Shared Story Collective Perspective Therapy: A Framework by Ryan Minti

Here is a framework for SSCPT, a novel exercise in treatment of trauma resulting from unsettling and confusing interpersonal experiences. It involves the **telling of a patient's story of a recent argument** or mistreatment which they are struggling to resolve for intent, meaning, or agency. It has the potential to provide a sense of external validation that can be difficult to achieve in individual psychotherapy. It weaves together elements of narrative exposure, social mirror theory, and cognitive reframing into a structured process with measurables. The combination of anonymised storytelling, external feedback from a diverse panel, and structured analysis **offers a fresh perspective** beyond traditional dyadic sessions with a trained professional or experienced family member, or tactful friend. It takes sufferers from **suspecting** that they were wrong/ wronged to **knowing** that they were wrong/ wronged, from an **individual's opinion** to **everyone's opinion**.

Abstract

Patients struggling in the aftermath of an interpersonal situation, whether their actions or 3rd party's were the prime mover, report finding it comforting to share the story, and furthermore find it illuminating to receive insights, assessments and lessons from the story whether these align with the patient's own or not. To hear how others weigh significance, blame, fairness, meaning, next steps, and typical reactions to different degrees is a clarifying process that for some people is prevented from acquiring by a lack of social friends or an ability to speak out about the specific people involved.

Depending on the patient's specific sticking point, sharing their story en masse and being guided to understand that their or the 3rd party's role in the incident was not optimal, mature, nor supported by common sensibility would prove a revolution in healing for some. Similarly it will be restorative of a sense of calm when they are informed that their (re)actions during and feelings about the situation were justified, or indeed that, as they might have suspected, their (re)actions were unjustified. Vindication or indictment, are circumstantially both powerfully healing. SSCPT promises to scale up the sharing of the patient's story and the quantity of feedback on the story by using a panel of lay persons who answer written questions on an anonymised account of the situation. The panel then forms a focus group and further discusses elements of the patient's story as it is presented to the group for freer discussion. A structured report of the findings is assembled and shared with the commissioning therapist for presentation in whole or in part back to their patient.

Benefits to be tracked include reduction in self-blame and anxiety, increase in self-worth, feeling understood, and validation.

Background

The SSCPT framework's emphasis on shared storytelling and group feedback echoes established practices in narrative therapy and related theories:

'Narrative Therapy' pioneered by Michael White and David Epston, invites outsider witnesses or reflecting teams to participate in the therapeutic conversation. In these practices, a person or group in therapy shares their story while a small team of listeners later reflects back what they heard. This reflecting process, sometimes structured as a definitional ceremony, allows clients to hear multiple perspectives on their story in a respectful, non-judgmental format.

Tom Andersen's seminal 'Reflecting Team' approach, for example, was an exciting approach to family therapy; families would listen in as a team of professionals discussed the family's story, offering varying viewpoints and tentative interpretations which the family could evaluate and then eventually respond to. Crucially, this approach allowed families to construct their own meaning and be open to others' through listening to varying perspectives and possibilities rather than imposing a single truth.

Cooley's "Social Mirror" theory, tracing back to his "looking-glass self" stance, posits that our self-awareness and identity are strongly shaped by how others perceive and respond to us. His findings harness a collective audience as a therapeutic mirror, much like SSCPT's panel format, to validate and enrich the patient's narrative. In Charles Whitehead's words, "there cannot be mirrors in the mind without mirrors in society", meaning that one's self-concept and ability to reflect on oneself depends on social mirrors and shared experiential worlds.

Judith Herman noted that recovery from trauma requires reconnection with others and sharing one's story in a safe context, reversing the isolating silence of trauma. In group-based trauma therapies, survivors often report that being witnessed by peers, and hearing victim stories such as in some court cases is deeply healing. As Irvin Yalom's group psychotherapy research emphasizes, the "mutual identification and mirroring provided by the group are potent therapeutic factors" in healing.

