Benefits of group cognitive remediation therapy in anorexia nervosa: case series

Kate Tchanturia · Emma Larsson · Amy Brown

Summary
Background Cognitive remediation therapy (CRT) is a treatment targeting cognitive difficulties in psychiatric disorders. CRT has been used with patients with severe anorexia nervosa (AN) in individual and group formats. Research of group CRT in AN is limited.

Methods Evaluation of a series of CRT groups delivered in inpatient and intensive daycare services was performed. Participants’ self-reported cognitive flexibility and central coherence, as well as motivation to change were assessed pre- and post-group. Additionally, patients’ evaluative feedback was collected after completion of the group.

Results There was a significant improvement in the patients’ self-reported cognitive flexibility and bigger picture thinking, as well as in their self-efficacy to change. The feedback questionnaires highlighted that patients found the sessions useful and reported confidence in using some of the skills and strategies they learnt in the group.

Conclusion In line with evidence from small-scale reports, this larger scale case series study indicates that group CRT leads to increased flexibility and bigger picture thinking, as well as improved confidence in the ability to change for participants. CRT in a group format seems to be a practical and helpful intervention for patients with AN in intensive treatment programmes.

Keywords Anorexia nervosa · Cognitive remediation therapy · Cognitive flexibility · Motivation · Cognitive training · Group therapy

Nutzen einer Gruppenintervention zur Förderung der kognitiven Fähigkeiten (Cognitive Remediation Therapy) bei Anorexia Nervosa: eine Fallserie

Zusammenfassung
Grundlagen Die Kognitive Remediation (Englisch: Cognitive Remediation Therapy, CRT) zielt auf die Behandlung kognitiver Schwierigkeiten bei psychiatrischen Störungen. CRT wurde bisher bei Patienten mit schwerer Anorexia Nervosa (AN) im Individual- und Gruppenformat eingesetzt. Die Forschung zur CRT im Gruppenformat bei AN ist jedoch begrenzt.


Ergebnisse Es zeigten sich signifikante Verbesserungen in kognitiver Flexibilität, zentraler Kohärenz und Änderungsmotivation. Die Patienten gaben zudem an, die Sitzungen als nützlich empfunden zu haben und zuversichtlich zu sein, einige der erlernten Fertigkeiten und Strategien auch im Alltag umzusetzen.

Schlussfolgerung In Übereinstimmung mit kleineren Fallstudien legt die aktuelle, größer angelegte Fallserie nahe, dass die Teilnahme an einer CRT-Gruppe mit...
gesteigerter kognitiver Flexibilität und verbeserter zentraler Kohärenz sowie mit einer Zunahme der Ände-
rungsmotivation einhergeht. CRT im Gruppenformat erscheint somit als machbare und hilfreiche Interven-
tion im Rahmen intensiver Behandlungsprogramme für schwere AN.

Schlüsselwörter Anorexia nervosa · Kognitive Remedia-
tionstherapie · Kognitive Flexibilität · Motivation ·
Kognitives Training Gruppentherapie

Introduction

Anorexia nervosa (AN) is a life-threatening psychiatric
disorder with high levels of functional and social impair-
ment [1]. The high morbidity and mortality rates associ-
ated with the illness [2, 3] emphasize the critical need to
develop tailored, evidence-based treatment interven-
tions. Over the last few years, focus has started to shift
from behavioural eating disorder symptoms to the “big-
ger picture” of recovery; addressing broader goals for
patients and providing strategies for reconnecting with
life outside of their eating disorder.

In the context of wellbeing and recovery, cognitive
factors play a critical role. During the last 3 decades,
research into cognitive styles [4, 5] and its importance in
treatment have been actively explored. Cognitive training
has been found to hold promises for personalized care of
individuals in numerous mental illnesses, as well as been
a target in the development of behavioural interventions
[6]. A key clinical intervention targeting thinking styles,
with growing empirical support, is cognitive remediation
therapy (CRT; for review see [7]). CRT is an easy to deliver,
manualised treatment, tailored to target problematic
thinking styles (for details of the manual see http://www.
katetchanturia.com-publications; for current research
evidence see [8]). CRT addresses the processes of thought
rather than content. The treatment package includes a
large number of specific cognitive exercises developed to
practice cognitive flexibility, attention switching, multi-
tasking and bigger picture thinking, as well as including
tasks where a less perfectionistic (estimation) approach
is required. After completing cognitive tasks jointly with
the therapist, reflection takes place—this is a very impor-
tant element as it helps patients to see the links between
the exercises and examples in their daily life [8]. CRT is
delivered in a motivational way and the collaborative
approach creates easy dialogue between patients and
therapists.

