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Reflective Practice Groups for Leaders

Helping NHS leaders to 'feel well and able to do my job': an interpretive phenomenological analysis of participating in a cognitive analytic reflective practice group

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Abstract:

Objectives

Healthcare leaders are required to manage a complex and emotionally demanding role, which impacts staff and patient care. Reflective practice is understood to aid healthcare workers in managing such roles. In addition, given the highly relational nature of healthcare, it has been suggested that ideas from cognitive analytic therapy have much to offer healthcare staff in terms of making sense of the relational dynamics that affect the experience and ability of healthcare workers to enjoy a positive experience of work and provide high quality patient care.

Design

This study was conducted as a service evaluation to gain understanding of the experience of leaders participating in an existing cognitive analytic reflective practice group.

Methods

Semi-structured video-interviews were conducted with 3 participants of long-term 1-2 monthly reflective group for a leadership team. Transcripts were then analysed using interpretative phenomenological analysis.

Findings

Findings generated four group experiential

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themes: ‘bearing the pressures of leadership’; ‘appreciating a nurturing and developmental space’; ‘needing to feel safe to use the group well’; and ‘accepting the limits of the group’s work in practice’. The study found that this intervention was highly valued by these participants. This included general effects of reflective space, as well as specific benefits of applying the cognitive analytic relational model.

Conclusions
These findings suggest that leadership reflection is an important and valued intervention for leaders. It also supports the growing evidence for the benefit of applying cognitive analytic therapy organisationally to help improve healthcare staff support, in line with NHS workforce commitments.

Key words
interpretative phenomenological analysis, leadership, reflective practice, staff support, cognitive analytic

Public Significance Statement
Healthcare staff, including leaders, have complex, emotionally demanding roles, upon which depend the quality of patient care. This study highlights the benefits and challenges of using a specifically relational model of reflection that allows leaders to better understand and manage the interpersonal demands of their role. It supports research evidence for cognitive analytic therapy to be used beyond direct patient care, to support and develop those who lead healthcare services.

Introduction

Healthcare leaders are instrumental in creating and maintaining high quality, safe, compassionate patient care (West et al., 2015). The act of care involves both kind, supportive help (e.g. ‘caring for’) and also thoughtful, mindful attention (e.g. ‘taking care’). Indeed, values of compassion and responsibility are embedded in the UK’s National Health Service (NHS) constitution (Department of Health & Social Care, 2024). However, the ability to provide such care is challenged by the current NHS system pressures, with insufficient resources to meet increasing needs, operational difficulties and disruptions and challenges to staff and teams trying to maintain workload, relationships and wellbeing (Page et al., 2024). Staff also face particular emotional costs of managing complex and challenging clinical presentations and risks (Anandaciva et al., 2018). Under pressure, care can fail, with serious consequences (Francis, 2013). A common thread in reviews of care failures is problematic organisational culture, which leaders have a key role in understanding and shaping (Mannion & Davies, 2018). And yet, while leaders are increasingly expected to understand and shape compassionate culture, leaders are subject to the same pressures as other staff that inhibit the capacities to be reflective, compassionate and emotionally aware (Marshall, 2021). Failures to provide compassionate, collaborative, thoughtful care can be understood as a response to such overwhelming emotional demands or pressures (Menzies-Lyth, 1960). Akin to a trauma response in individuals, organisations too can respond to interpersonal threats, such as exclusion, exposure or criticism, demonstrated by an impaired capacity to think, fragmentation and withdrawal from others and a lack of flexibility and empathy (Harvey, 2021, 2024). In fact, leaders may be particularly subject to such response, due to their increased responsibility, accountability, often, isolated position, and common cultural belief that failure is shameful (Anandaciva et al., 2018; Harvey, 2024). Therefore, a key question is how to support leaders to gain and/or maintain compassionate, collaborative, reflective care.