Psychologist Peter A. Levine noted that "trauma is not what happens to us, but what we hold inside in the absence of an empathetic witness". In the context of unresolved trauma, this suggests that external validation and witnessing are pivotal for recovery; the survivor needs to see their experience acknowledged through others' eyes to construct a coherent, empowered narrative. This is supported by trauma specialists as well: The group acts as a social mirror, reflecting back to an individual that their feelings are understood and that their reactions are human. This collective mirroring can counteract the self-doubt and shame that many trauma survivors carry.

Klein and Schermer observe that group therapy provides social support, new perspectives with speed and scale thus having an edge over one-on-one therapy. And friends weighing in even impartially. Friends are supposed to be validating and

uncritical, proposing new interpretations of the events without being absolute. But should several friends agree on a culpability, a sensitive patient will see social consensus functioning less as corrective information and more as a coalition of threat, outnumbering, shaming, and erasing. A therapist and a friend cannot easily say how a patient should (not) be feeling/ doing, only what they think they would be feeling/ doing. A commissioned report on an anonymised account is not constrained by the same considerations.

The effect of this kind of structured commentary when done in a safe, moderated setting will be shown to validate personal experiences while also gently confronting distortions or blind spots.. In summary, there is a rich foundation of research and practice supporting the SSCPT hypothesis that collective, external perspective-taking in lieu of sole reliance on a therapist-client dyad and the limits of interventions by the patient's social circle can foster healing, especially for trauma-related narratives.

Method Overview

This is a basic outline of the steps involved.

1. **Goal Setting**: The Therapist and Patient pick multiple KPIs to work on improving.

2. **Story preparation**: The Therapist and Patient collaborate on a written account of what happened ready for presentation to the volunteers and the question designers. It is best practice that the therapist writes this story and the patient checks it for accuracy and coverage but the therapist must stay within the guidelines of this step.

3. **Patient Self-Assessment**: The Patient answers questions about their thoughts and feelings about the situation.

4. **Volunteer Canvassing**: Volunteers are recruited from the general public. Care is taken to account for differences and similarities to the patients such as age, gender, cultural background, sociodemographics, geography.

5. **Volunteer Preparation**: 15-20 volunteers are selected to participate for the specific case. They must be available to attend a live session in person (possibly online) which is overseen by a trained professional.

6. **Question Preparation**: Standard SSCPT and case-specific additional questions are set within the objectival, tonal, and jurisdictional guidelines of the framework.

7. **Initial Questionnaire**: volunteers are presented with the case and answer set questions based on a written form. The reading and question answering of each case might take 10 minutes.

8. **Discussion Group**: After all volunteers have answered all questions for quantitative measurement, they are invited to discuss certain aspects of the case with each other and a trained moderator. This is audio recorded.

9. **Report Writing**: The results are collated and cleaned before presentation back to the commissioning therapist for the therapist to decide what to show to the patient.

10. **Initial Reaction Assessment**: If the results are presented to the client then their initial thoughts are captured.

11. **Post-session self-assessment**: The patient regularly answers the same pre-session questions about their thoughts and feelings about the situation, and additionally the extra question in Overall Satisfaction about the therapy.

1. Goal Setting

The reason why a therapist would commission such a report would be to assist their patient in reduction of:

- Fogginess of the events
- Self-blame
- Outward blame (if warranted)
- Self-pity - incoming unfairness/ unkindness
- Cyclical Rumination
- Depression

And increase:

- Recollection of the events
- Understanding of their own feelings
- Understanding of the causes of the situation - the parts that each actor/event played
- Determination and redirection of emotional energy
- Self image - outgoing fairness/ kindness
- Feeling connected (even to the faceless panel)

Resolution of all things pertaining to the pain of the experience for the patient are being considered as the treatment means different things to different patients. Their troubling may even have multiple events within their situation which can be

separated by questions and KPIs. The study may also be used to crowdsource a way forward in an imminent nerve-inducing situation like a breakup. Here are some guide key performance indicators and how they might be tracked before treatment, after treatment and thenceforth.

