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Service Evaluation of Cognitive Analytic Therapy for Patients with Complex Medically Unexplained Symptoms Referred to a Liaison Psychiatry Department

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Abstract: This paper describes the introduction of cognitive analytic therapy within a liaison psychiatry service in a general hospital. This therapy modality was offered as an alternative to cognitive behaviour therapy for patients referred with complex medically unexplained symptoms (MUS). A brief introduction to using cognitive analytic therapy in this group of patients is included.

The paper gives information about a sample of patients with complex MUS (n=28)who were treated by trained cognitive analytic therapists. Rates of drop-out, experience of previous therapy and the duration of MUS are detailed.

The outcome measure of the CORE34 was collected before and after completion of therapy. This measure showed a clinically meaningful reduction towards the normal range, from an average of 1.87 per item to an average of 1.09 per item.

The findings suggest that cognitive analytic therapy is an acceptable and effective therapy for treating psychological symptoms in patients with complex MUS.

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Introduction

MEDICALLY unexplained symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory, structural, or other specified, pathology (Guidance JCPMH, 2016). They are a common reason for referral to liaison psychiatry services and form a significant percentage of patients seen in the General Hospital. Studies of hospital outpatients suggest that between 49% and 60% of patients still have no organic explanation for their symptoms despite investigations (Nimnuan et al, 2001). The overall cost to the NHS of treating these patients is estimated to be around £3 billion per year (No Health Without Mental Health, 2011). Symptoms may vary from short term, stress-related symptoms, which are likely to improve with education and reassurance, through to those with moderate difficulties who are still able to function in work and social roles, and to those with severe and complex difficulties. While there is some evidence that brief interventions in primary care (Edwards et al, 2010) and Cognitive Behaviour Therapy (Nezu et al, 2001) can be helpful to those with mild or moderate symptoms, there is little evidence of efficacy for therapy approaches in the more severe end of the spectrum or those who report little benefit from Cognitive Behaviour Therapy.

A recent commissioning guidance issued jointly by the Royal College of Psychiatrists and the Royal College of General Practitioners suggests a multidisciplinary approach for these patients, which should include General Practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy, with an emphasis on education and training of all staff (Guidance JCPMH, 2016).

In the absence of such a comprehensive team approach, we have been offering Cognitive Analytic Therapy as an outpatient treatment for those with complex MUS. Reasons for referral for CAT, rather than CBT, are that the patient has already had CBT, that they express a preference for CAT when both therapies are explained, or where there is a history of early neglect or abuse and the patient is able to acknowledge a possible link between this and their symptoms. Sometimes the first few sessions are carried out while the patient is still in hospital, with a view to engaging the patient before discharge. We report on the outcomes of a group of patients treated in this way.

The Usefulness of Cognitive Analytic Therapy (CAT) in Physical Health Settings

Cognitive Analytic Therapy is a brief, semi-structured integrative therapy which focuses on the relationship patterns that an individual has developed in relation to others and towards themselves. This idea, developed from object relations theory, is that early relationship experiences become the template for how the individual expects relationships to be and how they are likely to treat themselves. So, for example, a child growing up with very critical parents will be learning what it feels like to be criticised and to feel as though he or she is not good enough but is also learning how to be critical. This reciprocal relationship of 'critical to criticised' is likely to become a relationship pattern that they fall into both with others, and with themselves, and is likely to drive their behaviour. CAT therapy involves the therapist and patient exploring collaboratively which relationship patterns the patient tends to fall into and drawing these out in a letter and a visual 'CAT diagram'.

This diagram, or CAT map, becomes a tool for reflection, facilitating recognition of unhelpful patterns and enabling identification of new, healthier ways of relating. In working with physical and medically unexplained symptoms, the symptoms themselves may be able to be linked to certain roles or stressful feelings on the diagram. So, for example, the person who is constantly critical of themselves, and feels not good enough, may put themselves under extreme stress to perform perfectly leading to stress-related physical symptoms. They may then be unable to rest or pace their activity, to listen to their body and recover. As the patient starts to recognise these links they can begin to make changes to the way they manage their health.