One suggestion has been to borrow tools and techniques from cognitive analytic therapy. Cognitive analytic therapy began as a 1:1 therapy, focused on understanding and improving both wellbeing and interpersonal relationships through identifying, understanding and adjusting repeated patterns in how individuals think, feel and behave both towards others and towards themselves (Ryle & Kerr, 2020). Such efforts are known as ‘reformulation’, i.e. a new way of making sense of complex relationships and patterns of emotion and behaviour. Authors such as Walsh and Freshwater (2024) have highlighted that such reformulation may be usefully applied to systems, organisations, and leadership dynamics, as well as individuals. CAT concepts have already been used in clinical teams to aid team formulation and care planning as a way of making sense of relational dynamics between services and service users. Such studies have reported improvements to teams themselves, in terms of increased communication, care for each other and clinical confidence, alongside greater insights into their patients and relationships with patients (Kellet et al., 2014; Kellet et al., 2020; Caruso et al., 2013). In some instances, CAT ideas have been applied to teams themselves. It has been used aa a way of understanding common relational patterns, such as between colleagues or between managers and staff (Shannon et al., 2016; Craven-Staines, 2019).

One of the earliest applications of CAT in an organisational context

was Walsh, who usefully explored the relational dynamics and 'exits' (i.e. alternatives) with a hospital surgical team and managers (1996). More recently, the same author has written about the use of CAT as a 'thinking framework' to understand how individuals and systems fit together, with specific utility in clinical supervision to help staff hold on to their capacity for thinking systematically when overwhelmed or challenged by organisational pressures (Walsh, 2019). Much of the existing evidence is practice-based, reported in grey literature. One paper examined the use of a tool outlining common reciprocal roles experiences by those in a 'helper' role. Questionnaires and focus group of NHS staff working in learning disability teams found the reflective experience predominantly valuable (Staunton, 2015). An additional reflective paper by one psychologist working in an occupational health service highlights parallels between personal and organisational psychology in the common reciprocal roles and coping procedures described by her staff clients, noting that the organisation itself can be both participating in the creation and maintenance of problems, and a partner in changing or resolving them (Appleby, 2003). A more recent published paper similar reports on improvements for staff clients accessing CAT in an employee psychology service, noting that CAT allows the helpful recognition that both staff and managers are drawn into interacting systems and will both experience both 'pain inducing' and 'pain receiving' ends of reciprocal roles (Craven-Staines et al., 2019). In additional work with teams, Craven-Staines (2019) described teams valuing a CAT 'mapping' exercise (also known as 'sequential diagrammatic reformulation'), which visualised the team's maladaptive reciprocal roles and procedures, and likewise allowed recognition of the reciprocity between staff and managers both experiencing pressures. An article and book chapter by Marshall (2014, 2021) describes the experience and challenge of facilitating a CAT-informed reflective practice group for a team following a crisis. It highlighted the value of giving staff a voice and having an opportunity to 'stand back'.

Several authors have suggested that CAT could have similar utility for leaders to look at wider organisational as well as team relational dynamics. This is argued to be that CAT can provide a shared language and framework for understanding relational issues. It is particularly useful given the power of leaders to influence the wider use of such a framework (Marshall, 2021; Harvey, 2024). However, the peer-reviewed evidence base for organisational applications of CAT is scarce, with leadership applications even more so. Thus, in this paper, we present the case for application of CAT ideas to leadership reflective practice and report on the experiences of NHS leaders who participated in a CAT-informed leadership reflective practice group ('Group').

Materials and Methods

Design

The study was conducted as a service evaluation, in collaboration between an English National Health Service (NHS) mental health Trust and a University partner. The project used a qualitative IPA design. IPA was selected as the goal of the project was to understand complex, emotionally-laden experiences of individual participants (Smith et al., 2021). Understanding the experiences of individual participants would then order to inform future development of leadership reflective practice groups within the organisation.

Participants and intervention

Purposive sampling was used. All participants of a leadership reflective practice group ('Group') which ran from 2022 to 2024 were invited to take part. The Group was started in response to a request from a leadership team to have reflective space to explore team relational dynamics, including those that had been problematic. Participants attended a 1-day introduction to CAT concepts prior to the Group sessions. The Group met 1-2 monthly in a mix of face-to-face and online meeting. On average, 3 individuals attended per session. When new members joined a review of 'map' and brief intro to CAT concepts was offered. The Group ended following a changeover in staff and difficulty for the leadership team and facilitator to attend a recap / teaching session. Taking into account leadership staff turnover and periods of leave, 7 individuals attended the Group over time, representing clinical and operational leaders from psychiatry, psychology and nursing professional backgrounds. Participant characteristics (e.g. professional background, length of time in the role, length of time in the Group) are not detailed to preserve anonymity of participants.