KPI	Why it matters	How to measure it	Metric
Emotional Clarity Score	Patient feels more confident in understanding what happened	Likert before/after eg: “I have all the facts”	Strongly/slightly (dis)agree
Causal Clarity Score	Patient feels more confident in understanding why it happened	Likert before/after eg: “I understand the reasons behind my actions” “I understand the reasons behind others’ actions”	Strongly/slightly (dis)agree
Typicality Cognition Score	Patient understands that they were victims to atypical, traumatic sequence of events	Likert before/after eg: “What happened was not normal” “The same events in different circumstances would have lead to a different outcome”	Strongly/slightly (dis)agree
Self-Blame Reduction	Patient reports a reduction in self-criticism	Likert before/after eg: “I was at fault” “I could have done more” “I was the problem”	Strongly/slightly (dis)agree
Outward Blame/ Self Pity Change	Patient reports a change in understanding of how they were wronged	Likert before/after eg: “I was mistreated” “I deserve an apology” “I shouldn’t be expected to heal/grow”	Strongly/slightly (dis)agree
Cognitive Reappraisal Shift	Patient changes how they view their situation (e.g. more/less fair)	Scoring re-telling exercise after feedback	Score out of 7 on: Tonal language Reasons given Emphasis on certain aspects
Mood Change	Patient reports less distress or anxiety	PaNASchedule (before/after) GAD7 (before/after)	0-3 x 7 = 0-21
Perceived Validation Score	Patient reports feeling more heard/seen by others	Likert before/after eg: “I felt understood by friends/ family” “I felt supported by friends/ family”	Strongly/slightly (dis)agree
Re-Exposure Resilience	Patient reports feeling less triggered by revisiting the story	Stress rating when retelling the story before/after	Score out of 7
Therapy Revisitation Rate	Patient finds that they need less therapy after the treatment	Frequency of visits to therapist if typically booked ad hoc before/after	Visits per month

Rumination Reduction	Patient escapes thought spirals and intrusive thoughts	Counting the frequency of mental resurgence	Times per day/week Earliest time in each day before therapy and daily since therapy
Past Right Decision Confidence	Patient reports sureness that they were not unreasonable in their actions	Likert before/after eg: “I made the right decision”	Strongly/slightly (dis)agree
Coverage + Validation Perception*	Patient reports that their story was interpreted acceptably by the volunteers	Likert after eg: “I felt understood by the panel” “I felt supported by the panel”	Strongly/slightly (dis)agree
Results Reference Rate*	Patient is able to recall without prompting the vindicating analysis of the situation	check feedback later when doubt creeps in?	Checks per week
Overall Satisfaction *	Patient values the therapy as an experience	Likert at 0, 1, 4, 8 weeks eg: “The exercise was worthwhile overall”	Strongly/slightly (dis)agree

*after treatment only

2. Story Preparation

In the drafting of a neutral, anonymised narrative of the troubling situation by the patient and their therapist there are some important considerations to be made:

- The account is written in past tense, 3rd person, and the primary character is referred to as ‘The Patient’.
- The patient's thoughts and relevant background may be included. Of the characters only their actions taken and words said are included:
    - Descriptions of intent behind actions are allowed, but only the patient’s intent.
    - Descriptions of feelings are removed.
    - Caveats about forgotten or murky details must be stated.
    - If the background of a character is required then this is provided in the format of how the Patient found out about it e.g. “...the Patient’s second cousin who, the Patient happened to have heard, was a mild acquaintance of The Patient’s Ex Boyfriend".
    - The patient should be reminded that the more accurate the account, the more useful the feedback will be.
- Speculation is kept to a minimum.
- Genders and Names are removed.
- Relationships are important, so instead of PersonA, PersonB, we say the Patient’s Friend, The Patient’s Schoolfriend, The Patient’s Partner, The Patient’s Colleague, The Patient’s Neighbour.
- Places and settings are important.

- Avoidance of leading or dramatic language, interpretation, nor emotional colouring.

Writing in 3rd person helps the patient convey their situation more objectively, and prevents empathy bias in the reader. LLMs may be of assistance.

