Can Compassion Focused Therapy be used for trans-diagnostic groups in a primary care setting?

- Preliminary analysis of a 8-session trans-diagnostic group treatment

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Background

In Sweden, over the last decade, emphasis has been on offering psychological treatment for mental health problems at an early stage before problems aggravate requiring longer treatments (Socialstyrelsen 2010, 2011). This shift has increased the need for treating a number of mental health problems at a primary care level, as well as an increasing need for better competence and methods for treating more complex problems.

Primary care facilities need to offer short-term therapy (6-10 sessions) to a wide range of diagnosis while seeing a maximum number of patients. A trans-diagnostic group therapy is ideal in this setting allowing primary care establishments to offer more people therapy than otherwise possible. Challenges are non-homogenous groups and lack of trans-diagnostic methods that can meet the needs of the patients.

CFT is an integrated therapy based on social, developmental, evolutionary and Buddhist psychology, and neuroscience. CFT has been developed primarily for trans-diagnostic problems linked to shame and self-criticism (Gilbert, 2010).

Questions

- Can CFT be used for brief group therapy interventions in trans-diagnostic groups in a primary care setting?
- What is the expected outcome of such interventions?
- What are the long-term effects on patients' well-being and mental health after group therapy?

Method

A trial of CFT group therapy was conducted at a primary health care facility in Malmö, Sweden. A total of 5 groups (*N*=22) took part in the trial. A sixth group was excluded due to compliance issues and because a stable group (too few participants) and group process could not be established. The group programme was developed based on Paul Gilbert's Compassionate Mind Training programme (Gilbert, 2009). Sessions followed specific themes but were not manual-based and took into consideration the groups' needs, fears and blocks for compassion, as they presented themselves during group sessions. To accommodate the short treatment standards of primary care the programme was shortened to 8 group sessions (2h/session) with 1 individual screening session and 1 final individual session (total 10 sessions). The groups were followed-up at a group level after 3 months. The groups were lead by CFT-trained clinical psychologists Linda Wiik and Jernett Karensen.

Screening tools

The following screening tools were used to assess the participants pre-intervention, post-intervention and at 3-month follow-up.

- Beck Anxiety Index (BAI) (Beck & Steer, 1993)
- Beck Depression Index (BDI) (Beck & Steer, 1996)
- Self-Compassion Scale (SCS) (Raes et. Al, 1996)
- EQ5D health questionnaire (not presented here)
- Fears of Compassion Scale (not presented here)

Group programme

All group participants received an initial screening and assessment session with a brief formulation and introduction to CFT. As well as an individual discharge session setting personal goals for further development.

- **Session 1:** Introduction to the tricky brain and CFT model + imagery practise, soothing rhythm breathing, awareness training
- **Session 2:** Introduction to the definition of Compassion, self-compassion and mindfulness + soothing rhythm breathing, safe place and compassion flowing out
- **Session 3:** Introduction to our emotions, complex emotions, functional analysis of emotions (training to experience different emotions and noticing blocks), soothing rhythm breathing and exercise in mindful awareness towards emotions
- **Session 4:** Multiple selves + soothing rhythm breathing and exercise in approaching difficult emotion (least wanted) with compassion
- **Session 5:** Introduction to Shame, evolutionary perspective on shame, difference between shame & guilt + soothing rhythm breathing and exercise in approaching shame memory with compassion
- **Session 6:** Introduction to Self-criticism, functional analysis of self-criticism, fear of giving up self-critic, exercise in approaching self-critic with compassion
- **Session 7:** Identifying threat-system triggers and compassionate responses, developing a compassionate image, introduction to compassionate letter-writing
- **Session 8:** Recapture course, exercise in loving kindness meditation, sharing compassionate letter, soothing rhythm breathing.

