case with J whose first reaction to and acceptance of the SDR was shallow, and abolished by a state shift as she left the session. Personality integration must precede other interventions. For this reason the treatment of multi-impulsive bulimics with CAT does not differ very much from the treatment of other kinds of patients with unintegrated personalities.

The stress must be on obtaining a reasonably accurate and empathic description of the sequential states occupied by the patient and the reasons for shifts between them. Key pieces of evidence used in delineating these states include the therapist's countertransference experiences, descriptions of encounters with others, and the patient's history. Once the states have been described the patient is encouraged to try to learn how to identify them using a variety of techniques. Clearly such an activity is in itself insight-promoting, and furthermore it is, in the words of one patient, 'off the diagram'. The use of this joint tool and activity contributes (it is to be hoped) to the building up of a new state or situation with a more general overview.

Two central features of CAT are that (a) it is undertaken as a consciously joint exercise by patient and therapist, and (b) it stresses the concept of procedures as units of goal-directed action. The aim of this chapter has been to demonstrate how both these features of CAT work out in the practice of treating patients with eating disorders. A central theme has been to show how CAT's stress on joint activities and on procedural thinking is helpful in work with patients whose motivation and insight are most often ambivalent or lacking.

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5 CAT in groups

Norma Maple and Ian Simpson

As both practising CAT therapists and group analysts, our experience of working with patients within the NHS and in private practice has shown us that brief individual CAT is a very good preparation for longer-term group therapy. Patients who have followed this path tend to stay longer in their groups and have good insight into the psychological mechanisms which lie behind their difficulties. They are more self aware, less likely to act out and can use the richer, interactional dynamic of the group to put into practice learning from the earlier dyadic relationship with their CAT therapist. After an individual CAT and an appropriate gap, a patient can take the opportunity in a group to explore the meanings of their procedures in a dynamic environment where they receive instant feedback. In a long-term group they are also given the opportunity to experiment with new ways of being and thus consolidate new behaviours into more successful interpersonal procedures outside the therapy setting.

This led us to wonder, along with other CAT colleagues, whether there was not a place for even further integration of the models: whether CAT understandings, tools and practice developed successfully in brief individual therapy could be combined with the theory and practice of group analysis into one integrated model. We were aware of some of the common features of both models:

1. a basic psychotherapeutic stance with the objective of providing a safe setting within which troubled individuals are able to explore their difficulties with the help of (an) empathic other(s)

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2. engagement of the patient into an active collaboration aimed at verbalising and giving meaning to a range of symptoms
3. the belief that through understanding the effect we have on others and our contribution to dissatisfying interactions, we can draw on our creative energies to challenge dysfunctional behaviour and develop more constructive ways of relating.

Both theory bases also have common features. Group analysis comes from traditional psychoanalysis but focuses on the social origins of interaction and develops ideas from object relations theory and self psychology, amongst others, to inform its theory of group practice. CAT's own roots are also in the ideas of object relations theory amongst other theories of psychological and social development. CAT understands the origins of neurosis through the Procedural Sequence Model as belonging to reciprocal role procedures. These derive from actual experience in the child's historical and social context, mediated by the tools, language and ideas in use within the family and culture. These seemed not too disparate in essence, although the use of and focus on such understandings in the treatment models differ in detail.

We were also aware of what might seem conflictual in the two modes. CAT is an active model using an educational stance to provide the patient with access to new or repressed feelings, understandings and behaviour. Written material has a high profile in this work and suggestions as to tasks aimed at self-monitoring and changing behaviour are offered overtly by the therapist. CAT is individual and brief. Dependency and regression is kept to a minimum and the rational, coping, cognitive functions of the patient are actively enlisted and engaged alongside emotional expression in the search for change. By contrast, a group analysis can take some years of once- or twice-weekly sessions. In group analysis, dependency is encouraged; the patient expresses thoughts and feelings in the group and comes to new understandings at her or his pace, and the length of the therapy is related to the individual need. Group analysts offer a listening stance and conduct rather than lead their groups, confident as to the power of the group to heal, nurture and provide an environment where long-lasting change can take place.

Below, we discuss some thoughts, experiences and conclusions drawn from our attempts at integrating these two models, both theoretically and in practice.

Group analysis

Group analytic psychotherapy is practised in a range of settings both in the NHS and in private practice in this country and throughout Europe, with the standard model being one conductor to eight patients in a slow, open group,

meeting once or twice weekly. Patients stay in the group for varying lengths of time ranging from months to many years, and in due course discuss with the group when it will be the appropriate time to leave.

In brief, group analytic theory rests on the premise that the essence of human beings is social rather than individual, unconsciously as well as consciously. The individual organism is the basic biological unit but the basic psychological unit is seen as the group (Hopper, 1980; Napolitani, 1980). Whilst the individual can seem separate and isolated from the group and the community, this separation, whilst palpable, is an artificial one. The terms are complementary as in the Gestalt notion of figure and ground, with the space between the isolate and the group the fertile ground for therapy. Neurotic symptoms are disguises for what cannot be expressed in communication, and in the group—the setting where difficulties originate—communication can be developed from autism through to interaction. In the group, everything that happens involves the group as a whole as well as the individual. The individual is understood as a nodal point for the group and is often the spokesperson for the group as well as for her/himself.

Group analysis provides a setting for analysis in the group, by the group including the group conductor. The psychoanalyst S.H. Foulkes, the originator of group analysis, saw the group analytic experience as an opportunity for 'ego training in action' (Foulkes, 1964) where it is the conductor's role to provide and protect the setting and its boundaries. Within this safe space the group provides opportunities for energy hitherto invested in symptoms to be translated into shared communication. All communication is relevant, whether verbal or non-verbal, and this communication can be on several levels: for example, present relationships; individual transference towards each other and the conductor; shared and projected feelings and fantasies often from early developmental stages; as well as a primitive level of archetypal universal images. The conductor leaves as much as possible to the group and refrains from directing or pulling material into consciousness; rather, the conductor waits for the point where it is possible just to tip preconscious material into the public arena.

An important aspect of the group analytic experience is that of socialisation, where collectively patients constitute the psychological norm from which their individual symptoms deviate (Foulkes, 1948); thus 'normal' reactions are reinforced and neurotic reactions corrected. The other side of this is that difference, felt and actual, is also experienced, be it of race, gender, class, sexual orientation or handicap. In this respect, individual views of normality are challenged and modified.