The therapist might also consider writing a story from the antagonist's perspective, again under the same rules but from the other perspective. Here, many assumptions must be made, depending on what is known about the antagonist's timeline around the events that are under dissection. An example:

Patient's partner of 9 months reported that mutual friend, AK, attended a cabaret show that Patient's Partner is frequently involved in. Partner reported that AK discovered they were not performing and said "Awww you're not dancing tonight..." Partner reported that AK's tone was one of gloating, as if to convey that Partner wasn't good enough to be selected to be on stage. Patient invited Partner to explore that AK was in fact disappointed that Partner was not performing. Patient messaged AK 2 days later:

PATIENT
Something is bugging me. [Partner] said they saw you at [show] and you said "you're not in the show". They took that to mean "you're not good enough to be in the show" but I know you and you obviously didn't mean that right? Just. "Sorry I don't get to see you dance". Why is [Partner] so sensitive? Anyway they are going through a rough patch. Hope you're good. Keep doing what you do"

Patient intended for AK to reply to Patient not Partner but no response. Later that day, Patient is contacted by Partner who says that AK contacted them to apologise. Partner is upset that their concerns about AK's tone at the show were shared. Patient shared the message to AK with Partner. Partner asked why Patient messaged AK. Patient apologised and explained to try to remove the misunderstanding or unveil AK as a mean person if they were indeed being discourteous. Partner expressed that Patient should get therapy and 'grow up'. Partner texted throughout the day:

PARTNER
YOU ENTITLED PRICK. No more talking about me to anyone. Please have mercy and space me.

Patient explained the situation to friends who were sympathetic. Partner texted that night:

PARTNER
You embarrassed me so much. So much. Can't believe people said you did the right thing? This is over.

Partner blocked Patient. Patient messaged AK:

PATIENT

OK Partner is angry. I was just trying to smooth things over here so that she isn't mean to you if you spot her again. And I fucked up. I don't mind that you reached out to her but. She minds that I told you in the first place. I fucked it. : I don't know what we can do to rescue this. I want someone to say "if my partner was upset about something my friend said...then I'd do the same". You're the only one that can save this AK. If you have any sympathy for me at all... I'd really really appreciate it. I'm sorry.

Patient reports understandably feelings of confusion and remorse about their actions intervening in light of what happened and the repercussions. Patient wants Partner to understand that this won't happen again but also that they don't think this is a legitimate reason to dump, nor ignore, nor block. Patient has not attempted to contact Partner since. Patient cannot speculate as to whether AK blocked out of annoyance or embarrassment of the situation.

Also of note: Patient and Partner had just resumed spending time together after a recent argument about an interaction between Partner's performing partner and Patient.
Partner had previously expressed annoyance at Patient trying to sort Partner's career issues in the past.
Words like "This is over" was regularly used by Partner in their on-off relationship.

3. Patient Self-Assessment

In order to track the objectives, at this point the patient is proposed questions about the situation under examination. Taking from the Goal Setting stage then, questions may take the form:

- "I have all the facts of Event1/ Event2"
- "I understand the reasons behind my actions"
- "I understand the reasons behind others' actions"
- "What happened to me was not normal"
- "The same events in different circumstances would have lead to a different outcome"
- "I was unlucky"
- "In the context of their situation, I was mistreated by PersonA/ PersonB"
- "In the context of my situation, I mistreated PersonA/ PersonB"
- "I was at fault in Event1/ Event2"
- "I could have done more to prevent the situation"
- "I deserve an apology from PersonA/ PersonB"
- "I shouldn't be expected to heal/grow"
- "I felt understood by friends/ family"

- “I felt supported by friends/ family”
- GAD7 Questions
- “I made the right decision”
- What my stress level is when I retell the story
- How many times I think about the situation every day
- How many times per month I feel that I need therapy

4. Volunteer Canvassing

Volunteers are found using public posting in forums and existing mailing lists. They must be ok to contribute uninterrupted for up to 2 hours on the discussion day. They must be ok with their demographics being aggregated in the report. Further considerations on the characteristics of the contributors:

- Age - similarly aged people are more likely to see things the same way than people of great age difference. This is an intrinsic property shaped by their internal maturity and the formative nature of an ever changing environment.
- Gender - males and females have different communication styles, expectations of relationships, and societal conditioning that shape their interpretations of events.
- Cultural Background - nurtural conditioning profoundly impacts communication styles, conflict resolution strategies, emotional expression, family dynamics, and perceptions of fairness and responsibility where what is considered "normal" or "justified" in one culture might be seen differently in another.
- SocioDemographics - different life experiences, education level, occupation, comfort, and income shape an individual's values, priorities, and understanding of societal norms and expectations influencing how they interpret interpersonal situations.

