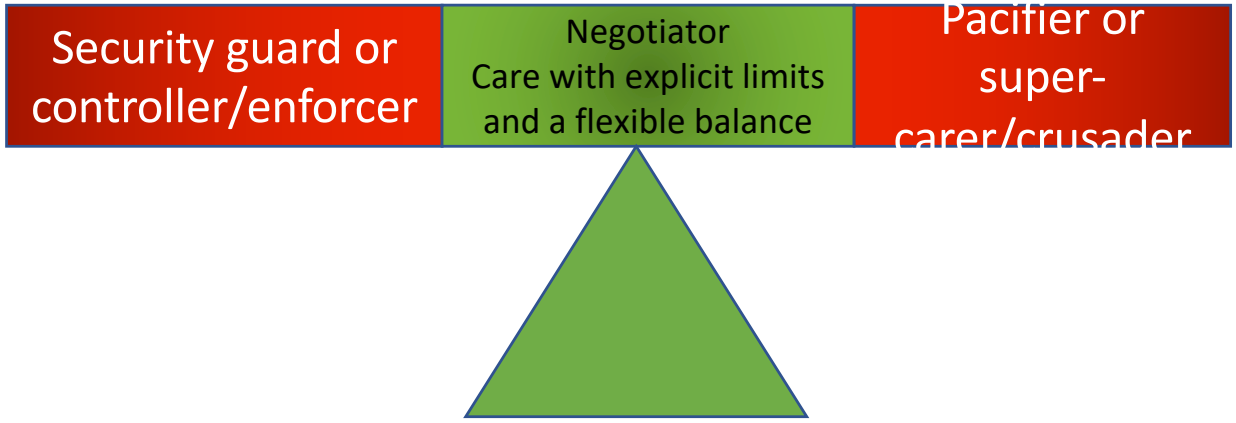
- factors likely to predispose risk behaviour
- factors likely to trigger risk behaviour
- function of risk behaviour
- factors likely to reduce risk behaviour
- This information can underpin the risk formulation completed with a structured professional judgement tool guiding risk assessment

SOME IDEAS FOR THE MDT

- Be mindful of the 'pushes and pulls' AND aim for balance – notice and name what is happening out loud within the team or wherever possible and safe to do so with the client too
- Generate some ideas about what responses from staff/the team may compound problems or escalate distress and so risk – try and side step these wherever it feels safe to do so
- Consider the underlying drivers behind risky behaviours and plan to try and meet them in safer ways with the client
- Give opportunity to the client to understand the context and reasons for the risky behaviour
- Couch triggers and maintaining factors in relational terms (RRPs) to emphasises the importance of relational experiences in risk escalation and avoiding this wherever possible
- Hold in mind that the client may not always be able to engage helpfully in conversation about risk or vulnerability – adapt approach and topics of conversations appropriately where needed
- Provide support for linking inside and outside events – increasing awareness of emotional experiences and the relationship with the outside world
- Notice if any 'parts' of the client tended to be 'left out, avoided or warded off – do the plans/formulations take into account risk of harm to others; vulnerability/trauma; and day to day presentations? Build up an overview of the key main parts with the client and help each other hold all parts in mind
- Expect relational difficulties – and try to increase a sense safety so newer ways of relating may emerge

The Boundary SeeSaw Model

(Hamilton 2009)



- The red areas represent risky/danger zones in terms of boundary shifts or violations, the green area is the safe zone.