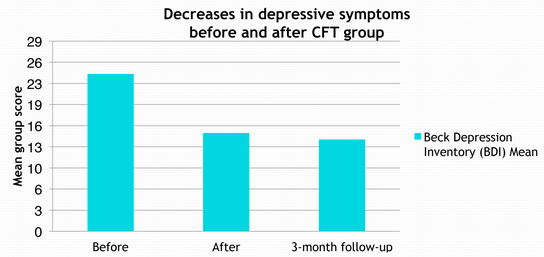
- **Follow-up:** Group session evaluating how the participants were feeling and how they used their new skills

Results

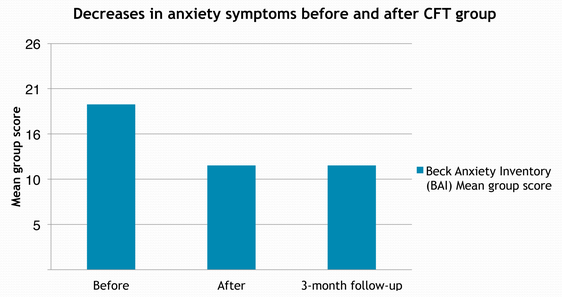
A total of 35 patients out of 42 followed through the therapy, and 23 participated in 3-month follow up. The data collection generated in total 22 complete screening results (before, after + follow-up) presented in the graphs.

The primary assessment of the results are presented in the graphs. The results show, at end of the therapy, an increase in self-compassion (SCS) with a continued increase at follow-up. Mental health improved with decreases in depressive and anxiety symptoms after the group ended. These results were maintained at low levels at follow-up.

Levels of self-compassion was measured with self-assessment SCS Short (Raes et. Al, 1996). Results show a mean group score of 27 before start of the CFT group. After the group it had increased to 34. The greatest change was seen after 3 months of ending the group with an increase to 53.



Upon start of group therapy mean group score was 24 indicating moderate depression. Upon ending the group therapy this mean group score had dropped to 16 (mild depression). In-group variations were greater. At follow-up depressive symptoms had further dropped to 14 (cut-off for minimal depression 13p.)



Upon start of group therapy mean group score was 19. Indicating moderate anxiety. Upon ending the group therapy this mean group score had dropped to 12 (mild anxiety). In group variations were greater. At follow-up the anxiety levels stayed the same.

Discussion

The preliminary analysis of data at group level shows promising results for using CFT in a primary care context for multiple diagnosis. Results show decreases in anxiety and depression and increases in self-compassion for all participants. Most noticeable change is the almost doubling of self-compassion at 3-month follow-up meanwhile anxiety and depression remains at low levels. This may indicate that the group therapy initiated an individual process that continues even after discharge. A number of participants reported how the group and the therapists functioned as internalised support between end of the group and until the follow-up.

Statistical analysis can render further correlations and establish statistical significance. Such analysis can also show clearer individual differences. For example the data contains examples of participants rating their state as worse after finishing the group meanwhile stating that they feel better and are more consciously aware of their feelings and thoughts. The focus in CFT on noticing and staying with suffering may have increased awareness of suffering affecting the self-report. Further analysis would also be able to show differences depending on initial diagnosis and whether this affected the final outcome of the therapy.

Noticeable is a low drop-out rate which has shown to be a problem with mindfulness programmes in primary care settings (Sundquist et al. 2014). The low drop out rate may indicate that the needs of the patients are being met.

This preliminary analysis is not conclusive and further analysis could render more precise data.

Further analysis of the material

Preliminary analysis
- Increase in self-compassion, decreases in anxiety & depression
- Group programme feasiblity on transdiagnostic groups in primary care

Further data analysis
- Further analysis of excluded measures (fear of compassion, EDQ5)
- Statistical analysis on group and individual levels
- Qualitative data analysis
- Comparative research

Possible outcomes
- Treatment guidelines for CFT Group therapy in primary care context
- Therapist skills training programme
- Increased accessibility for therapy and CFT treatment in a primary care setting

Conclusions

In many countries there seem to be a growing need for effective short-term therapies in primary care settings. A larger number of patients with complex problems are supposed to be treated at primary care facilities rather than in secondary care. As the context of primary care has changed the need for research on effective transdiagnostic therapies increases. In addition as more complex cases are shifted from secondary care to primary care the need for specialised therapeutic competence increases. The future calls for research validating therapeutic interventions at primary care level to ensure evidence-based practices.

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