Procedure

Six out of seven attendees were contactable at the time of the service evaluation and were invited to participate via an email communication

from the lead researcher, using contact details gathered from the Group's facilitator. Three agreed and were given written information and consent forms to complete. Participants took part in individual 50-60 minute online interviews, using Microsoft Teams software. Semi-structured interview guide questions were developed through discussion within the research team and in consultation with a senior CAT practitioner. Questions were designed to elicit participants' retrospective views on their experiences of the Group, helpful and unhelpful aspects, and any perceived changes in understanding and/or other impacts of the Group on individuals or teams.

Analysis

Interview data was video-recorded and a draft transcription automatically generated within videoconferencing software. The transcription was reviewed and revised to ensure accuracy and completeness, and identifying details of individuals and teams were redacted. Video recordings were then deleted, with the final anonymised transcripts analysed. Analysis was via interpretative phenomenological analysis. This qualitative approach focuses on both phenomenology, i.e. individuals' lived experiences of the subject in question, and interpretation, i.e how both participant(s) and then the researcher(s) make sense of the experiences described. Analysis followed the steps outlined by Smith et al. (2021), acknowledging that the steps involved repetition, revision and back and forth between steps and between single and whole perspectives, as themes were tested and revised.

- Step 1 – Familiarisation – data was repeatedly listened to and read in the process of transcription.

- Step 2 – Noting – concurrent with and continuing beyond Step 1, items of interest were noted on beside the transcript, focusing on described feelings, attitudes, and perceived impacts.

- Step 3 – Experiential statements – in turn, each noted transcript was systemically read through and units of data summarised, aiming to concisely capture participant specific experiences and attitudes.

- Step 4 – Making connections – considering each participant's transcript one at a time, statements were collated into related clusters, which were then triangulated in discussion with the research colleague external to the organisation.

- Step 5 – Naming and tabling individual themes – for each participant, these were then revised, charted in a table.

- Step 6 – Developing group experiential themes – individuals' themes were then considered as a group, to generate overarching themes, retaining divergent experiences. Themes were then reported in writing.

Findings

This analysis generated four group experiential themes regarding the experience of being in a CAT-informed leadership reflective practice group: 'bearing the pressures of leadership', 'appreciating a nurturing, developmental space'; 'needing to feel safe'; and 'accepting the limits of the Group in practice'.

Bearing the pressures of leadership

This theme represented the participants' awareness of the challenges involved in their leadership roles, formed the context of their attendance of the Group.

Feeling responsible but not empowered

Participants were mindful of the multiple, sometimes conflicting, roles and responsibilities they held as 'mini leaders'. This included caring for team members, patients and the service itself while holding responsibility for decision-making and ensuring good quality, safe service provision. At the same time, participants described working under operational pressures and near-continual upheaval, often without the autonomy or resources to effect desired change. Power was seen as residing in the organisation's more senior leaders who were variably seen as judgemental, supportive, or absent, leaving participants to 'get on with it'.

> 'It's almost like we have all this pressure and responsibility placed on us but actually we're quite powerless to do much about some of the challenges that arise.' (P1)

> 'It was demands and expectations from below and from above, which altered during the time we, had altered the whole time we existed, are still altering. You just, you just get used to being built on, I don't know, tidal sands.' (P2)

> 'It wasn't like we could just do something, and it would make it all better, and so people. . . people felt like we didn't care.' (P3)

Feeling the emotional fallout of managing trauma and risk

Participants all spoke about the enduring emotional impact of working with trauma and risk, which held specific challenges. Firstly, participants felt leadership responsibility and blame, particularly in instances where service users had experienced harm. Secondly, their position as authority figures made it difficult to express their own emotional needs and access the same support resources available to non-leadership staff members. Thirdly, there was a recognition that the leadership team themselves and their wider staff team were disconnected and fractured, so not able to 'come together for support'.