Foulkes likened the group situation to a 'hall of mirrors' (Foulkes, 1984) and linked the group experience to that of the early caretaking experience

where mirror reactions help in the developing differentiation of the self from the not-self. In the group, the individual comes to see more and more of himself through identifying parts of himself in others and by reflections back from other members and the group conductor. The experience of receiving care from other members and learning to give care in return, of finding oneself playing a familiar role in the group/family, of having this identified by other members, and eventually attempting a wider range of role behaviours and of receiving greater understanding from others in return, are but some of the factors in the diversity of the group experience that contribute to a highly versatile and eminently creative forum for therapy.

Attention to the group process as described above, initially by the conductor and increasingly by group members, allows group members to learn to hear and be heard and to care and be cared for, to observe others and then themselves in interaction, and through this ultimately to develop a capacity for more fulfilling relationships within and outside the group. Therapy within a group can also provide a sense of other people being reliable and concerned, which may be highly appropriate for individuals whose early parenting was fragile or unreliable. Unlike in individual therapy where the therapist can seem an omnipotent mediator of power, in the group the caretaking qualities are shared as if in a family and negative transference onto the person of the conductor can be more contained and manageable. Other group members can help someone experiencing a negative transference, which might otherwise lead to great difficulty or even to dropout in individual therapy, by pointing out the reality of the behaviour and the therapeutic stance. There is a sense, too, of Winnicott's 'going on being' quality to group therapy (Meinrath, 1992) where the individual in turn can also seem less omnipotent. For instance if a session is missed, in contrast to that of individual therapy, the group can be thought of as taking place and continuing its existence despite one member's absence, thus increasing the sense of stability and commitment.

With all these factors contributing to group therapy as a therapy of choice, it seems unnecessary but relevant to point to the factor of economy. In group analysis, eight people can be seen by one worker in the time that would otherwise be devoted to an individual patient.

How compatible are CAT theory and group analysis?

The theory base of CAT, the Procedural Sequence Model (PSM), identifies the development of the individual's dominant interactional procedures as reciprocal role procedures and uses these understandings to guide the course of therapy. Procedures are sequences of mental processes, action, environmental events

and outcomes which take place in pursuit of a given aim. Procedures are interrelated hierarchically, from sub-procedures such as those aimed at basic self-care (e.g. tying shoelaces) through to higher-level procedures aimed at, for example, career progress. Object relations theory and Vygotsky's developmental psychology (Wertsch, 1985) inform the CAT view of human aim-directed activity being learned and shaped in the early relationships with parents and other figures who represent both care and control. Learning takes place within these interpersonal interactions and leads, through the process of internalisation, to intrapersonal functioning where the internal dialogue re-enacts the earlier interrelational experience in self-care and self-control.

Problems arising from distortions and conflicts in these early interactions lead to difficulties and limitations in later life through unsatisfactory relationships and conditional views of the self. Of particular concern to CAT therapists are the role procedures related to the maintenance of psychological self-care and of social interaction; in other words reciprocal role procedures concerning care and control in self-to-self and self-to-other relationships. Here, personal and acquired beliefs and values, together with perception and appraisal of thoughts, memory, meaning and feeling, followed by action which produces responses and consequences, are all involved. In CAT, these procedures are accurately identified in collaboration with the patient and are described and presented to the patient in various ways in the reformulation; subsequent therapy is aimed at challenging dysfunctional procedures and finding more satisfying alternatives. Thus making links between the interpersonal and intrapersonal, both in the patient's history and therapy, are the focus of work in CAT and fit most appropriately with the group task. By helping patients, fellow group members and the therapists make sense of reciprocal role behaviour, CAT tools and descriptions can be a useful adjunct to the group structure in offering a greater sense of containment and for helping people to engage with the group.

This is particularly relevant for individuals whose early containing experiences were fragile and fragmented and whose reciprocal roles developed accordingly. In 'A theory of thinking' (1967), the psychoanalyst Bion suggested that, in the complexities of life in a group, the adult tended to regress to earlier stages of development as she or he struggles to make contact. If the process is to be manageable and meaningful, the SDR—a tool of reflection, identifying and describing meaning and affect in interaction—has much to offer. Whilst the 'child' part of the patient in the child-derived pole of the reciprocal role procedure can be sharing anxieties and feelings in the group, the 'adult' part becomes more able to observe self and others, with the ability to think, although under attack, supported through the use of the diagram.

Mirroring too has particular connotations for CAT. Whilst identifying and

observing the mirroring roles in other members is a powerful part of any group experience, CAT sees the transforming effect of therapy as requiring both the experience and the commentary/conceptual tools as described above. Similarly, CAT can equally contribute to ego training in action with its invitation to the patient to see her or his reciprocal role procedures as patterns of behaviour which have been developed to cope with difficult situations. The group provides a stage where corrective adjustments may be made.

Foulkes, like Bion, saw that the group experience raises 'deep conflict and characteristically brings up the early family situation, Oedipal situation and . . . (members) are really afraid to become independent, a kind of fear of freedom' (Foulkes, 1975). Such issues raised by the group and in the group, affected by the nurturing experience found there, are influenced not only by the group members' own experience of their early family situations, but also by social and cultural aspects and expectations appertaining to these. For example, living in a society which believes that families provide the best environment within which to bring up children, leads us to groups where such values are initially accepted unquestioningly and where those with unsatisfactory family experiences struggle with their envy and longing for an idealised stereotype.

As family situations are changing in a social environment where women and men are now questioning the roles expected of them, we need to recognise that the institution of the family has inbuilt dynamics which have been accepted as the norm, often unquestioningly so. Just as these dynamics have affected our social policies and individual desires, so they have also affected the development of psychoanalytic theories which have influenced our therapeutic practice.

Stereotypically, mothering roles in our post-industrial society have been passive, nurturing and caretaking, with fathering being seen as active, independent and repressive of emotions. Father brings the outside world into the hitherto private sphere of the nursing dyad. Whilst his actual involvement with his children's day-to-day care has remained a limited and certainly optional role over the centuries, our society has supported an acceptance of the father's dominance in his provision for the family. We have given him, in the guise of the doctor and psychoanalyst, the authority to prescribe for good mothering, for example, from his only experience of that situation, that of a child in relation to a more powerful mother. In recent years, of course, women and men are attempting to challenge and modify these stereotypes to something more appropriate to a gender-sensitive environment. Women are beginning to speak out from their experienced position as mothers whilst men struggle to find a way to express their fatherhood appropriately.

So what, if anything, does this mean for group therapy? In psychoanalysis, Freud developed the idea of the analyst as a reflective screen, keeping as much of her or his personality as possible outside of the analytic situation. Foulkes

recognised the need for a greater involvement in the group than the purely analytic stance in his definition of leadership in group analysis (Foulkes, 1964). He moved from the essentially narcissistic concentration of the Freudian model and the analytic neutrality of the analyst to a point where the individual in relation to the group is the focus of the experience.