Questions are posed to determine nominal emotional functioning pre-participation, ensuring that they will not project unresolved trauma, give careless feedback, or otherwise derail the therapeutic benefit for the client. Looking to assess emotional maturity, regulation, empathy, and self-awareness without interrogation, the standard qualifying questions and acceptable answers are:

1. "How do you typically respond when someone shares something emotional or painful with you?"
    a. Accept keywords around “empathising”, “listening”, “supporting”
    b. Reject keywords around “blaming”, “dismissing”
2. "How did you change your mind after hearing someone else's perspective?"
    a. openness, flexibility, humility.
3. What helps you stay calm or grounded when discussing sensitive topics?"
    a. self-awareness, mindfulness, healthy coping

4. What kind of situations tend to emotionally trigger you, and how do you manage those reactions?"
    a. Honest self-knowledge is more important than perfection.
5. "Describe a conflict between two people that you felt conflicted about—how did you view both sides?"
    a. Look for capacity for nuance, not black-and-white thinking.
6. "If two people disagree about who was hurt in a situation, how do you decide who to believe?"
    a. willingness to sit with ambiguity, avoid quick judgment.
7. "Is it possible for two people to both be 'right' and still be in conflict?" Explain.
    a. Evaluates capacity for complex interpersonal understanding.
8. "What personal values or biases do you think might influence how you read a story?"
    a. Self-awareness of bias is key—not claiming to be "unbiased."

Finally they should be asked "Why do you want to join this panel?" Keywords around empathy, curiosity about people, curiosity about psychology, altruism, and helping others are all valid answers. Further Likert enabled questions can be posed:

1. I can hold space for someone else's pain without needing to fix it.
2. I can see multiple sides to most interpersonal conflicts.
3. I handle emotionally intense situations well.
4. I can name my biggest personal trigger.
5. I can stay respectful and reflective even when I strongly disagree.
6. I tell rather than ask.
7. I insert myself into other's interpersonal problems to help them to heal.
8. I am able to be direct with my take on a situation between 2 friends.
9. I am able to give friends bad news.

This protocol is suitable for digital platforms, group therapy settings, or therapist-administered sessions. Volunteers are strictly unpaid to deter biased undesirables but may be incentivised with recognition, community membership, stimulation by the very content itself (much like a jury), and the reward of understanding their altruism and time sacrifice, much like a magistrate, is helping a real person.

5. Volunteer Preparation

From the volunteer roster, those that have been more useful with the subject matter at hand might be selected to form a diverse panel of 10-20 people. The subject of an argument/ firing/ breakup can be divulged but the specifics are only revealed during the session in the written format. A time and place is arranged for the exercise.

6. Question Preparation

The moderator assembles questions about the situation for the panel. Questions are designed to explore:

- perceived fairness,
- emotional proportionality,
- abnormal behaviour,
- Unfelicitousness,
- responsibility for communicating boundaries/expectations
- agency of the characters in breaching boundaries and considerate behaviour.

Examples:

Purpose 1: Assess accountability for conflict initiation/ escalation.
On Event 1, The Patient was justified in their actions.
Strongly/Slightly (dis)agree

Prior to Event 1, The Patient should have known that their actions would have consequences
Strongly/Slightly (dis)agree

Prior to Event 1, The Patient's Friend communicated boundaries
Strongly/Slightly (dis)agree

Prior to Event 1, The Patient's Partner upheld boundaries reasonably
Strongly/Slightly (dis)agree

Prior to Event 1, The Patient respected their Partner's boundaries
Strongly/Slightly (dis)agree

On Event 2, The Patient's Ex-Partner was justified in their actions.
Strongly/Slightly (dis)agree

Around Event 1, who is acting most reasonably
☐ The Patient
☐ The Patient's Partner
☐ Both/Neither
☐ Cannot determine

Around Event 2, who is acting most reasonably
☐ The Patient
☐ The Patient's Ex-Partner
☐ Both/Neither
☐ Cannot determine

Qualitative question - What specific facts influenced your answer above?