> 'Our team dynamics in the leadership set were really problematic and dysfunctional… the communication within the leadership team broke down quite significantly ….and it caused real friction between individual leadership members.' (P1)

> 'I didn't want to unsettle people, I also didn't want to cause ripples, because how does it look if I'm starting crying or if I start saying 'I hate this', you know, 'I can't cope anymore', you know, you feel like you've got to keep it together for people.' (P3)

> 'At the point the pandemic hit, we were [a relatively new service], we didn't yet have a business as usual, we haven't settled into that, then we all get, we're dispersed anyway, so team spirit, closeness, connection, all those things were a challenge.' (P2)

Appreciating a nurturing, developmental space

This theme represented the ways in which the Group was valued by the participants. Participants each focused in on different aspects, though these were echoed in others' accounts.

Relief at being heard, validated, supported

Participants all spoke about the vital nature of the Group during an emotionally and operationally difficult work period. Participants described the Group as supporting them to stay in work and keep on engaging in trying to support and improve things for others.

> 'I'm not sure I could have stayed, actually, without this.' (P2)

> 'When I look back now, I think it was just a really positive experience and certainly helped me at work feel well and sort of able to do my job. Otherwise, it would have made me just withdraw. . . because there was just so much chaos. . . I think I would've just thought, it's just too overwhelming.' (P3)

One participant spoke in particular about the importance of having their views and experiences seen, heard and validated by the facilitator and, literally, put 'on the map'.

> 'I think it was a sort of a safer way to have difficult conversations and sort of depersonalised it as well, but also, for me personally, allowed me to acknowledge some difficult emotions that I had in response to what was happening.' (P3)

Another participant focused on the relief of being able to discuss and understand each others' experiences with compassion and not blame.

> 'I had some level of awareness then that I had, that I'm not always easy, and, yeah, so what if people say things and it doesn't work and the team is completely broken. . . you know, I wasn't personally in the best place at that point, but overall, it just, it, it just, it was such a relief, the map made so much sense [and] didn't feel personal because the dynamic has several parts.' (P2)

Another participant particularly valued the opportunity to step out of the emotional pushes and pulls of the work, to be able to think, reflect and so be bolstered to withstand these dynamics when they arose.

> 'There was a real sense of all of these problems coming to me and me not being, actively not being in a position to be able to do anything about them other than just contain and then kind of hold. . . It gave me that kind of reflective space to think about, actually, 'What's mine? What's the system's? How's the system pulling me into this? How can I step out of that for a second'? So that was really helpful, particularly at that point.' (P1) Participants noted the value in having a specific leadership Group, where their needs could be met, rather than being on duty as leadership figures in other meeting spaces.

Participants noted the value in having a specific leadership Group where their needs could be met, rather than being on duty as leadership figures in other meeting spaces.

> '[In other reflective spaces] I was always conflicted about whether I should be there, 'cause it felt like a space where people needed to be able to say anything, but equally, you're sometimes sat there and thinking, well, as a member of the leadership, I can't ignore you've just said that.' (P2)

> 'We met weekly [in leadership meetings but] it was like, 'oh, there's this crisis happening, what are we going to practically do about this' or, you know, 'there's this staffing issue'. It wasn't like, 'how do you feel, and also how do you frame how you feel, and how you move forward from it', you know, it wasn't therapeutic, it was like task-focused fire-fighting every week.' (P3)

Appreciating the opportunity to learn, understand, connect

Participants spoke positively about what they had learned about relational dynamics, demonstrating use of CAT terminology and sharing examples of using some CAT techniques in and out of sessions. Participants spoke about the value of being able to see (literally, through mapping) and being able to make sense of difficulties in a way that recognised the interplay of personal, interpersonal and systematic responsibilities and vulnerabilities and strengths that influenced the team's patterns of relating.

> 'It answered, really quite quickly, it answered a whole heap of different, like 'what the hell's gone wrong there', you know. . . we're all, we're all just falling into these same dynamic patterns, and it just made so much sense. And that was a massive relief.' (P2)

Participants felt they had built better communication and stronger connections with the other team leaders. This was due to developing shared understanding, shared language, shared practice in safely talking about issues when they arose 'live' in the room, and simply sharing face-to-face time with colleagues, getting to know them personally.

> 'Many times it's been the only space that we've had to come together without a task, so just being with my colleagues and in a space where the expectation is different has real value.' (P1)

The experiential nature of the Group was highlighted by one participant as building empathy and compassion, which had improved their professional relationships.