In group analysis, the group conductor is responsible for the dynamic administration of the group and for holding the boundaries of the setting. During the sessions, she or he maintains a stance of careful listening and is ready to protect the group from situations that might threaten the safe space. Whatever the actual gender of the group leader, a stance of mainly careful listening during the sessions could be seen as passive, rather than active father or mothering. It is in this respect that the activity of the CAT therapist could, in our view, bring an additional quality to the group conductor's role, in a way analogous to the struggle of the male in our society to find an active fathering role that is neither intrusive nor abusive but allows for creativity in the true meaning of potency.

So it seems that within a brief model, there is room for both a nurturing, care giving and depriving mother/group therapist as well as a potent and educative father/group therapist, one who by facing both the internal and external worlds, provides containment yet brings the advantages and disadvantages of the external reality to the child/patient's experience. The danger of over-dependence on therapists is also guarded against in CAT by the model of sharing and collaboration, of handing over to the patient the therapist's understanding of their problems in written reformulations, in descriptive diagrams and goodbye letters etc. This can remain so whether support for change comes from an individual or from a group, and indeed the group could be viewed as the forum of choice.

A final advantage that CAT can bring to group therapy is that of researchability. Group analysis as a model has all the difficulties of evaluation of psychoanalysis and finds itself open to criticism of the subjectivity of its assessments of effectiveness. This position leaves open questions such as which patients are best served by group analysis and which are not. In the reality of scarcely resourced settings, as well as in the interest of group workers wishing to research their efforts, CAT can bring to group therapy one of its other strengths, that of a capability for evaluation.

Can we integrate CAT theory and group analysis?

Consider the following questions:

1. How adequately could a brief CAT group experience explore individual difficulties?

2. Who is suitable for a brief CAT group?
3. What effect would the relatively brief time-span have upon the group process?
4. How would the tools of traditional CAT practice be used in a group context?
5. How would the activity of the CAT therapist combined with the demands of a brief therapy group affect the therapists and the therapeutic stance?

Before attempting to answer these questions, we shall discuss some of our experiences of brief cognitive analytic group therapy.

St Thomas's Hospital Group 1 (STH1)

Two brief CAT groups have been run at St Thomas's Hospital. Both drew patients from referrals to the psychotherapy unit. The first group was facilitated by a senior registrar and a clinical psychologist. Neither of the facilitators was a trained group conductor, although one was participating in some group work training. This group was supervised within the unit by one of us (I.S.), a trained group analyst. Eight members started and seven finished. One woman left after only a few sessions, and one was admitted as an inpatient after a psychotic episode near the end of the therapy but did return to the group.

Research data was collected from the members and the group also utilised the traditional 'tools' of CAT. Each member was given an individual written reformulation subsequent to some individual sessions with one of the facilitators. Similarly an SDR was drawn up for each member. Members met both conductors prior to the start of the group but worked with only one on the SDR and reformulation. The group's life-span followed the pattern of individual CAT and was for 16 weeks. Four of these were with the facilitators working on the SDR and reformulation, the remaining 12 were in the group. Members were invited to read their reformulations out to each other or they could ask someone else to do this. SDRs were put together on one A4 sheet and these were made available during the sessions and collected by the conductors at the end of the sessions. Group members were also asked to complete a repertory grid (Watson, 1970) before the start of the group section, midway through and at the end of therapy, and everyone was asked to write a goodbye letter. Two papers describing this experience are reviewed in Chapter 10.

Day Hospital Group (DHG)

Dr Dilys Davies, a clinical psychologist and CAT therapist of George Eliot Hospital, Nuneaton, facilitated a day-unit group. This group comprised four men and two women, longstanding attendees of the unit for whom the staff felt that basic unit attendance had little more to offer. The group had weekly

sessions for a period of four months. The members were given individual reformulation letters and SDRs and then developed, in the group, a group model of the common reciprocal roles by identifying the common parent-derived and child-derived roles being acted out in the group. These were as follows:

- *Parent*

  powerful
  abusing
  punishing
  conditional love
  precarious security

- *Child*

powerless, helpless	abandoned
abused, victim	insecure
worthless	unimaginable terror
rage (retaliation)	fear
guilt (magic)	isolation, loneliness
precarious dependence	

This became a powerful group exercise bringing together members who on the surface would seem to have little in common, to a point where they functioned as a very cohesive group, sufficiently so as to challenge the ending and to continue to meet once monthly as an ongoing self-help group.

Counsellor Training Group (CTG)

In another setting, a CAT group has been used to help in training counsellors. In Wokingham, Berkshire, Jane Melton, a CAT therapist and counsellor trainer, has utilised this forum to facilitate group members' understanding of their own reciprocal role procedures prior to their working with clients' problems. The group comprised three men and three women, who were either counselling trainees or were considering undertaking training, and ran for ten sessions. This group used before and after measurements which identified a clear numerical increase on the scoring of awareness of reciprocal role behaviour by the end of the group. This work points towards the effective use of CAT groups for couples work (Melton, 1994).

Guy's Hospital Group (GH)

One of us (N.M.) conducted a 24-session CAT group at Guy's Hospital where the seven group members were mainly patients who had already had an

individual CAT but at follow-up had asked for, and been assessed as needing, more therapy. This group format had four individual sessions to clarify an SDR, based on, but not always the same as, the reformulation used in the previous therapy, prior to 24 group sessions with a single group conductor.

Particular features in this group were an initial extreme difficulty in sharing, which was finally successfully addressed by a group reformulation letter prepared by the conductor describing the group process and the dominant reciprocal roles in operation:

GH group reformulation

We came together in November with each person wanting something from the group. C hoped for help with her panic attacks, agoraphobia and fear of being with others in public. A and Y to deal with the anxiety and fear that makes them feel unable to cope at work or socially. N and G had experienced abuse in early life that left them fearful of trusting others, whilst M and P had been disappointed by those who should have cared for them unconditionally and felt isolated, alone and guilty.

The group raised hopes of finding help for these problems but also anxieties about aggression and attack. In the first session people spoke of group therapy they had seen on TV where people confronted each other about their behaviour and also of the doctors who had variously let group members down. So even at the beginning, it seemed difficult to think that we could achieve a group where people could be cared for, nurtured and supported as they tried to find new ways of sharing themselves with each other and expressing their vulnerabilities.

The group seemed quickly to become a place where people feared to expose themselves and their feelings. The diagrams that we had worked on individually, were kept by the individuals and handed back to me at the ends of the group rather than shared with each other. N spoke of depression and her fear of letting others see behind her 'mask' and did not return to the group. Subsequently, P and G showed us their vulnerable sides and then did not return. It also seemed that I, perhaps like some of your mothers, might be too fragile or too self-absorbed to be able to help or to protect people from abuse.

