CAT Reflective Practice Groups

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Introduction

Over the last ten years I have been adding to the development of the model of CAT in groups for clients (Hepple 2012, Hepple and Bowdrey 2015), I have more recently been asked to run reflective practice groups for doctors in training and for consultants in Somerset. Having participated in traditional Balint groups throughout my training in psychiatry, I already had an awareness of the benefits of this sort of regular reflective practice and was keen to take on this role.

CAT has a strong history of being applied contextually in the context of teams (for example, Annesley and Jones 2016, Kellett et al 2014). Inevitably I began to incorporate CAT into the way I was leading the groups and also to feel slightly ambivalent about the fact that I had moved away from the traditional Balint structure. This paper is really my attempt to describe, unashamedly, the way I now run these groups and to think about why added CAT may be a positive benefit to reflective practice. I think that there is now a need to set out what a 'CAT Reflective Practice Group' can be.

The Rise of Balint Groups

In the late 1950s Michael Balint (1957) started running psychological training seminars for GPs in London. The group is usually 90 minutes long and has one or two leaders or facilitators who traditionally have a psychoanalytic background.

The role of the leader is to maintain the group boundaries and to provide a safe space for reflection. The focus of the discussion is explicitly on the 'doctor – patient relationship' so it is clear that it is not a personal therapy group and there are limits to self-disclosure by participants. It is usual to ask the question: 'Who has a case', at the beginning and then to allow that person to present their case without interruption. Once they have finished the other members of the group are encouraged to discuss the material. The leader will discourage further interrogation of the presenter to enable the other participants to use their own capacity for reflection. The leader would not usually offer educational advice or a formulation of the patient or comment on issues they can see that relate to the presenter or participants.

The Balint Society was founded in 1969 and the International Balint Federation represents national associations in over twenty countries worldwide. There is evidence of the benefit of Balint groups for clinicians (Ludvig-Becker, 1998) and there is interest in expanding the network of Balint groups to doctors in all disciplines, other health professionals and to medical students (O'Neill, 2016).

CAT and the Balint structure

My attendance at regular Balint groups and 'Sensitivity' groups (analytically facilitated staff groups) during my training enhanced my overall training experience and my ability to be in a group, to deal with praise and criticism and to feel part of something, but, there were, from my point of view, drawbacks. On occasions I felt that the leader left us to our own devices too much, resulting in unresolved conflict, endless silences, regression and participants carrying unmanageable feelings for long periods of time; what Tony Ryle has described as the therapist position of 'unself-revealing omniscient interpreter'(Ryle and Kerr, 2002, p.103). If an individual tried to talk about how their own material resonated with a patient being discussed there was sometimes implied criticism that they were inappropriately trying to use the group for their own therapy. Sometimes I felt that the person had not been treated with compassion nor helped to work out where they might get support if not in the group.

Now, as CAT psychotherapist I am fortunate to have my CAT tools and collaborative stance to call upon, so I will naturally run a reflective practice group in a different way, as I think would (do) many CAT therapists.

Adaptations to the Balint structure

The original Balint groups were for experienced GPs who would have made a longer-term commitment to attendance. Running CAT reflective practice groups for other types of clinicians will present challenges and opportunities. For example, I run a group for doctors in training; some doctors are new to psychiatry and are on four month placements, working shift systems and are entitled to compensatory rest, study and annual leave. This can mean that they are only able to attend a handful of groups during their placement. In this situation I have found that I need to be more actively containing in my role as leader. This active containment could be divided into the following functions:

Education / Reformulation / Supervision:

Participants may know little about psychiatry, personality disorder or the links between childhood abuse, and neglect and borderline, narcissistic and histrionic personality trait presentations; most of the cases volunteered fall in to this latter category, understandably, as they generate the strongest enactments and unmanageable feelings in the participants. Working, for the first time, on a psychiatric in-patient unit immerses the trainee in complex systems of contextual enactment in which they can easily end up taking a polarised stance. For example, the commonest issue brought to the group may be summarised as: 'She must take responsibility for her actions. She doesn't have a mental illness. There is nothing we can do for her,' (feelings of anger, futile striving and rejection). Sometimes the whole group will agree with this position and commiserate with each other that psychiatry is no place for doctors who are employed to use their training to treat 'illness'. Now, am I going to sit back and let this group enactment pass without comment, knowing that I may not get another chance to help the trainees think about these crucial issues?