The CAT approach to MUS is described in more detail elsewhere (Jenaway, 2011). One advantage of CAT is that it has not been designed for use in patients with a specific diagnosis. Therefore, it is not necessary for the patient to be convinced that their symptoms are medically unexplained. Many patients are unsure about the cause of their physical symptoms and are still hoping for a physical diagnosis. In CAT both explained and unexplained physical health problems can be explored in the same way, and the process of therapy is the same whether the symptoms have an organic basis or not. It is therefore also possible to use CAT when patients have a comorbid organic condition alongside suspected MUS (this is true for 20% of the patients referred for CAT in our department). In addition, partners or family members can be invited

to join therapy sessions to help them understand the patient's relationship patterns, and to think about how they might also be pulled into unhelpful ways of relating. This can be particularly useful where the patient is very cut off from their emotions. The model can also be used as a consultancy tool with staff teams who are struggling to cope with complex patients (Kellett et al, 2014).

Description of sample

Patients were referred to the therapy team of the liaison psychiatry department in Cambridge University Hospital by liaison psychiatrists assessing both inpatients and outpatients. We describe a series of consecutive patients treated by qualified therapists in the department with CAT. Additional patients with less complex presentations were treated by trainees, often junior psychiatrists who needed to take on a psychotherapy case as part of their training, or trainee clinical psychologists. However these have not been included as they were considered less complex at assessment, we are less confident about the quality of the therapy provided and data collection was poor. Over three years, 32 of those patients who were referred for CAT were seen by qualified CAT therapists, of which 28 were formally engaged in therapy. Of these 28 cases, 4 dropped out later in the therapy. The overall drop-out rate from CAT in our department has been reported previously as 27% (Channer and Jenaway, 2015). In that sample of patients, the drop-out rate was higher in patients seen by trainees than in those seen by qualified therapists, and higher in those travelling from outside the Cambridge area. This high rate probably reflects the practical difficulties of travelling to the clinic for those with MUS, as well as ambivalence, which we frequently see, about accepting a psychological therapy for what is experienced as physical problems. It is likely that more experienced therapists are more able to maintain the therapeutic relationship through the early sessions when the patient is still not sure that therapy will be helpful.

Of the 24 patients who completed therapy, 3 had incomplete data. Therefore, only 21 individuals (of whom only 2 were male) completed pre- and post-therapy CORE34 questionnaires, following an average of 17 sessions of CAT (SD=2.42). The CORE34 is a self-report questionnaire with 34 questions, designed for use as an outcome measure in any psychotherapy. Each question has a maximum score of 4, indicating high severity. Patients were referred from various departments in the General Hospital, with the majority suffering from functional neurological symptoms or chronic, unexplained pain. As can be seen in Table 1, most patients had experienced symptoms for more than 2 years. Table 2 shows rates of previous psychological therapy, with just over half the sample of patients having had previous psychological or psychiatric treatment.

Table 1 Reported duration of medically unexplained symptoms

	Duration of symptoms		
	1 yr	2-5 yrs	5-10 yrs
Patients	7	8	6

Table 2 Reported historical psychological input

	Previous psychological treatment			
	None	CBT for MUS	Non-specific counselling	Multiple psychiatric input
Patients	9	6	3	3

Results

Overall, CORE34 scores fell from an average of 1.87 per item (SD=0.77) to 1.09 per item (SD=0.60). Jacobson and Truax's (1991) methodology was applied to the data, to identify the extent to which this difference represented an effective move towards more normative data (clinically meaningful index), and the confidence with which such a change could be attributed to factors external to measurement error or chance (reliable change index). As shown in Figure 1, the observed decrease in CORE34 scores represented a clinically meaningful change; post-therapy scores fell below the clinical cut-off mark (females=1.29; males=1.19; CORE manual). However, with a reliable change index calculated at 1.06 (using reliability co-efficients reported in Evans et al, 2002), this difference falls short of a statistically reliable change. The number of patients is small, but the change in average CORE34 scores in those who have had previous psychological therapy (1.79 at start to 1.21 at end, n=12) was similar to those with no previous experience of therapy (1.79 at start to 1.21 at end, n=9).