Purpose 2: Assess emotional proportionality/ regulation
On Event 1, The Patient's Friend was justified in their reaction.
Strongly/Slightly (dis)agree

On Event 2, The Patient was justified in their reaction.
Strongly/Slightly (dis)agree

Around Event 1, who is (re)acting more fairly to the situation?
☐ Person A
☐ Person B
☐ Both/ Neither
☐ Cannot Determine

Sub-Questions - How emotionally justified does The Patient seem to you?
[1 = Overblown, 5 = Reasonable]

How emotionally justified does The Patient's Brother seem to you?
[1 = Overblown, 5 = Reasonable]

If you were The Patient, how would you feel?

If you were The Patient's Father how would you feel?

Purpose 3: Assess responsibility for reconciliation/ progress
The Patient has a valid action point to take.
Strongly/Slightly (dis)agree

The next action point is on the Patient.
Strongly/Slightly (dis)agree

The Patient should feel sorry for their actions.
Strongly/Slightly (dis)agree

The Patient's Friend should feel sorry for their actions.
Strongly/Slightly (dis)agree

Which person should take the next step toward resolving the issue?
Answer Format:
☐ Person A
☐ Person B
☐ Both

☐ Neither – pause is needed
☐ Cannot Determine

What next step would be constructive in this case?

If you were The Patient, (when) would you feel safe or ready to reach out?

Purpose 4: Explore foresight, boundary setting, and communication
Who could have taken clearer steps to prevent the conflict?
Answer Format:
☐ Person A
☐ Person B
☐ Both
☐ Neither – this was likely inevitable
☐ Can't say
Sub-Questions: (short answer)
What specific choices or communication could have changed the outcome?
Did anyone miss a warning sign, or fail to express a need clearly?
What emotional needs might be driving their reactions?

Qualitative Questions for focus group discussion
What unmet needs are present?

If you could say one sentence to each person that might help them grow or understand the situation better, what would it be?" What advice would you give either party?

What relationship does the story describe?
Strangers
Weak Acquaintances
Colleagues
Friends
Lovers
Primary Partner
Cousins/Siblings
Parents/Children

How many of you said that PersonB was being over-reactive? Why?

What moral does the story convey?
Angst, Conflict, Misfortune, Corruption, Malice,

7. Initial Questionnaire

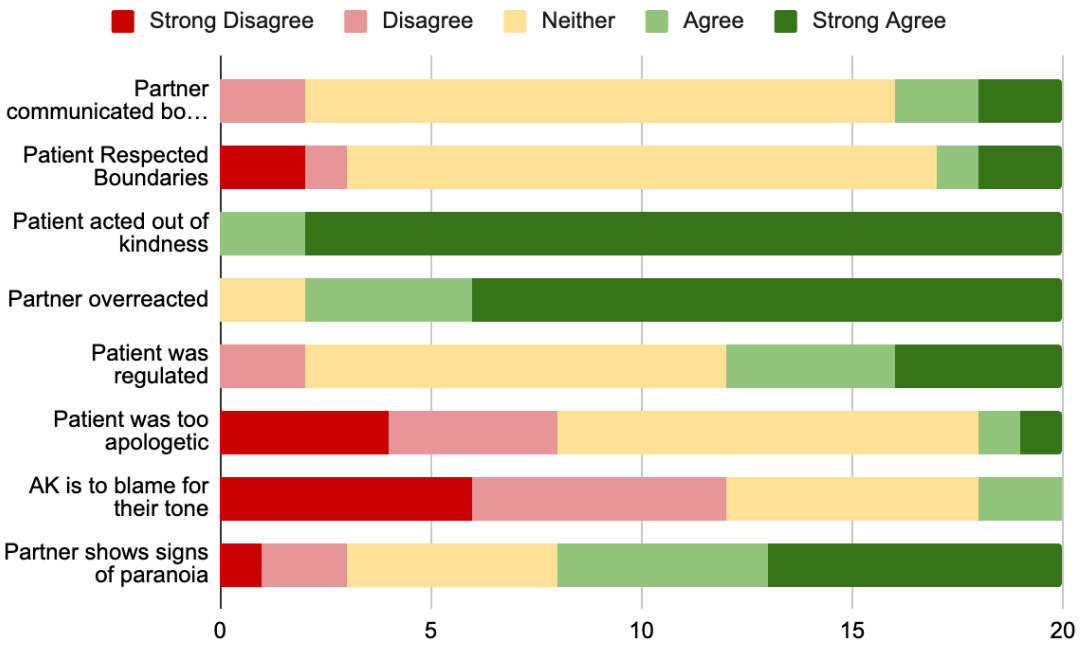
As the session begins, volunteers are given 10 minutes to read and answer these questions.