Currently those members remaining with the group are confronting the dilemma of keeping the group a seemingly safe and 'comfortable' space where people are pleasant to each other. This is in contrast to an outside world that seems so full of frustration, disappointment and the threat of violent attack. But it is as if 'safe and comfortable' is also a way of masking real feelings and real communication and satisfaction in being together meaningfully.

There is a sense that belief in the group as a valuable experience for help towards changing lives remains with me alone rather than the members. It is as if the group is still being experienced as the unsatisfactory families you once had and longed to escape from rather than an opportunity to find more support and nurture in a new environment, where people can be heard, cared for and appreciated for who they are, and not for the masks they have learned to wear.

In summary, it is as if in the group to date it has felt necessary to be

- **either** masked, isolated but safe, keeping true thoughts and feelings inside for fear of ridicule, aggression, rejection or disappointment.
- **or** vulnerable, exposed, and likely to be looked down on, rejecting others before they can reject or abuse me.

The opportunity exists in the group to create a setting where vulnerabilities, difficulties and true selves can be valued for what they are, can be shared appropriately and the group strength employed to give people more options in their future relationships outside. But this requires taking risks and opening up to change within a group committed to helping themselves and each other. I invite the group to make such a commitment to themselves, to opt in to our experience togethér and find in the group a place where new understandings can be gained and your future lives considerably enhanced.

N.M.

This had the effect of bringing the group together and group interaction finally took place, culminating in a genuine sharing and caring for each other and the development of a group ethos. Subsequently, people dared to describe and share some powerful anxieties; one man told the group that he had thought he was HIV-positive and the group gave him sufficient confidence to go for an AIDS test, whilst one woman spoke of her real fears of being a bad mother to the son of whom the group knew she was over-protective. Independent research which included before and after interviews with the group members confirmed the group reformulation as being the mobilising therapeutic factor towards group cohesion and change. Group cohesion, of course, is one of the main therapeutic factors identified by Yalom (1985) as contributory to successful outcome in group therapy.

St Thomas's Hospital Group 2 (STH2)

This group was facilitated by one of us (I.S.) a group analyst, and the senior registrar who had led the first St Thomas's group. Six members started and all finished, although one member's attendance was erratic and another missed several sessions and had to be seen individually prior to her return. The model used was as described for the first St Thomas's group and some of the group experience is discussed below.

Early sessions in any group are likely to mobilise considerable anxiety. This group swung between anger at being dependent on powerful figures 'who could shove you around irrespective of your wishes or needs', to the opposite position of complete independence. They speculated about whether or not

they needed the facilitators there. They had their reformulations and their SDRs; maybe they could do without us? They seemed to be desperately seeking a way out of the painful anxiety generated by the group situation. Accordingly they swung between extremes of total dependence, and the loss of self-identity which goes with that, to a fantasy of complete separation from safe, containing structures. Being able to express their ambivalent feelings towards each other and the facilitators helped them come to terms with the group. This was assisted by the facilitators understanding and containing the angry feelings.

Gradually the anxiety lessened, although in a brief group with ending always in sight, this is never very far away from the surface. As the initial anxiety lessened, members were more able to individuate and relate to the others reciprocally. As they began to work, their individual patterns began to emerge:

J, a young woman in her late twenties, who presented with relationship difficulties and a fear of group situations, was very resentful in the early sessions. She was angry with the facilitators (largely indirectly) and often asked why a group had been chosen for her instead of individual therapy. Her early group behaviour closely followed the patterns outlined in her SDR (see Figure 5.1).

P, a young man in his mid-twenties, often narcissistically preoccupied, also began to conform to the patterns in his SDR. He too had presented with relationship difficulties and he eagerly joined with the others in expressing his ambivalence about being in a group. However, he always kept a wary eye on the facilitators and he was quick to repent if he thought he might incur their wrath.

E, a young woman in her mid-twenties, who presented with problems of lack of confidence and low self-esteem, was invariably quiet and withdrawn for much of each session. As her SDR highlights, she gave little of herself spontaneously and invariably had to be coaxed into contribution by the facilitators.

K, in his mid-thirties, who complained of tiredness and lethargy at work and at home, found no difficulty in identifying and sharing with other members. He seemed to be the one who was most at home in the group and the others began to look to him as a unifying and stabilising influence. Following the pattern in his SDR, he worked hard trying to make the group work and he would often take up someone else's case when he felt they needed support.

B, in her mid-thirties, who presented with difficulties at work and in her personal relationships, managed to stay aloof and apart from the other members. She had a dismissive and contemptuous manner which helped to keep her at a distance. She seemed very defended and quite reluctant to risk exposing herself to closer contact. This behaviour conformed closely to that outlined in her SDR.

C, in his late twenties, who was concerned about recent violent and self-destructive losses of control, appeared distant and introverted during the early sessions. However, he often came to the defence of the facilitators when they were under attack. This mirrors his fear, reflected in his SDR, of close or intimate contact with others and it also highlights his propensity to get into self-destructive situations.

The behaviour patterns of the members was fed back to them through the use of the SDRs and through group and individual interpretations. This was soon being done by the group members as well as by the facilitators. As the group progressed through its middle stage into the last few weeks, some changes became apparent. The following example of the modification of a reciprocal role procedure took place during these later stages of the group.

P, who was convinced the other members would not like him if he followed the patterns of his SDR, was pleasantly surprised when they not only tolerated his acting out and occasional episodes of outrageous behaviour, but also emphasised how much better he was when he was not trying to be something he was not. He found this difficult to comprehend and was very resistant. Similar types of exchanges took place between the group members and C, E, J, K and, to a lesser extent, B. All these interactions resulted in established patterns being challenged and changed behaviour being reinforced and supported. This was achieved through either the group as a whole or one particular individual standing for a parental figure. This dynamic was in addition to the transference relationships with the facilitators.

Group process Scapegoating is a process common to all groups. It occurs when one individual or easily identifiable group of individuals takes or is given unwanted or unmanageable feelings which belong with other group members or with society. In a small group this is usually associated with a displacement of feelings about the facilitators away from these figures and on to some unfortunate individual. There may be a fear that the facilitators will not be able to cope with powerful feelings and that they might collapse or be destroyed. Alternatively, they might retaliate and attack group members or destroy the group. It is therefore felt safer to place these difficult feelings elsewhere.