> 'I'm a better practitioner because of it, in what I do in my day job. There's some, something really powerful in that experiential learning and having it all drawn out for you and thinking actually it's not just, it's not just the sort of people who get mental health, but because we all have some bias somewhere. . . I could have gone to a lecture about CAT therapy and it would have made sense, but it wouldn't, would not have been the same as realising that I could be 'CAT-ed onto a map.' (P2)

Needing to feel safe

Throughout participant accounts there was a strong theme relating to feeling safe/unsafe, comprising two sub-themes.

Dealing with anxieties and fears stirred up by the Group

Participants all spoke about anxieties and fears they experienced and/or perceived in others, particularly at the start of the Group. None of the participants were very familiar with using the CAT model beforehand, so that the Group required a 'leap of faith' that engaging in the process would be safe and worthwhile – especially, as noted by one participant, given that the exploratory, unstructured nature of the reflective practice was in sharp contrast to the leadership set's usual highly structured, task-oriented management meetings.

> 'I was like, oh, great, we're gonna do something exciting, it's gonna be great, learn a little bit of CAT. . . that's right up my street, but I, I was really aware of the feelings of my other colleagues that were very, very anxious about being vulnerable.' (P1)

One participant evocatively described the prospect of opening up talk about the team's problems as dangerous, exposing, perhaps even lethal. Another participant described their concern about the 'fragility' of individuals and of the service.

> 'I knew it was necessary, but I was scared of what it would show and that the cure might kill the patient. . . I stopped feeling anxious fairly quickly [that] it would destroy us completely quite quickly [but] I was still quite nervous when we came to do the actual CAT mapping because I knew there was some difficult, yeah, I knew I'd have to think about my part in the dynamic.' (P2)

Participants described tolerating their anxieties by recognising the necessity of the intervention – one compared it to alcoholism, with the hardest bit being 'admitting you have a problem'. All noted that some

attendees struggled in the Group and generally at that difficult time, noting that numerous leadership members took sick leave or left the service. Participants felt capacity to deal with anxieties varied depending on personal history, current state, and professional background.

> 'To reflect openly on, on a dynamic that's live in the room [is less common in some professions than others] and that then intersects with how you are in that moment and your personal well-being and how much you feel like you can tolerate.' (P1)

Needing the Group to be made safe enough

Participants highlighted the role of the facilitator as key in creating enough psychological safety to participate in reflective exploration. Participants' descriptions of the facilitator highlighted their skill/expertise, as well as their important position as an external authority. They were described as kind and non-judgemental, facilitating issues to be raised without individuals 'being scapegoated for raising them'.

> 'I don't think we could have done this ourselves, 'cause I don't think any of us, erm, were brave enough to open the conversation ourselves. . . if [any one of us] tried to open those conversations, I think it would have been excruciating, and sometimes you need a neutral, you need a neutral person so you can say what you need to say without it feeling, yeah, you need somebody else to hold the safety in the space for you.' (P2)

> 'We're all like living and breathing work together and there's a lot of intense emotions, so we all, we can all get caught up in things and not realise, and so it's just helpful to have a different viewpoint or person there that can help us think, 'what does it look like somebody else here?' '(P3)

> 'Whenever I see a CAT practitioner working in that way, it feels like magic because it feels like there's all these words coming at them, and they find the perfect word, just the key. . . that can just strip away all of this, all of the kerfuffle of team stuff. . . but you have to have an ear to that and also be feeling it.' (P1)

Participants described aspects of the CAT model that facilitated safety, such as its emphasis on patterns and reciprocal behaviours rather than single individuals or events. This made the Group less judgemental – even if not completely free of judgement.

> 'It was a function of team pattern as opposed to it being 'that person's being difficult' . . . so it really brought us together and created a sense of this is what's happening and we're part of it, but it's not us.' (P1)

Perceptions of how safe the Group was varied between participants. For one participant, it was intially scary to open up oneself to difficult personal conversations, such as hearing about own's own difficult behaviour, but this become really powerful and worthwhile learning experience, beyond what could be gained from 'listening to a lecture'. On the other hand, such conversations reflecting on past behaviour represented for one participant some avoidance of the Group's primary task of exploring live dynamics as they happened between participants within sessions. They felt this happened because the Group did not (yet) feel safe enough for the latter, noting the nuance required by the facilitator to attune to the needs and capacity of the Group.