8. Discussion Group

As the session continues, volunteers are given 15 minutes in a group session to workshop the matter and answer questions from the Facilitator. The Facilitator moderates a guided discussion for focus, safety, and clarity. They promote balance, exploration of ambiguity, and noteworthy reasons behind answers.

9. Report Writing

The facilitators take the audio recording and the survey responses and assemble them into a multi page report for handing back to the commissioning therapist. LLMs may be of assistance. The raw data is not typically for the patient but the therapist is able to access it and review it for additional quotes and as proof that the session took place and was compiled into a report accurately and effectively. Here are some fabricated demonstration results based around the example given above:



Attachment style speculation: 4 panel members openly proposed that the Patient's Partner suffers from a fearful-avoidant attachment style based on how Partner failed to communicate the Patient (other PMs were not familiar with the theory); these members wondered if the Partner's distancing behavior was rooted in personal fear rather than lack of love.

Interpretations of explosive relationship decision making: 4 PMs discussed the timing and magnitude of the Patient's Partner's decision about pulling away being over-reactive depending on the nature of the 3-way relationship. 20 panel members found that, on the information given, Partner did not treat Patient fairly in pulling away.

Interpretations of silence: 5 PMs interpreted AK's silence during the situation as a form of indirect cruelty or passive aggression against Patient. From their perspective, AK's inability to speak up in the moment was seen as a deliberate choice that added to the Patient's hurt (e.g. "silence can be as cutting as words"). However, 3 other members offered a different view – they felt AK might have been too scared to to interfere or was unsure what to say, suggesting the silence could have been an awkward attempt to respect boundaries rather than an intentionally cruel act. BPD was discussed as an area of investigative interest for Partner.

Empathy for the Patient's feelings: About 6 PMs expressed strong empathy with the Patient's sense of betrayal. They commented that the lack of support from the Partner was profoundly hurtful, validating that the Patient's reaction (feeling angry and abandoned) was justified. Some in this group used phrases like "emotional betrayal" and noted that anyone would be upset in the Patient's shoes, reinforcing that the Patient isn't "crazy" for feeling devastated.

Concerns about communication: PMs wondered if Patient should know their Partner well enough to know that they did not welcome help with AK miscommunication or even need to fix it. This was backed by 4 PMs. 4PMs however found that Partner should not have told Patient if they are known to intervene and fix with good intention if that would cause such a response in Partner. They posed the question of whether misunderstandings played a role, indicating a more systemic view: maybe everyone's feelings and expectations weren't fully out in the open, which contributed to the conflict. And only the Patient is still in the forum and willing to straighten things out which shows a higher emotional intelligence.

What the Panel would have done: 10 would have messaged AK if in Patient's position. 2 would not have or would have asked Partner if they wanted someone to speak to AK. 3 would have used different wording in the messages or asked AK not to reply to Partner first.

What the Panel would do now: 8 PMs are sure that Partner will reappear. 5 PMs are sure that AK will re-appear. 5 PMs think that if Partner does not reappear they will be open for an apologetic approach within 2 weeks.

Quotes from panel:

"As I hear the story, I just want to say I empathise. The patient deserves acknowledgement for how they've been affected."

"I noticed that the Partner's reaction – shutting down and pulling away during the conflict – might come from fear. It reminds me of a fearful-avoidant attachment style, where a person nurtures grievances into conflicts and withdraws emotionally."