A scapegoat may be a willing or unwilling victim of this process. However, what invariably happens is that they carry the unwanted feelings and may act these out by behaving in certain ways within the group boundaries or by being driven away for the greater good of the group as a whole. This is primarily a preconscious process in which the scapegoat sacrifices himself or herself, or is sacrificed, so that the other members may survive. In this group, although P often seemed the most likely candidate for the scapegoat role and he did find himself flirting with it in several minor ways, E was the one chosen for sacrifice.

E did not return after the third session. During the fourth session it was revealed (by P, interestingly enough) that the whole group had gone to the pub after the last session. This of course, was a direct rebellion against 'sensible' parental advice, as all group members knew that outside social contact was disapproved of for reasons of group cohesion and safety. It is quite common

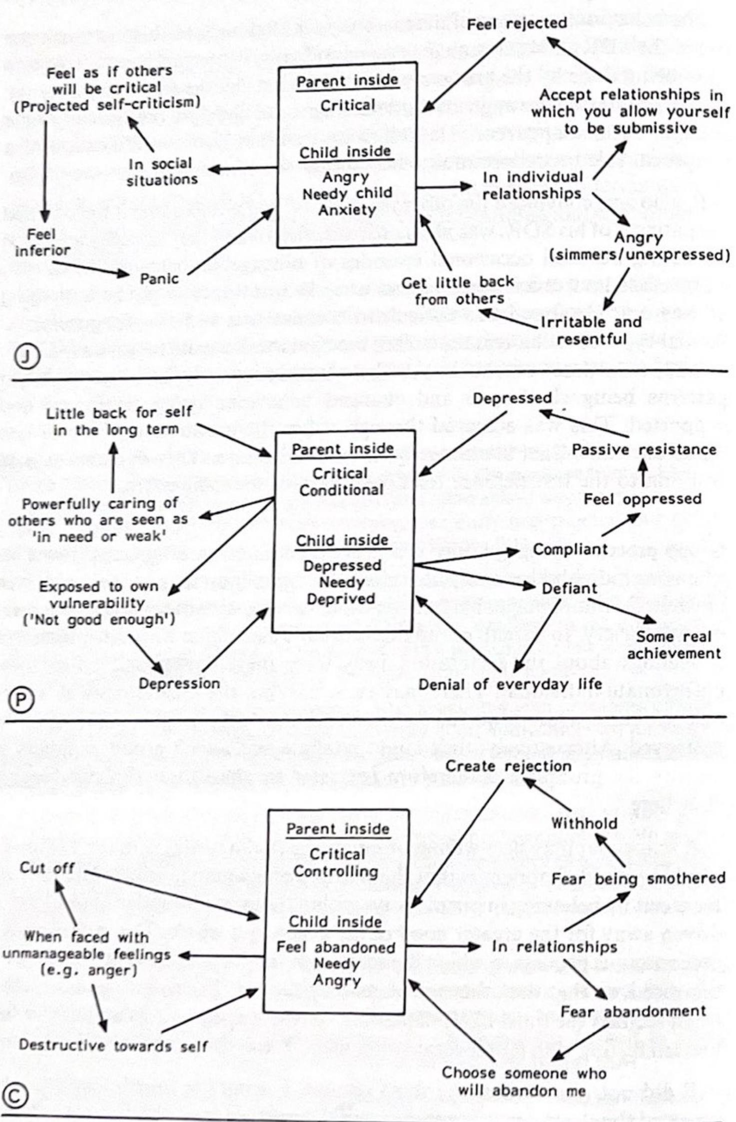
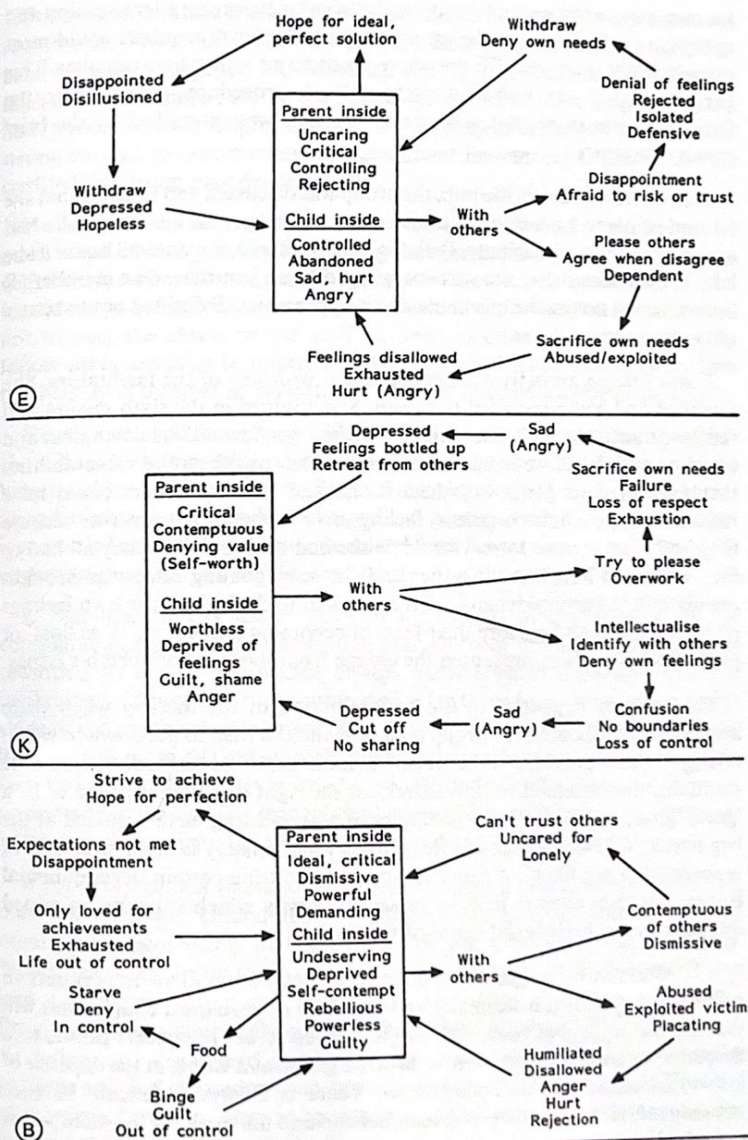


Figure 5.1: SDRs of the group members of STH2



for members to test group boundaries by meeting before or after a session and many have a fantasy that the group would be better if members could meet outside; but it is unusual for the whole group to go somewhere together. This suggests that a very powerful reciprocal role procedure in relation to the facilitators was in operation here and that this was intensified by the brief group experience.

During the sojourn in the pub, the group was discussed and E stated that she felt out of place, uncomfortable and uncertain as to whether or not she had anything useful to contribute. Perhaps, she wondered, it would be better if she left? It then seems that she was encouraged to do just that. One member (J) accompanied her on the bus home and it appears that E decided not to return after their conversation.