The individual format of CRT is actively researched in
the field of eating disorders and even more in other dis-
orders (e.g. see systematic reviews in patients with tra-
matic brain injury [9], epilepsy [10], attention deficit [11]
and schizophrenia [12]). Evidence to date shows that CRT,
delivered in an individual format, is beneficial to engage
less-motivated patients in treatment [13]. Crucially, it
improves cognitive performance and some evidence
suggests that it contributes to improvements in quality of
life. Moreover, patients and therapists rate the interven-
tion highly beneficial (for systematic review of the litera-
ture in eating disorders see [7, 8]). In psychosis literature,
its been clearly demonstrated in randomized treat-
ment trials that patients who went through remediation
programmes had significantly better employment rates
and better functioning compared to those who did not
receive CRT [14]. Whereas in the field of eating disorders
more research is needed to explore associations between
improved cognitions and quality of life [15, 16].

Unlike individual CRT for AN where several case series
and three published randomized treatment trials (RCT)
are available [16–18], CRT in a group format is less sys-
tematically researched, although small pilot studies have
been conducted with positive results [19–24]. Since the
first pilot work of CRT in a group format [24], five peer-
reviewed studies have been published to our knowledge,
with significant differences between the studies (in terms
of number of sessions, number of participants, outcome
measures). Importantly, they have all presented poten-
tial benefits of the intervention.

The original study conducted by Genders and Tchan-
turia [24], investigated the effect of group CRT on patients’
self-reported motivation and cognitive styles after four
weekly sessions. Significant changes were observed for
the participants’ motivation, in terms of their self-rated
ability to change. Similarly, Pretorious and colleagues
investigated the effect of four weekly session of group
CRT in an adolescent sample. The authors did not find
significant changes, however their effect sizes indicated
small improvements on the Cognitive Flexibility Scale
(CFS) and the participants’ importance to change (Moti-
vational Ruler subscale) [22].

Two studies investigated the effect of group CRT over
ten sessions [21, 23]. It was observed that participants
appeared more aware of individual cognitive deficits
after completing the group and noticeable improvements
were found on performances on some tasks during the
course of the treatment [23]. Additionally, the authors
reported positive evaluations from patients and facilita-
tors, and patients were able to reflect on their thinking
style more post-treatment, as well as tolerating own
mistakes [21]. Due to the small sample size no statistical
analysis was conducted.

Group CRT for AN in a guided self-help format deliv-
ered in collaboration with carers was recently explored
in a pilot study [19]. The study reported overall posi-
tive feedback from qualitative interviews, as well as an
improvement on both patients and mothers neuropsy-
chological performance after treatment with small to
large effect sizes. In a French study—[20], Asch and col-
leagues reported improved scores on various neuropsy-
chological assessments after 10 weekly group sessions of
CRT for the two remaining inpatients participating in the
study. Across the literature evaluating CRT in a group
format, there is agreement on the positive feedback received
from patients, clinicians and carers [25]; however, more
formal evaluation and research is needed.
The key purposes of this study were (a) to examine a larger case series of CRT groups delivered in adult inpatient and daycare services for AN with self report measures, (b) to evaluate feedback from study participants and (c) discuss possible future developments and how to generate further evidence for group CRT work.

Methodology

Participants

Participants had a The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of AN and were part of the intensive care programmes in the South London and Maudsley NHS Foundation Trust (SLaM). All participants in this study were females. Ethical approval for the study was granted by the local ethics committee (reference 05/Q0706/315). There were no specific inclusion/exclusion criteria as the sample was from a clinical programme including all patients who were females, receiving treatment in the specialist eating disorder service with a diagnosis of AN on admission. Participants at all stages of the treatment programme and recovery were invited to attend the group. All participants received other clinical input during the treatment, including nutritional, medical, individual therapy and therapeutic groups as part of the inpatient programme.

Self-report measures

Detail and Flexibility Questionnaire (DFlex) [26]

A 24-item questionnaire measures cognitive rigidity and attention to detail on a 6-point Likert scale ranging from one (strongly disagree) to six (strongly agree). The measure is scored across two subscales, cognitive rigidity (e.g. “When others suggest a new way of doing things, I get upset or unsettled”) and attention to detail (e.g. “I can get hung up on details when reading rather than understanding the gist”), where the clinical cut off for the cognitive rigidity subscale is 53 and above, and greater than 44 on the attention to detail subscale. The authors reported high internal reliability with a Cronbach’s alpha of 0.88 and 0.91 for the “attention to detail” and “cognitive rigidity” subscales, respectively. The measure also displayed a good construct validity (moderate to large correlations) and discriminant validity when compared with similar subscales of the Autism Quotient [27]. In the current study, the overall Cronbach’s alpha coefficient was 0.94.