Reformulation of the effects of earlier trauma on adult behaviour can take many forms, from a gentle enquiry to a full blown CAT map with reciprocal role procedures and the naming of the enactment taking place in the room. Even the question: 'Why do you think she is doing this?' or 'What do you think happened in the past to cause all this?' can lead to sudden realisation that the focus is only on present behaviours and not on unmanageable feelings and underlying causes.

Often the participants will not be able to think about the patient's past history even if they have read it in the records. Sometimes the discussion will raise enough curiosity for the participant to go back to the patient and spend some time finding out more about their history.

On occasions I will use the technique I have called 'the microcosm' to unpack words or feelings from the case that is being presented (Hepple 2016). For example, a doctor was deliberating on which of two cases to discuss; one a patient with psychosis and another that clearly elicited stronger feelings. When I suggested that she go with the latter she said: 'I will if I must.' I drew attention to these words and the way that the doctor had (half jokingly) said them in a childlike and resistant way. In later discussion of the case these words turned out to be a powerful SNAG in relation to the client and service and ultimately to the relationship with her mother.

It is not unusual for the session to end with some form of CAT representation of the themes covered; maybe just a reciprocal role or sometimes a procedure.

There will often be recognition of the enactments that draw in professionals and recognition of the dangers of enacting unhelpful top role positions or 'joining the dance'. For example, in a situation where a client is escalating self-harm and eliciting a critical and rejecting response from staff, an exit might be to stay with the distress without offering a quick solution and to provide some containment by seeing the patient empathically and negotiating a way forward that is neither rescuing, punitive nor unrealistic. Less often I will become more explicitly educational where I think that there is a significant gap in knowledge or some important issue to do with risk or safeguarding is being missed. For example: the practicalities involved in a patient disclosing historic sexual abuse and the balance between safeguarding children and protecting the adult survivor.

The feedback on this style of group is very positive and, I think, evidence that a balance can be achieved. A participant wrote this comment on the feedback form:

'Helpful advice about how to deal with psychiatric presentations, differential diagnoses; to think about how they affect you and the way you react to them. Learning to recognise and alter my own behaviour towards patients to be most helpful. Learnt the importance of taking a thorough history and considering how life events affect people. I like how (JH) is non-judgemental and encourages us to be non-judgemental too.'

Managing participant distress:

Working with participants with a wide range of experience, it is important for me to notice, witness and attempt to signpost any distressed participant to appropriate help. As would be the case in a CAT supervisory setting, there is no absolute rule that says all personal material is out if bounds – it is a question of balance. CAT understanding of enactment recognises that the therapist as a person is resonating with the patient and that this is always partly due to qualities and experiences of the therapist. It may help to give a fictionalised example:

A participant came to the group in a regressed and distracted state. It was known by his colleagues that he was having a crisis and individuals already knew more or less of the details. He made flippant comments and appeared disinterested in the normal purpose of the group. I asked explicitly what was going on and it turned out that he has been the victim of a criminal assault some time ago but that the alleged perpetrator had been found not guilty in a Crown Court the week before. Other members of the group empathised with this awful situation - taking the risk of exposure

only to be humiliated and disbelieved. This was a powerful witnessing of his distress (Hepple 2005) and provided an immediate antidote to his experience of being disbelieved. It was not necessary to go into any more details of his past. Colleagues advised him that he might take some time off as they felt he had been distracted at work. Finally I was able to ask his permission to talk to his line manager and to ensure that he had access to the support structures for doctors in difficulty from the Deanery.