E was offered an individual appointment with one of the facilitators. She attended and was persuaded to return. She rejoined in the sixth session and remained until the end. She returned to face her fears of unworthiness and rejection and therefore handed back to the other members the vulnerabilities they had tried to place with her. If she had left, the others could have rationalised the whole episode by feeling sorry for her or felt superior because they had what it took to survive while she had not. As it was they all had to face what had happened together and the scapegoating issue was brought openly into the group dynamic. Everyone had to deal with their own feelings of vulnerability and explore their fears of becoming the one who was 'lost' or unwanted. E's return prevented the escape from these uncomfortable issues.

This episode happened in the middle period of the therapy when there appeared to be a desire for group cohesion and the wish to get down to work. Alongside this pressure to conform to some sort of commonly acceptable standard, there seemed to be a search for the right qualities required to be a 'good' group member. Other examples of scapegoating have occurred at the beginning and the endings of brief groups when anxiety is high. Attempts at scapegoating are likely to occur in any group during certain developmental stages, but they emerge in brief groups in a way which suggests an added intensity and a heightened sense of urgency.

It is common for anger to be directed at facilitators at various points in group therapy, but it is normally an individual or perhaps a couple who will take up the scapegoat roles. For the full group to act in concert points to a desperate attempt to over-identify with the group as a whole at the expense of individual autonomy and judgement. There is always a delicate balance between individuality and group membership and the work for the members is to find this balance, to maintain a separate identity whilst staying in relation to the group.

J managed to stick it out. Despite her constant unspoken criticism and resentment, she was able to be more in touch with the anger and pain which lay behind her intransigence. She found an exit by expressing her anger rather than letting it simmer, and in her follow-up interview she admitted that she had found the group helpful. She said that shortly after the end she had been strong enough to take a major decision about her current relationship. She credited the group experience for this.

P was eventually able to break free from his ambivalence. He also seemed to make some limited gains by identifying the maladaptive patterns into which he fell when he confronted painful feelings. However, he was not able to stop his old ways. He missed several sessions including the last and found it hard not to play the clown or act as if he were superior to everyone else. At follow-up he asked to be referred for longer-term therapy where, sadly, here too he stayed trapped in his patterns and left unsatisfactorily after a year.

E came back and faced her problems. The scapegoat was not sacrificed but she still found it impossible to relate freely and openly to the others and kept herself hidden and inaccessible. The fact that she returned was significant and an exit of sorts, but any gain was limited and her negative self-image pulled her inexorably back. She would have benefited from longer therapy but missed the opportunity as she left the district shortly after the end of the group.

K managed to risk anger. Around the middle of the group's life, he complained angrily about not getting enough from the facilitators. He was rewarded by a tacit acceptance of this request which coincided with the facilitators' feelings that it was appropriate for them to be more active at this stage of the group's development. At follow-up, he said the group had helped him. He was more relaxed at work and his relationships were going better. In fact, he had decided to get married soon. He had found a clear exit from his primary dilemma and felt that this had enabled him to have more confidence in his own judgements and to risk saying what he was feeling.

B probably gained the least from the experience. She revealed herself on only one occasion. Undoubtedly she got something from sharing with the others and recognising that she was not the only one with problems. Nevertheless her desire to stay in control was very powerful. She decided to join a long-term group and, at the time of writing, is still in that group. Progress has been slow as she continues to find it difficult to relinquish control. At follow-up, she agreed she had gained some insight into her negative patterns and that she understood more about her lack of boundaries. The brief group does, however, seem to have been a useful introduction to therapy for her and this is significant in itself.

C achieved quite a lot. About halfway into the group he re-established

contact with his mother and began to explore a very painful episode of his childhood, his father's mysterious death/suicide. He was surprised and gratified by his mother's positive response. This was his first tenuous step towards acknowledging that he had unresolved feelings. Towards the end of the group he was also able to share the problems he had in his current relationship. Speaking about this and having this accepted by the group was very important to him. He felt validated and understood in a new way. In his follow-up, he was positive about the group experience and recognised that he had begun work he may need to continue in the future.

Group epilogue Two members (B and P) went on to long-term group therapy. For them the experience was useful in opening up areas which they felt needed further work, and it provided a model of therapy in which they felt relatively comfortable. One member (C) contacted the unit 18 months later to ask for further therapy and was referred on. E left London to live elsewhere and we have not heard further from K and J subsequent to follow-up.

Discussion and evaluation

Brief group psychotherapy can be seen as a pragmatic response to NHS waiting lists. More people can be given the opportunity to participate in psychotherapy, and certainly the provision of long-term individual and to a lesser extent long-term group therapy is constrained by limited resources. Therefore an exploration of what can be achieved in a brief CAT therapy group must be a worthwhile enterprise.

Although it may be the case that something is better than nothing, this cannot be used as a justification for 'placebo' therapies or for those that are second-rate. Brief individual CAT has shown that it is a safe first intervention, and there is no evidence to show that it is any less effective than once-weekly psychodynamic therapy. In reality, very few CAT patients go on for longer-term therapy. CAT can enable individuals to see the benefits of talking about their problems within a professional structure, and its focused and cognitive elements can quickly give a sense of gaining some control over their lives. With prospective patients drawn particularly from disadvantaged groups, CAT is wide enough to lend itself to an educative function which can enhance contact and encourage engagement in the therapeutic process.

Brief CAT groups appear to have been a positive experience for most of the participants in the groups described above. Without question, the patterns outlined in the SDRs emerged in the group dynamic and were acknowledged and recognised by all the group members. What is unresolved is whether or not the time-span of the group gave them sufficient space to work through these therapeutically.

Duration

Ultimately this question rests on the aims and objectives set for the exercise. If these were limited to acknowledgement and recognition then the groups were reasonably successful. If these were to make perceptible changes in behaviour then it is not so easy to make a satisfactory evaluation. As in individual CAT, some people seemed able to take on the cognitive reframing of their problem areas, use understandings from the SDRs etc., and to employ what they had learned very quickly. This resulted in quite major shifts for some whilst others found it more difficult. In the STH2 group, K and C for example both made significant gains and J achieved what she wanted. On the other hand, E, having been rescued from the sacrificial altar upon which she had placed herself, had difficulty in seeing this as a positive step, rather viewing continuing in the group as being returned to the torture chamber. B and P remain unable to relinquish their old procedures.

We would see this outcome as not unusual for any therapy setting where there will always be some who can use the experience more readily than others. As with individual CAT, we would expect change to continue (and sometimes only to commence) subsequent to the group's ending but outcomes from this and the other CAT groups in operation currently are being collected with a view to informing further the development of the model.