Cognitive Flexibility Scale (CFS) [28]

A 12-item questionnaire assesses the participants’ perception of the options and alternatives available to them in everyday situations. The scale gives a total score between 0 and 72, with higher scores representing greater cognitive flexibility. The authors reported good test-retest reliability by displaying a correlation quotient of 0.83 in a student sample [28]. The measure has been less used in clinical populations. In the current study, the overall Cronbach alpha coefficient was 0.54.

Motivational Ruler (MR) [29]

A 2-item self-report measure assesses participants’ importance and ability to change. The scale ranges from 0 to 10 with higher scores indicating greater importance or ability, respectively. This scale was used in previous evaluations of the individual and group work.

Feedback questionnaire

The patients were also given a feedback form in the last session. The questionnaire first asked patients to rate on a 5-point Likert scale how much they enjoyed the sessions, how useful the sessions were, whether they had learnt any new skills and what they thought about the length of the group. In addition, there were three open-ended questions asking patients what they liked most about the sessions, what could be improved and other groups they had attended.

The cognitive remediation therapy groups

The outcome data was collected from 20 CRT groups facilitated in inpatient and intensive daycare services for patients with AN in 2010–2015. The typical admission criteria for these programmes are low weight and psychological problems which are difficult to manage with only weekly outpatient appointments/sessions. CRT groups are also named “Flexibility workshops”—a title suggested by patients in previous groups with the rationale that workshops sounded more engaging. CRT groups and “Flexibility workshops” have the same content but for the consistency with existing literature we will use the term CRT groups in this manuscript.

All sessions include the following elements: psycho-education, practical exercises, reflection and discussion, as well as planning of homework tasks and challenges to try outside the group. The facilitators aim to take a motivational and collaborative stance, for example, facilitators take part in all the group exercises and discussions. We explore the different thinking styles of the group members, highlighting that there are no right or wrong ways of thinking, but pros and cons for each. The first session involves information and current research findings about the brain, thinking styles and what research tells us about cognitive styles in eating disorders. The following sessions focus on bigger picture thinking, switching and multitasking. The last session involves creating mind maps (summarizing the group) and relating the group content to the bigger picture of recovery. The groups are designed to be delivered by multidisciplinary staff mem-
Qualitative data

Thematic analysis as described by Braun and Clarke (2006) was used to analyse the feedback questionnaires and to identify themes. First and second authors coded and organized responses and created tables with most common themes. Calculations were made on frequencies to demonstrate the proportion of patients highlighting the same point in the open-ended questions.

Results

Patient characteristics

The mean age of the participants was 26.3 (range 17–59). The mean body mass index (BMI) at the first session was 15.6 (range 11.6–19.4). Of the individuals 7% were in the severe and enduring range of AN (BMI < 13); 32% had severe AN (BMI between 13 and 15); 40% were in the AN range (BMI of 15–17.5) and the remaining 21% of the individuals were in the underweight range (BMI between 17.5 and 20). Participants at all stages of the treatment programme were invited to take part in the groups, thus a proportion of patients would have restored weighed before starting CRT. Overall weight gain was significant ($p < 0.001$, $d = 0.3$) presenting a mean BMI of 16.1 at the last session.

The majority of the patients were diagnosed with either restrictive AN (70%) or AN binge-purge (22%), with the remaining participants having a diagnosis of, EDNOS or atypical AN. The mean age of onset was 16.8 years (SD = 4.9), and the mean duration of illness was 9.7 years (SD = 7.5). Of the patients 42% received individual CRT in addition to the group.

Cognitive flexibility and motivation to change

Mean scores, standard deviations and results from t-tests, including effect sizes, on all outcome measures after the first and last sessions are displayed below in the Table 1.

Data analysis

Paired t-tests were conducted on the scores from each of the outcome measures from the first and final sessions using SPSS version 22. Cohen’s d effect sizes were computed for the pre- and post-measures. There was a 39.5% drop out from the group; this was due to various reasons (e.g. discharged from clinic prior to the end of the group, failed to complete the last set of questionnaires). Out of the total participants, 21 participants had not completed the questionnaire at the beginning of the group. Thus, only the remaining 98 participants who completed both time 1 and time 2 of at least one outcome measure (at the first and last sessions) were included in the analysis. Number of participants varies across outcome measures (DFlex = 42, CFS = 77, MR = 98) due to variation of outcome measures used in the clinical audit over time.

Patient feedback

Figure 1 displays patients’ mean scores on the feedback questionnaire. The means suggest that the patients found sessions useful, enjoyable and have used some skills and strategies learnt in the group. When asking about the length of the group, the mean suggests that the patients thought it was “just right”, although approaching the group being “too short”.