"From an outside view, I actually wonder if there's another side to AK's silence. Sometimes silence isn't malicious but just clumsy. I feel it's important we also gently challenge that interpretation so you don't carry extra resentment unnecessarily."

10. Initial Reaction Assessment

In the readback of the report to the patient lies a crucial ethical and clinical design feature; not all truth is helpful all at once. The patient's commissioning therapist has the final say on whether to share the full report, or partial insights based on the need of the patient and the preselected KPIs. Feedback is tailored to support the patient's emotional readiness and therapeutic goals. Some guidelines:

KPI	Helpful to Share	Unhelpful to Share
Self-Blame/ Guilt Reduction	Majority consensus that the patient acted fairly or understandably.	Harsh volunteer language or feedback implying the patient is fully at fault.
Emotional Clarity	Balanced interpretations that explore both sides with empathy.	Highly polarised opinions or contradicting statements that confuse rather than clarify.
Validation/ Worthiness	Supportive quotes affirming the patient's needs, hurt, or confusion.	Cold or dismissive comments ("they're being dramatic").
Rumination Reduction	Feedback indicating the situation was understandable, inevitable, or already handled.	Feedback that reopens the wound with new "what if" paths or moral judgments.
Action Confidence	Comments encouraging autonomy or gentle accountability.	Feedback pushing a pressured decision or "shoulds" (e.g., "They need to fix this now").
Anxiety / Hypervigilance	Responses normalizing the patient's emotional response.	Feedback that implies paranoia, exaggeration, or overreaction.
Boundary Rebuilding	Reflections that highlight healthy boundaries and unmet needs.	Comments advocating passivity, appeasement, or self-sacrifice.

Evaluate the Emotional Readiness of the Patient. The commissioning therapist should categorise the patient's current state and tailor the intensity of the feedback, potentially spreading it over multiple future sessions. Apply a "Therapeutic Utility" filter. Before including each section or quote, ask:

- “Will this help the patient grow or stabilize right now?”
- “Is this insight already known, or is it too destabilizing to introduce now?”
- “Can this point be paraphrased in a gentler, guided way during a live session instead?”

If in doubt, reframe or withhold and plan a phased reveal.

Mental State	Feedback Sentiment Allowed
Fragile	Only affirming, neutral, or softly constructive content. No ambiguity or critical takes.
Processing	Share mild-to-moderate disagreements, light nuance, and soft emotional challenge.
Integrated	Full report allowed, including polarizing or critical reflections for cognitive growth.

More suggestions on the intensity of the readback:

Patient Journey	Aspects of Report to Share
Fragile or early-stage	Summary Only
Mid-level processing	Paraphrased Insights
Integrated	Redacted Report
Robust, growth-stage	Unfiltered Report + Session Debrief

11. Post Session Self-Assessment

In order to track the objectives, at this point the patient is proposed questions about the situation under examination. Taking from the Goal Setting stage then, questions may take the form:

- “I have all the facts of Event1/ Event2”
- “I understand the reasons behind my actions”
- “I understand the reasons behind others’ actions”
- “What happened to me was not normal”
- “The same events in different circumstances would have lead to a different outcome”
- “I was unlucky”
- “In the context of their situation, I was mistreated by PersonA/ PersonB”
- “In the context of my situation, I mistreated PersonA/ PersonB”
- “I was at fault in Event1/ Event2”
- “I could have done more to prevent the situation”

- “I deserve an apology from PersonA/ PersonB”
- “I shouldn’t be expected to heal/grow”
- “I felt understood by friends/ family”
- “I felt supported by friends/ family”
- GAD7 Questions
- PSQ9 Questions
- “I made the right decision”
- What my stress level is when I retell the story
- How many times I think about the situation every day
- How many times per month I feel that I need therapy
- “I felt understood by the panel”
- “I felt supported by the panel”
- How many times per week I consult the report
- “The exercise was worthwhile overall”

Next steps

This framework is at time of publishing is looking for funding that it might be trailed at scale. Help or follow its progress by emailing info@duftonenterprises.com