> 'Some things that are on the map. . . I understand how they may have impacted people in the past, but in terms of what was happening in the here and now, they just didn't connect with me. . . like talking to something that happened in the past that created some context, but almost as like in a way to avoid some of the more difficult stuff from the here and now.' (P1)

Accepting the limits of the Group in practice

This theme captured both disappointments and realistic understanding about the limitations of what had been achieved in the Group.

Frustrations at the impact of staff turnover

Participants all described widespread staff absence and turnover as a key factor in the story of the Group. Participants agreed that a lot of positive changes had taken place in the team's work and relationships, but the staffing changes made it difficult to parse what effect the Group itself had. Buy-in was weaker for newer members who missed the starting orientation and mapping days and were not so closely connected to the dynamics on the map, such that eventually there became no point in 'limping on' and the Group came to an end.

> 'it's hard to do that when you've got, like, rolling team members all the time.' (P1)

There was a sense across participants of a divide between 'older'

and 'newer' leaders, with the sense either that older members were guarding against the reappearance of dangerous dynamics to which newer members couldn't or wouldn't see, or that older members were stuck talking over past problems without their map evolving sufficiently to represent and engage newer members.

> 'They didn't really know some of the history as to why it was important, they didn't feel it like we did.' (P3)

> 'We feel like we really need to guard against [historic patterns recurring but] they don't see it as a problem, and we've never managed to find a way of, erm, helping them see the full value.' (P2)

Participants noted disappointments that wishes to share their learning (the map) and/or the experience of CAT-informed reflective practice had not come to pass, e.g. with their non-leadership colleagues, senior leaders, or other leadership teams. There was an overall sense of seeking to share and be understood by others, but feeling 'left to get on with it ourselves'.

> 'I think [having the wider team do CAT mapping too] would have helped them understand us as well as us understand them. . . (pause) and that sense that we were, trying to make a difference.' (P2)

> 'You were kind of left to sort it out and nobody really wants to know what's happened and if it, if it's actually changed what's happening in the team.' (P3)

Accepting the limits of individual and service capacity and impact

All participants recognised that there had been logistical difficulties in maintaining the Group due to the nature of the clinical service (e.g. needing to respond to risk), as well as leaders' and the facilitator's limited availability, and practical challenges in securing a suitable space to gather together for a team that was spread out geographically (and for some of the time operating with COVID restrictions). These constraints were all accepted as part and parcel of NHS working. However, the end of the group was still viewed as a loss.

> 'When we when we get together, it's helpful, but we've had limited times that are workable, always at the jeopardy of clinical urgency . . . when you're under pressure, the first thing that goes is your supervision, it's the thing you most need.' (P2)

Participants also linked the Group end with underlying ambivalence towards the process, acknowledging that reflective practice could be effortful and challenging, especially as some people were more 'psychologically minded' and others were more 'doers, just getting on'.

> 'I think the busyness of working with people's priorities and also the capacity to commit [got in the way]. . . but, in a way, maybe [also] people not quite understanding what it was about, I think sometimes people wanted to pretend everything's OK.' (P3)

> '[To feel] safe enough to discuss it with people, with each other when we're in those moments, say for example, 'I'm feeling like you're being a bit critical' or 'I'm feeling like I'm being criticised' . . . that takes a lot of like practice and confidence and safety and insight and all of those different things to do, and when that's, when your running around like a crazy person trying to manage people and manage risk and write clinical notes and all that stuff, so yeah, I just don't know that we had the space psychologically and practically to kind of really embed that.' (P1)

All participants reflected on the importance of individual mental health, both as a prerequisite for engaging in self-reflective practice and as a factor in the improvements seen in the team.

> 'Change occurred because of the change in team members and a change in team members' personal wellbeing. . . individually, people had their own resources restored and were able to not be pulled into some of the more difficult roles that they would have been before, because they were operating from a more 'healthy island'.' (P1)

> 'One of the things that has come out of it is that we've had a real focus on sort of well-being development and conversations about well-being and connectedness and how important these things are.' (P2)

Participants noted too that change processes take time and effort, and that even though finding 'exits' (alternatives) had been harder than identifying the problems, even just being able to see and understand issues had been really important.