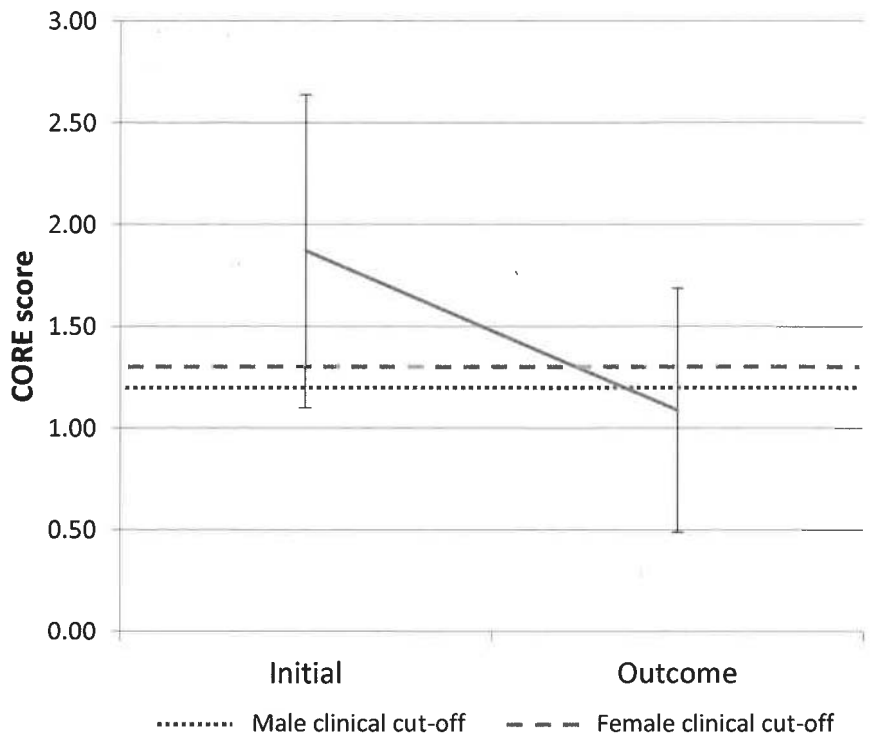

Figure 1. Change in CORE scores following CAT therapy

Discussion

We describe a service where it has been possible to introduce CAT as an alternative therapy model so that patients, and clinicians, have increased choice. This is particularly useful since many of the patients referred to us with complex medically unexplained symptoms report little benefit from previous cognitive behaviour therapy. Cognitive Analytic Therapy appears to be acceptable to patients with complex MUS and shows promise as an effective outpatient therapy in terms of reducing psychological symptoms as measured by the CORE34. One problem with self-report questionnaires, such as the CORE34, is that some patients with MUS show low scores initially. These patients have been described in the Health Psychology literature as 'Repressors' as they fail to report negative affect and appear to be out of touch with their feelings (Myers, 2000). These same patients sometimes report an increase in distress as therapy proceeds, as they get back in touch with warded-off feelings. This phenomenon may have reduced the average before and after differences in our sample.

Two of the patients reported here appeared to fit this description, both were female with severe physical symptoms and disability, but surprisingly low initial CORE34 scores (both scoring below 0.5 per item at the start). Neither had previous experience of psychological therapy, and both scored higher at the end of therapy, despite reporting it as helpful. Further research is indicated, using a larger sample and a randomised controlled design, with more objective measures of functioning included. Our intention is to start collecting outcome data using the Brief Illness Perception Questionnaire (a scale which provides a picture of the patients' cognitive and emotional representation of their illness) (Broadbent et al., 2006) as well as the CORE34.

In summary, we feel that CAT is a useful addition to Cognitive Behaviour Therapy in a service designed for complex patients with MUS. It offers both patients and the treating team a choice and may be more effective for those patients with significant history of early childhood neglect and abuse, and where problems in relationships are part of the clinical picture. Because the CAT model also provides a structure for understanding problematic relationship patterns, it is often helpful in assisting family and staff members in coping with the complex interactions which can occur with these patients. □

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Therapists' Experiences of Facilitating Cognitive Analytic Therapy Groups

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Abstract
Background: Cognitive Analytic Therapy (CAT) is an integrative relational therapy with psychodynamic and cognitive roots, subsequently transformed by Vygotskian activity theory and Bakhtinian notions of a dialogical self. CAT groups have been described as being successful, although there is a limited evidence base. This study sought to research the views and opinions of therapists involved with CAT groups.

Methods: Ten respondents took part in an online survey to answer the question 'what is it that you feel CAT groups offer and individuals gain that they don't from other psychological interventions?' Thematic analysis was used.

Results: All respondents reported positive outcomes from facilitating CAT groups, describing an environment of support and safe containment. This led to individuals being able to access deeper seated and more challenging aspects of their problems, allowing for 'real time' examples and active commentary on their problematic relational styles. CAT groups were described as a unique and rewarding experience for therapists and patients alike. Further research is needed and limitations are discussed.

Key words: Cognitive Analytic Therapy; groups; therapists; qualitative; relational

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Introduction

Cognitive Analytic Therapy

Cognitive Analytic Therapy (CAT) facilitates the clinical integration of psychodynamic therapy and personal construct/cognitive psychology (Ryle et al, 2014). As a time-limited relational therapy with a focus on