Effectiveness of Group Cognitive Analytic Therapy (CAT) for Severe Mental Illness

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Abstract

This article describes an approach to running Cognitive Analytic Therapy groups for clients under the care of secondary mental health services. The article will include a presentation of one approach to running these groups as well as the outcome data gathered to date.

Background

Cognitive Analytic Therapy (CAT) is traditionally offered as an individual therapy but increasingly is being offered as a group. Conducting therapy in a group setting creates an opportunity for observing, exploring and reflecting on how we relate to ourselves and others, allowing for recognition of Reciprocal Role (RR) enactments and opening up the possibility of trying out new ways of relating. When CAT is conducted in a group setting there is the added benefit of learning a shared language with a group of others, and the creation of a safe space to give and receive feedback (Stowell-Smith, Gopfort and Mitzman, 2001). The group is able to attend to relationship patterns within the group setting, which are linked to the group RRs and procedures as well as providing an opportunity for a 'good enough' ending. This allows learning from experiences of the group with the tools of CAT offering additional scaffolding.

There is increasing research on the effectiveness of group-based CAT for people with severe and enduring mental illness. CAT groups reported in the literature vary in duration, structure and content. The duration of groups includes 6 week (Mulhall 2015), 10-week (John and Darongkamas, 2009), 12-week (Duignan and Mitzman, 1994; Stowell-Smith, Gopfort and Mitzman, 2001) 16-week (Ruppert et al 2008) and 24 week programmes (Calvert, Kellett and Hagan 2015). Other CAT therapists, including those from a group analytic perspective, have provided open-ended CAT groups (Maple and Simpson, 1995, Hepple and Bowdrey, 2015). The reported sizes of the groups vary between five and eight clients whilst the structure and content of group sessions also differs, with some groups requiring participants to read their individual reformulation letters to the group whilst others create a joint CAT map and reformulation letter. Groups may include some psycho-education on reciprocal roles (RRs) and reciprocal role procedures (RRPs) and include ending letters. There is some debate in the literature as to the usefulness of pre-group individual sessions, and some group formats have included up to four individual sessions prior to starting the group (Maple and Simpson, 1995 ; Ruppert et al., 2008).

Method

Selection and set up of the CAT group

This paper draws on the experience of running 8 groups and on outcome data collected on 5 of these groups run in secondary mental health services within one NHS Trust. Group members all met criteria for secondary mental health services and had severe long term and complex mental health difficulties. Clients were referred to the groups via their care coordinators in the wider Community Mental Health Teams and Acute Mental Health Teams. Each of these groups were facilitated by the first author and co facilitated by a number of different experienced or trainee Cognitive Analytic Therapists or on one occasion a trainee clinical psychologist. For some of the groups a trainee clinical psychologist contributed as a third facilitator and covered absences. This avoided any sessions being cancelled. During the running of the groups, facilitators attended supervision with an accredited CAT supervisor.

Presenting problems varied in the group and included depression, anxiety, borderline personality disorder, stress induced psychosis, trauma related to Childhood Sexual Abuse and Obsessive Compulsive Disorder. During the assessment phase no specific diagnosis was included or excluded however, in line with Maple and Simpson (1995), the importance of group cohesion was acknowledged.

All group members were offered between 1 and 3 individual assessment and formulation sessions, this included creating a simple CAT map with at least one procedure. Fears regarding attending for group therapy were explored and commitment sought for attending the full group programme. At the end of these assessment sessions a CAT informed assessment letter was written to the client. These letters included a description of Target Problems, one or more key RR, a brief summary of history and key Reciprocal Role Procedures (RRP) which had been identified. In addition goals for therapy were explicit and where

possible a prediction was made of potential procedural re-enactments. These were presented tentatively with an acknowledgement that the group would allow further exploration and clarification. Unlike a reformulation letter however the letter was written as a clinical letter, and included information such as risk (as appropriate), was shared with the GP and entered onto the clinical records system.

Content of the group sessions

The groups followed a set structure, and as with individual CAT, followed the stages of reformulation, recognition and revision. Reformulation was achieved in early sessions by the group working together to develop a shared understanding which was summarised in a group map. The initial group sessions had a greater element of psycho-education and were led by the facilitators. Over the course of the group the facilitators increasingly stepped back to allow the group members to converse with one another and assist one another with their recognition and revision. A group map was created gradually using discussion, feedback from homework and exercises such as using an optional picture or family photo to describe reciprocal roles. As each reciprocal role, core pain and subsequent reciprocal role procedure were identified they were written on A4 pieces of paper and placed on the floor. In this way, gradually the group map was created with each group member able to identify themselves on the map. All group members were encouraged to participate in the creation of the map and to get up and move the paper. The map was revised in this way throughout the group and exits were added during the revision stage. A computerised A4 version was created around session 4 or 5 and later updated with identified exits allowing group members to have a copy for use outside of sessions and to take with them beyond the group.