> 'We could name it, but we weren't very good at working out how to do it differently, that's taken a long time, and I'm not sure we'd have ever done that if we hadn't had the ongoing [reflective practice group], so those of us who were there at the time massively valued it and would ideally still like it to be going on.' (P2)

While the wider benefits to the team were uncertain, participants themselves all found the experience of the CAT reflective practice group to have benefited them personally, in terms of self-understanding and mental wellbeing, and professionally, in terms of their ability to communicate and repair/build relationships, empathise and view issues with a systematic, relational perspective.

> 'We changed in how we understood what the problems were and how we related to each other. . . whether that changed the wider team, I don't know, it certainly changed how I felt.' (P3)

Discussion

The aim of this evaluation was to learn about the phenomenological experiences of taking part in a CAT-informed reflective practice group, in order to inform the development of future similar activities. Key questions were if, and in what way, participants experienced and valued the group and whether the group helped participants feel better able to understand and manage the relational and emotional experiences of work. Participants did report valuing that Group as a supportive and learning space, which helped them to bear the pressures of leadership. Participants were mindful of the need to feel safe in order to use the Group well and were accepting of the limitations involved in running the Group in a changing NHS service context.

There is little existing literature in this area. However, the broadly positive experience of participants reflects a recent grounded theory analysis of CAT-informed staff reflective practice groups (Priddy et al., 2024). It aligns more broadly with the value for leaders of peer reflective practice groups (DaniÎls et al., 2020) and relational leadership development interventions (Park et al., 2023). Findings also support CAT literature recommending CAT's utility for leadership (Marshall et al., 2021; Harvey et al., 2024).

The first theme captured the context in which leaders were accessing the Group. Participants' experiences of high responsibility, low power and multiple demands reflects the critical operational and financial pressures that NHS currently faces (Darzi et al., 2024). This includes the specific pressures on healthcare leaders as responsible for 'delivering the impossible' (Anandaciva et al., 2018). NHS leaders often juggle multiple roles, including managerial and clinical duties, as well as competing responsibilities to take care of staff wellbeing while also ensuring that staff performance is up to standard (Marshall, 2021; Kline, 2019). In CAT terms, this requires balancing between pacifying/care-giving and controlling, reflecting an interpretation of leaders' experiences as parental, perhaps unsurprising in a care-giving organisation (Marshall, 2021). Furthermore, participants' experiences of lacking power and perceiving senior leadership as absent or neglectful, reflects a sense that the NHS not being a 'good enough' mother and that staff are 'not being taken care of'. In addition, mental healthcare work is understood to risk negative secondary effects on staff from working with people who have significant trauma (Collins & Long, 2003). Leaders may also feel less able to seek emotional support due to their need to maintain an appearance of authority and capability (Appleby, 2003). Moreover, if and when things go wrong, leaders are more likely to face, or fear facing, being blamed (Marshall, 2021). Participants' accounts of their team being disconnected and isolated in part reflects the realities of service provision during the COVID pandemic but also reflects Ryle's (1997) multiple self states model of trauma response, applied to organisations (Harvey 2021, 2024). In this, an organisation may respond similarly to an individual following trauma, for example through avoiding emotion, responding rigidly, relating to others with mistrust, blame, control and neglect.

The second theme captured the two-fold nurturing and development value that participants had for the CAT reflective practice group, enabling them to better deal with work pressures. This aligns with the idea of a reflective practice groups as an emotionally containing space (Thorndy-craft & McCabe, 2008). In analytic terms, the Group may provide a 'corrective emotional experience' (Hartman & Zimberoff, 2004). In this, experiences were validated and re-formulated, self-understanding, self-compassion and self-reflection developed, and thus ego strengthened to better withstand work pressures. In CAT terms, the participants take in their experience of being compassionately cared for and the experience of compassionately caring, giving them practice in offering this to others. In addition, McVey & Jones's (2012) study of reflective practice groups for staff in cancer services highlights the value of being able to talk about stressful and emotional subjects with peers, as does a national evaluation of reflective 'Schwartz Rounds' spaces for healthcare staff (Flanagan et al., 2019). Yiu et al. (2025) similarly assess staff reflective practice groups in inpatient mental health services, finding multiple benefits among which is being able to reflect with some distance from their emotions. In addition, the sense of leaders learning and developing their understanding of relationships, ability to communicate and thus ability to build better relationships is reflective of much of the literature on using CAT thinking with teams, with studies reporting better team

cohesion, shared language and better communication (Thompson et al., 2008; Kellet et al., 2014; Caruso, 2013).