On balance it seems that 12 weeks of group time is too short. Whilst some members of the St Thomas's groups were able to make positive changes, others did not move at the same pace. This, of course, is a phenomenon which is common to all groups in their various stages of development, and individuals change in relation to the particular needs and psychological patterns they bring with them. The temptation is to think that more change could have been achieved and consolidated if there had been a longer time to work things through. The findings of Butcher and Koss (1978) support this view with their suggestion that 25 weeks is an appropriate duration for a brief group, whilst Budman and Gurman (1988) suggest 65 sessions of one-and-a-half hours for a time-limited group for those with chronic and severe difficulties in intimate relationships.

In CAT groups, as in individual CAT, we are aware that the issue of time and the denial of time must be confronted throughout the therapy. Despite this there will still be individuals who can only function fully in the last few sessions. For others, the approaching time boundary will be responded to with

anger and/or regression. Therefore, although we are not convinced that a longer time will necessarily produce twice as much consolidation, we do feel that 24 sessions for a standard CAT group may be a more appropriate time limit than 12. This is the model currently in use at Guy's Hospital and the experience seems to suggest that it is a good time span for a brief group. However, there still needs to be some flexibility as there may be instances where the ending needs to be staggered according to the needs of the members.

The example of the DH group supports this view. Here group members, patients from a day unit for the chronically mentally ill, seemed to choose an ending which was appropriate to their needs at the time. The group, initially very disparate people coming from very different ends of the social and educational spectrum, decided, as ending came, that they wanted to continue meeting. They chose monthly sessions in which they could revisit the setting where they had struggled to make sense of the histories of abuse that they had in common.

Some of our anxiety as therapists is tempered by the inherent flexibility of the CAT model in terms of extending endings or adapting the therapist's techniques as we have discussed. Careful composition of the group is equally important and the difficulties of assessment and selection must be acknowledged.

Selection and group composition

For successful referrals, brief CAT groups need to show that they can be a 'good enough' or even more than 'good enough' intervention for a range of identifiable patients and/or particular problem areas. To do this we must establish an appropriate yet flexible structure and a subtle and comprehensive assessment to discriminate who are the most suitable recipients.

Not surprisingly, it seems that brief groups are most appropriate for those people who are functioning reasonably well in the world outside, and have a relatively stable social network. This is particularly true for individuals who have come from backgrounds where emotional expression was suppressed. A brief therapy can greatly ease their sense of separateness and difference. They can be reassured that they are not going mad or are bad because they feel angry or are depressed. Sharing thoughts and feelings can be liberating and these individuals can find themselves acknowledged and validated as 'normally neurotic'. Patients with presenting symptoms ranging from panic attacks, post-traumatic stress disorder, depression, phobias and eating disorders have all responded well in our groups.

It is when we come to consider the more 'borderline' patients that concerns arise. As described in Chapter 1, there is sufficient evidence to show that

individual CAT can have a powerful therapeutic effect on borderline personality disorder in a high proportion of cases. This may not be the case in brief groups and we need to research this area more fully before anything definitive can be said. The high levels of anxiety together with the added elements of competitiveness and rivalry which a brief group experience throws up, may feel dangerous and threatening for such individuals whose experience of parental figures and family life will have included little of the containment necessary for integration. Yet these patients will often demonstrate a strong commitment to the group, finding in this setting a 'holding containment' not available elsewhere in their chaotic lives.

There is growing evidence in the groups we have experienced that some of these patients do survive very well in a brief group. Outcomes from STH1, the membership of which included three members with borderline personality disorder and one with narcissistic personality disorder diagnoses, showed that the group was able to hold all but one member and only two required further therapy subsequent to the completion of this group. We are also aware that, for instance, the borderline personality disorder diagnosis does not represent a homogeneous category of patient; within this group patients may have markedly differing characteristics and will respond best to differing therapeutic interventions.

A large number of our NHS patients will, however, be classified within the range of this diagnosis and we are looking at ways of responding to them. In group analysis, we would suggest up to two 'borderline' patients in a group of mainly neurotic patients could be a good mix and to the benefit of all. However, in brief CAT groups, because of the heightened intensity of the interactions, it may be better to attempt to avoid a situation where only one or two patients in a group would have such pronounced difficulties. One option might be to develop specifically 'homogeneous' groups of all 'borderline' patients. These groups might well be of longer duration, be co-led of choice and allow for some adjunctive individual therapy to support group membership.

There is also the possibility of a pre-group structured workshop. This would provide an opportunity for prospective members to gain an experience of what it would be like in a group before making a commitment to join and for the facilitators to assess the individual's ability to relate in such a setting. It is hoped, as described by Yalom (1985), that this would also help with some of the difficulty of early dropouts, something that can be more easily handled in a long-term open group than in one that is closed and brief.

An alternative is to consider attempting to provide a common working focus for the group such as that developed by Dr Davies in Nuneaton. Here the common focus in the group was that all were coming to the end of their time in the day unit and a supportive structure developed around this theme,

minimising some of the more rivalrous and competitive aspects. Much more work needs to be done in this area but preliminary findings do seem to indicate that a broad range of patient difficulties can be worked on in a CAT group.

Group cohesion and CAT tools

Unless there is a quickly developing sense of cohesiveness and trust in a short-term group, it is unlikely that the group will be viewed by members as providing a valuable experience. In CAT groups, as in individual CAT, the reformulations and SDRs give a clear focus which helps to initiate a sense of cohesion. Members also have a common group language from the beginning through the use of diagrams in their individual sessions and then gradually through sharing them in the group. On balance, the SDRs are a valuable tool in a CAT group although there are times when attempts are made (both by members and even facilitators!) to use them to block, hinder or avoid difficult issues. If the facilitator(s) are aware of SDRs being used defensively, draw attention to this and interpret its meaning in the context of the group, then the impact can be reduced. Members gradually become more fluent at translating the patterns on the SDR into interactions in the group. They become more proficient at observing themselves and other members. For STH2 as the group progressed, the A4 sheet containing all the SDRs (Figure 5.1) became a shared and common group focus. It became a fluid map showing where individuals were at any point on the group's journey.

Different groups use SDRs differently. In the St Thomas's groups, SDRs were shared at the first session. In the GH group, members were invited to share but were only confident enough to do so towards the middle of the group life. This group made an ending 'ritual' of giving each other copies of the SDRs of the group to take home—symbolically as if 'transitional objects'.