Creative ideas and activities were weaved into the groups and were different for each group depending on dominant RR and RRPs. Video clips and Ted Talks were used to help share information and ideas. In addition to homework activities such as No send letters and compassionate letters to self. The process was attended to throughout the group, including responses to homework tasks or activities and interactions with one another.

At the end of each session a 3-minute mindfulness exercise was led and reflected upon. The aim of this was to aid the development of the observing eye, i.e. the ability to step back and observe allowing them a greater capacity to make change. An ending letter was written for the entire group, which included an individual paragraph for each group member. This described in brief their journey in the group and what they may need to attend to once the group is finished. Group members were invited to write their own goodbye letters to the group. Whilst attention was paid to endings and goodbyes for all groups, some required more time than others to process feelings of grief and loss.

Whilst all the groups followed this set structure they varied in the number of sessions offered, in part in response to what was achievable in terms of running the group without breaks. A 16 week session structure was the ideal length however this was not always possible and one group offered just 11 sessions due to the second facilitator being absent. A minimum two hour session structure fitted best and allowed time for a mindfulness practice and for each group member to have had an opportunity to feed back their experiences over the previous week and / or their homework task. A five minute comfort break was included during the group. Group size also needed to be limited to a maximum of 8 members per group for this to be achievable. All group members were offered a review appointment.

Measures

The assessment measure, Clinical Outcomes in Routine Evaluation (Evans et al., 2000), was given to all clients at the start of the group and at the end of the group. This follows the services routine audit practice. The CORE is a standardized measure which asks participants to respond to 34 questions about how they have been feeling over the past week on a 5 point scale ranging from 'not at all' to 'most or all of the time'. Questions include for example 'I have felt criticised by other people'. The CORE measures participant's levels of distress in comparison with national 'cut off' scores and is separated into four subscales, risk, problems, well-being, and functioning.

Results

Within the 5 groups 35 people were assessed as appropriate to start the group, including 2 males and 33 females (94% females). Of these 35, 5 did not complete, giving a completion rate of 86 percent. Of the 30 who completed the groups, 1 was male and 29 were female. Ages ranged between 22 and 64 years

	Mean	*N*	*St dev*	*St error mean*
Pre	*2.0175*	*28*	*.63055*	*.11916*
post	*1.4243*	*28*	*.76926*	*.14538*

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old, with a mean age of 38. 28 of the group members who completed the groups gave back both a pre and post CORE. Statistical analysis of these measures suggested that scores were significantly improved at the end of the group t=5.004, df = 27, p=.000.

Discussion

Whilst a small data set, the results support previous findings in the literature of the usefulness of Group CAT in providing symptom reduction, as measured by the CORE for people experiencing a range of difficulties. Several limitations of this study are noted, including lack of control comparison group, meaning conclusions are made tentatively. The groups were limited to mainly female members, in part a response to fewer referrals for men, but also being aware of needing to ensure there would not be one male in an otherwise all female group. The data set is also limited by an inconsistent group length being delivered as well as some data missing from those who did not return their post outcome measure.

Drop outs occurred most frequently between assessment and start of group. Overall drop out rate is low when compared to other group programmes run within the service of a comparable length, for example the Dialectical Behaviour Therapy informed 14 week programme has a completion rate of 59% compared to 86% for CAT. There may be a number of explanations for this, but one possibility is that the pre-group individual sessions may enable the development of a therapeutic relationship between therapist and client which can reduce anxiety about initial group sessions until relationships between group participants have been established.

The facilitators require the skills to attend to the group process in order to use the process to inform the progress of the group. It differs from other groups in that the content is set based on the needs of the specific group and also the skills already present in the group. In order to successfully do this, the presence of two active facilitators is needed. The third trainee facilitator also has an important role of observer, and can also take on specific tasks such as leading the mindfulness practice.

The group map, completed at around session 5, gave a sense of containment for the group. The map allowed the development of a short hand way of communicating, and group members were able to help one another name where they might be on the map. In addition, difficult discussions, such as one member consistently being late to the group, were facilitated using the map on the floor, for example by naming the overlooking to overlooked reciprocal role.

Group members qualitative feedback suggested they had a better understanding of themselves following the group and felt they were less likely to respond to situations in unhelpful habitual ways. Some commented in particular on the value they placed on the opportunity to give and receive care within the group and how this had allowed them to build on healthy reciprocal roles of caring to cared for. One group member, struggling with depression, described a reawakening of her feelings of altruism and how this motivated her to arrange voluntary work after the group had finished. The experience of universality that is generated by creating a shared map was also described as important. The map allowed the group members to experience how they are the same as others, rather than a sense of how they are different, as may occur when people receive a diagnosis. We noted a new internal dialogue linked to a reciprocal role we named normalising to normalised. This in turn linked to strong feelings of warmth and compassion towards self and others. Taken together the qualitative feedback and the improvement found in wellbeing, functioning and risk suggest further exploration of CAT delivered as a group is indicated.

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