The third theme focuses on participants need for safety. Menzies-Lyth's (1960) classic studies explore the unseen ways in which organisations manage the anxieties stirred up by working with people who are sick, suffering or in pain, by avoiding emotional engagement, such as through focusing on tasks. This is echoed in participants' accounts of the team, other spaces being structured, task orientated, and the unstructured reflective Group thus generating a lot of anxiety for people at the start. Psychological safety is a prerequisite for reflective spaces, requiring a shared belief that taking risks and trying something new and unknown is safe, that potential failures and mistakes will not expose individuals to shame or ostracisation (DaniÎls et al., 2020). Facilitation is key. Craven-Staines & Finch (2024) theorise about the importance of facilitator competence and confidence. They discuss the value of CAT in bringing unspoken ways of relating and behaving into the open in a way that does not blame individuals because it allows visibility of all the intersecting factors that contribute to problematic patterns. This capability of the CAT model to create safety echoes the accounts of participants. A significant factor in these participants' experience was the degree of staff absence and turnover during the course of the Group. This aligns with the experiences of healthcare leaders in the NHS (Anandaciva et al., 2018). A thematic analysis of nurse reflective groups in inpatient mental health settings noted that turnover of attendees in an open group likely limited the depth of reflective exploration that could take place and that it was vital to secure protected space for reflection (Thomas & Isobel, 2019). Similarly, it is likely that the Group's progress was slowed because of the continual changes in membership.

Finally, participants also noted the importance of personal mental health and self-reflective capacity in order to engage with the Group, recognising that this varied between and within participants over time. It is not clear if this these constitute prerequisites or outcomes of the Group, or both. It is notable that previous studies have highlighted the accessibility of CAT to staff across professional backgrounds (Jones & Annesley, 2019). Yet, for these participants there was a sense that newer members didn't have the same level of engagement and buy-in.

Limitations

IPA is idiographic by nature, providing an in-depth analysis of the phenomenological experiences of a small homogenous sample (Smith et al., 2021). Still, the sample of 3 represents participants that were relatively engaged in the Group and were motivated and able to be interviewed. Their accounts refer to perceptions of differing experiences across the leadership team, which may or may not have been fully captured.

IPA's qualitative approach is not concerned with issues of reliability and bias, instead recognising that the orientation and interpretation of the researcher(s) will influence the themes that they generate. However, to support rigorous analysis, the project design included regular research supervision and triangulation of findings with the third author who was an experienced qualitative researcher and external to the organisation. Still, the positionality of the lead researcher as relatively new to IPA and a relatively junior employee of the same organisation as the participants may have affected what participants shared as well as the interpretive depth of the analysis.

The data collection and analysis were designed to maximise participant safety and avoid identification of participants by those within the organisation. However, this required not reporting demographic and biographical characteristics of the participants, which removes an otherwise useful contextual layer of these individual's accounts.

Given that the leadership-focused applications of CAT and reflective practice literature in general are relatively scarce, and that the experiences of the participants reported here are largely very positive, further implementation and assessment of this kind of intervention is warranted. Furthermore, given the ubiquity but lack of clear definition about what constitutes reflective practice, future studies may benefit from more detailed investigation the nature and benefits of a CAT model reflective practice group beyond other theoretical approaches (Kurtz, 2020). A longitudinal design with a larger sample may also be useful. Further implementation of such reflective practice groups should: advocate for the importance of protecting reflective space; create and review psychological safety at the start and with each/any change in membership; raise and explore how ruptures (e.g. absence) may reflect dynamics being played out; and be mindful of the position and power of the facilitator as a skilled, informed but external model of 'good enough' authority and care.

Conclusions

CAT reflective practice groups may offer a valuable resource that is particularly needed and beneficial for leaders. Firstly, as an emotional support for a cohort who may be less likely or able to access other existing

resources, bolstering leaders' ability to withstand the pressures and meet the requirements of their role. Secondly, as a professional development opportunity to build interpersonal and reflective skills that are vital for contemporary leadership, helping leaders to create and spread compassionate, reflective culture that is vital for the long-term health and success of the NHS workforce. □

Data availability Statement
Data available on request due to privacy/ethical restrictions.

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