When we consider use of the written reformulation letters, a question revolves around when this is done and for what purpose. Reading them in the first session, as in the St Thomas's groups, proved cumbersome and ineffectual with the anxiety of the first session making it difficult for members to take in other people's material. Also the actual process of reading them aloud felt rather dry and detached, leaving little opportunity for interaction. This was in contrast to the graphic simplicity of the SDRs. However, very effective use was made of reformulations in two other group formats as we have mentioned. In these instances written reformulations were used in much the same way as containing or holding interpretations, which encompass the whole group or address all individual members separately, might be made during a long-term analytic group. These provide a timely focus and understanding of underlying issues which contain anxiety and lead to a recognition of the shared enterprise

members had undertaken, while emphasising that individual autonomy could exist alongside group cohesiveness. In this way group analytic techniques can fit well into the methodology of brief group work.

Issues for group conductors/facilitators

Although the facilitators should be relatively active in a brief CAT group, they need also to strive against creating too much dependency upon themselves. This is a challenge best overcome by being clear and direct, keeping the members focused by using the SDRs and concentrating on current events in members' lives. Although the facilitators may weave in an examination of some historical material, for the most part this should be directed to identifying similar patterns of relating in the here-and-now, whether enacted inside or outside of the group.

Strict boundaries are also important and, although they can sometimes foster a mystique or leader-centred focus, they are necessary to contain anxiety and to create an atmosphere of confidentiality and trust. This can be difficult for inexperienced facilitators, but there is for all CAT group facilitators, as for individual CAT therapists, a tension between the openness of our collaborative stance and our overriding responsibility to provide a safe space where overwhelming feelings can be explored safely.

Transference issues and characteristic modes of dealing with authority figures will certainly arise within the group context. The dilemma for the facilitators in CAT groups, as in individual CAT, is how to address these and allow the here-and-now reciprocal role invitations sufficient exploration to be understood without engaging into an enactment. They should be addressed and interpreted as in any group with the transference identified as belonging with the facilitator(s) if this is appropriate.

Research aspects can become a vehicle for compliance/non-compliance transference issues if the facilitators are involved in the practical aspects of collection of material. For this reason, it is easier for the administration and collection of research data to be done by someone unconnected with the group. This also allows for material such as group repertory grids to be compiled with constructs relating to the group facilitators included. If members are aware that group facilitators are collecting such material, it may well influence their ability to respond to the grid spontaneously.

In individual CAT, endings can be a painful and potentially anxious time for the therapist. In the group some of this anxiety can be mediated and held by the group experience. The members and the group as a whole are able to share, hold and contain some of the loss and separation difficulties which

emerge. Ending thus becomes something of a shared property, taken on by everyone and not left either with the facilitators or with those individuals prone to carry the painful aspects for others. Interestingly, in the St Thomas's groups there was a strong desire for group members to meet after the group ending, indicating that the ending was not fully dealt with within the group boundaries. Dr Davies' group have avoided an ending by arranging for monthly meetings, and the Guy's group has arranged for a group follow-up rather than individual. This all suggests that there are difficulties in the intensity of the CAT brief group experience that makes dealing with endings particularly intricate. It might also relate to the life experiences of many of the patients referred for these groups, in which there figured a predominance of fragile care or of abuse, neglect or abandonment. Therapists also can have their own personal difficulties with endings.

This all emphasises the importance of having experienced facilitators responsible for brief CAT groups. The anxiety and tensions generated require careful handling and facilitators need to be trained to recognise the varied and complex group processes which take place. It may be that the best way to facilitate these groups is to use co-conductors. This does have resource implications but the ability to establish trust and safety early on in the life of the group would probably be enhanced if two facilitators were present. This is not to suggest that one person could not run a CAT group perfectly well, but rather to note an area for further research.

If brief CAT groups are to be facilitated by therapists with very little or no training, then a training programme built into the experience would be essential. This should include academic input to increase their knowledge and understanding of group processes and the way in which individuals function in a group context. A contemporaneous experience for the trainee group facilitators in a group might also be considered, as well as the possibility of trainees acting as co-conductors with more qualified therapists.

Conclusions

Our emerging research evidence (Duignan and Mitzman, 1994) and current experience described above appear to suggest that this integration has much to offer. It certainly seems that a brief CAT group intensifies feelings and processes which would take longer to unravel in a longer-term group. In a CAT group there is no time to sit back or rest on our laurels, but neither is it always possible in a slow/open group to deal with everything, to take our time and pick our spot either. Overall our impression is that the experience of a CAT group is more probably akin to travelling to America by luxury aircraft as opposed to taking a leisurely cruise on an ocean liner. Whilst the outcome may be something approximately similar, the process will have both advantages and disadvantages and certainly a different purpose and meaning.

To continue the metaphor, piloting a CAT group requires close attention, a strict adherence to boundaries and careful monitoring of interactions. Obviously not all issues touched on will be able to be developed in a brief CAT group, but the limited time-frame clearly helps facilitate an atmosphere in which participants are eager to work quickly. There is an urgency and tension in a CAT group which gives its own flavour, with the intensity bringing out underlying group processes very quickly and members can feel exposed and unnerved. On the other hand, there is much to work with and members are forced to take up difficult and challenging interactions almost immediately. This can be exciting, stimulating and creative, and if the facilitator(s) can provide the safety and containment sufficient to enable a sense of cohesiveness, the enterprise has considerable potential. Whilst we are not proposing it as a *replacement* for longer-term individual or group therapy, we hope we have said enough here to suggest that, for certain patients and for certain problems, brief cognitive analytic group therapy, viewed as an intervention in its own right, may have much to offer.

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6 Early development

Mikael Leiman

My interest in a closer examination of early development has been inspired by my experience of the frequent presence of the patient's non-verbal procedures in the consulting room. Both neurotic and more severely disturbed patients enact such patterns that seem to be more or less articulated. Sometimes they have the structure of a reciprocal role procedure which invite me to play the complementary role. In some cases the pattern is much less clear, creating either a strong feeling in me or sometimes only a somatic sensation.

In object relations theory these phenomena have been described in terms of countertransference and projective identification. While clinically useful, both concepts seem to be limited by their attempt to account for intersubjective processes without articulating how they are mediated; i.e. what happens 'in between'. Countertransference refers to processes that take place in the therapist. Projective identification presupposes the concepts of projector and recipient and describes their interchange that seems to dissolve the separateness of the two subjects. Yet it does not clearly spell out the process that mediates such a merger. If we accept the common opinion of the primitive nature of projective identification, then by studying very early development we might elucidate its peculiarities (Leiman, 1994a).

Another line of interest in very early development has been stimulated by my long-lasting enthusiasm for Vygotsky's theory of sign-mediated activity (Leiman, 1994b). His remarks concerning the problems in defining the object of psychological research are, even nearly seventy years after their publication, still very relevant.

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