Zone of Proximal Development:

According to CAT principles, the activity of the leader of the group will be governed by the ZPD of the group. There are two general factors here: The first depends on the level of experience of the group as a whole. The other group I lead is for consultant psychiatrists. Here I am much more likely to allow extended peer-led discussion of the case presented without the need for intervention. I may offer some 'microcosm' observations or offer a reciprocal role to explain some of the enactment that is going on in the room. For example: When talking about another hospital that seemed to have some questionable practices a participant suggested he should write to the papers about it. I connected this to issues of exposure that had previously come up in the patient's history and this led on to acknowledgement of the fear of exposure for making a mistake in what was a high risk clinical situation.

The second general factor is to do with what is going on in the group that particular day. It is about my duty of care for the participants in the group and the need for me to prioritise what is most important in the work that day.

If a participant is struggling I need to notice this and take balanced action. Clearly this will happen more frequently in a group of inexperienced clinicians but may come up occasionally with very experienced staff.

Basic rules and prompts for running a CAT Reflective Practice Group

- Try to make sure that the participants are a peer group in some way (all senior staff, all trainees, all medical students etc.).
- Consider how long the group should be. 90 minutes may be too long for trainees to be released from their normal duties. Both my groups are 60 minutes.
- Consider the timing carefully so that the group clashes with as little as possible (handovers, educational events, training, other supervision).
- Try to ensure managers, consultants and other staff are on board with the idea of allowing their colleagues this space for reflection.
- Advertise the dates of the group well in advance and communicate any cancellations carefully.
- Expect people to turn up on time and stay for the duration but some flexibility is needed when people are very busy.
- Expect an individual's attendance to be intermittent and don't make them feel unwelcome if they have had to miss some groups. It is optional after all.
- Treat each group as an event and opportunity in itself. With a high turnover of participants the group will not develop much sense of history or continuity.
- Attend to participant's distress in a balanced way and help them to find the support that they need. Sometimes this work is the priority for the group for that particular week.
- Be aware of the group's zone of proximal development and gauge your intervention level based on the overall experience of the participants and the needs on that particular day.
- Ask the question: 'Who has a patient to talk about' as the starting point where possible.
- Be prepared to move between facilitating a peer discussion with very light CAT supervision to being prepared to reformulate the material using CAT tools like procedures, speed mapping and the generation of exits.
- Occasionally more didactic intervention is needed around risk and safeguarding issues.
- I make brief anonymised notes on themes discussed that participants are sent a copy of for their appraisal folders.
- The group is a confidential and a safe space for creative reflection on themes around cases. It is not a formal supervision session and group members and the facilitator should not be quoted in formal records unless this is explicitly discussed and agreed (this may occur when risk or safeguarding issues have led to specific actions).
- Enjoy the experience of meeting and supporting clinicians from a range of backgrounds and perspectives; their experience of the CAT Reflective Practice Group may be an important part of their future development.

Conclusion

I hope that this has been an honest discussion of how I have adapted the Balint structure to incorporate CAT concepts and tools. I am no longer going

to feel guilty that I am not adhering to the traditional Balint structure and feel that, for myself and possibly other CAT therapists and psychotherapists, this format sits more comfortably with the way we practise as therapists and may offer benefits in terms of containment and the speed with which development may occur for the participants. I would be interested to hear from others who have or who are thinking of running CAT Reflective Practice Groups.

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Wounded Healer

Theresa Turner

I'll carry this gaping wound for you
I'll nourish the flesh
And start the healing
I'll bare the pain and keep it safe
So you can go on feeling

I'll embrace this weeping wound for you
I'll make it mine
And hold it tight
I'll stem the flow of blood and tears
So you can bear the fight

I'll love this closing wound for you
Admire its courage
Nurse its soul
Then offer it back when you are strong
A gift to make you whole