The Security Guard

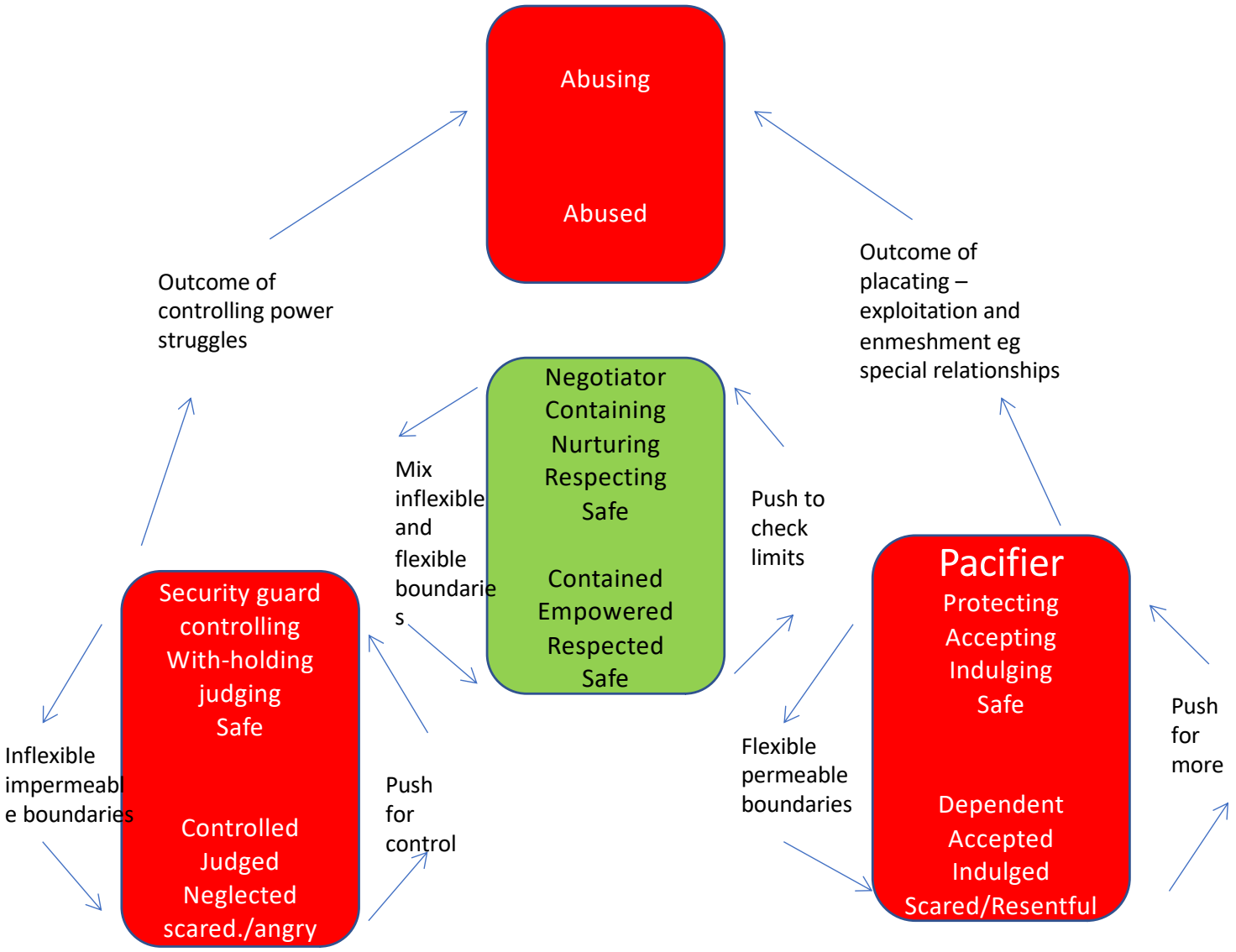
- Mainly focused on 'offender' part of patient
- Concerned about rules, regulations, tasks, risk management
- May hold negative attitudes about treatment and bonding with patients
- Inflexible boundaries
- Believes – safety and treatment achieved by controlling, judging, emotional distance
- But this elicits a counter position – the patient in response feels controlled, judged, emotionally neglected and vulnerable
- In response patient pushes boundaries to regain control, moving staff into more vulnerable position – leads to battle for control
- Dominance of this can lead to patient neglect, compliance (false), seclusions and power struggles

The Pacifier/ Super Carer

- Main focus on victim part of the patient and attempts to 'rescue'
- Very involved approach to relational boundary management
- Indulging, protecting, accepting role
- This elicits a patient position of indulged, accepted but vulnerable as they are co-dependent on the other
- Can lead to further pushing of boundaries to find where the limits are – putting staff in vulnerable position
- Leads to further changing or loosening of boundaries – can become confused, overly flexible, enmeshment between staff and patient needs
- Either party may reach limits of flexibility and flip into controlling role

The Negotiator

- Awareness of both offender and victim parts of patient
- Relational boundary management – involving care and control components
- Openness, being contained, balanced, respectful
- Clear about non negotiable boundaries and negotiable boundaries
- Explicit limits – managing boundaries in nurturing, respectful and negotiated way
- Collaborative professional relationship – not too close or too distant
- Patient feels contained and safe with limits and also able to assert independence and influence with those negotiable boundaries


Abusing
Abused
Outcome of controlling power struggles
Outcome of placating – exploitation and enmeshment eg special relationships
Negotiator
Containing
Nurturing
Respecting
Safe
Contained
Empowered
Respected
Safe
Mix inflexible and flexible boundaries
Push to check limits
Security guard
controlling
With-holding
judging
Safe
Controlled
Judged
Neglected
scared./angry
Pacifier
Protecting
Accepting
Indulging
Safe
Dependent
Accepted
Indulged
Scared/Resentful
Inflexible impermeable boundaries
Push for control
Flexible permeable boundaries
Push for more

3 R's in working with teams

- Reformulation – how can we use CAT understanding to help with understanding the patterns we as a team get pulled into
- Recognition – noticing before, during after when we are on the map
- Revision – how could we as a team do something differently to step off the map, not go head to head and possibly end up with a different outcome

- We don't need to keep doing the same dance if it always end up with treading on each others toes.

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