Patients’ feedback was collected in three open-ended questions in both inpatient and daycare programmes in order to further improve group content and delivery.
Benefits of group cognitive remediation therapy in anorexia nervosa: case series

The results indicated that there is a significant improvement on the patients’ self-perceived cognitive flexibility and bigger picture thinking. This is an important finding as patients with AN often have difficulties with their cognitive flexibility and bigger picture thinking [4, 5, 30], which is thought to contribute to the maintenance of the disorder [31].

In addition, consistent with previous literature [24] patients rated their ability to change higher after completing the CRT group, suggesting an increase in the patients’ self-esteem and confidence in the recovery pro-

Table 2 Synthesis of feedback from patients: CRT elements patients liked the most are organized in themes with examples

<table>
<thead>
<tr>
<th>Interactive and practical elements</th>
<th>Knowledge, reflection and relating it to real life</th>
<th>Approach to group/relaxed atmosphere</th>
<th>Sharing</th>
<th>Group facilitators</th>
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</thead>
<tbody>
<tr>
<td>Out of the 54 responses in this theme, 37% of the patients commented on games and interactive elements of CRT as a positive aspect of therapy:</td>
<td>From the 18 comments in this category, responses included learning about different thinking styles (44%) and real-life applications (39%)</td>
<td>All eight comments in this category highlighted the relaxed atmosphere (100%). The majority of the patients felt that this group was very different from other groups which are more focused around illness symptoms. Examples:</td>
<td>There were 16 comments which included sharing thoughts and experiences with the group. Examples:</td>
<td>About 35% of responses in both programmes included comments about group facilitators (facilitators names removed). Examples:</td>
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<td>Games and tasks- kept me from switching off</td>
<td>Tasks relate to real life. They are objective but not subjective</td>
<td>The “safe space” given for people to talk about rules/ routines. Also hearing suggestions from other people including group facilitators</td>
<td>They were interesting and also fun. I learnt things about myself. The staff were lovely</td>
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<td></td>
<td>Applying things learnt to our eating habits</td>
<td>The approach to the group and the atmosphere it created. People felt comfortable to input their thoughts</td>
<td>Sharing ideas with peers. Provision of “food for thought” and reflection</td>
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<td>The mixture of light-hearted exercises which</td>
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<td>Session leaders were very knowledgeable and welcomed our thoughts and feelings. They were very understanding and gave us a very clear idea about what expectations we could reasonably have as a result of the workshop</td>
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<td>It was brilliant! Very engaging every week</td>
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<td>The light heartedness sometimes with exercises and games</td>
<td>Thinking about introducing flexibly into my daily life. Not forced to talk. Liked the “quotes” handout, with positive affirmations on it</td>
<td>The gaining of a larger perspective on things and being able to zoom out and see the bigger picture</td>
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<td>The games that got me trying new things</td>
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<td>Games—positive distraction and example of flexibility</td>
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<td>Of the patients’ feedback 30% included positive aspect of interactive elements of CRT:</td>
<td>The incorporation of tasks, it was not all passive. The group was small, therefore it was easy to talk and contribute</td>
<td>The practical activities we did in the session, the different tasks we were given for homework, interacting in a group. Sharing 30% of the responses had component of having fun:</td>
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<td></td>
<td>Interactive games and visual images, well organized, fun, not too serious</td>
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<td>Doing activities took my mind off of thoughts after lunch</td>
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<td>Being practical and being able to see links between behaviour and thought patterns. I liked coming away with something practical to work on during the week</td>
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<tr>
<td>The practical activities we did in the session, the different tasks we were given for homework, interacting in a group. Sharing 30% of the responses had component of having fun:</td>
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<td>Interactive games and visual images, well organized, fun, not too serious</td>
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<td>Feedback is summarized in Tables 2 and 3. Due to large amounts of qualitative data, we have provided main themes and some illustrative examples from the patients’ responses on the open-ended questions.</td>
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</table>

Discussion

Previous research has found positive feedback and potential benefits of group CRT. Results from this study replicate most of the previous CRT findings within a larger sample. The results indicated that there is a significant improvement on the patients’ self-perceived cognitive flexibility and bigger picture thinking. This is an important finding as patients with AN often have difficulties with their cognitive flexibility and bigger picture thinking [4, 5, 30], which is thought to contribute to the maintenance of the disorder [31].

In addition, consistent with previous literature [24] patients rated their ability to change higher after completing the CRT group, suggesting an increase in the patients’ self-esteem and confidence in the recovery pro-
The positive feedback elicited from patients on the feedback questionnaires highlights the wide acceptability of the treatment. Patients generally found the group positive, and the feedback from the group indicated that the majority of patients found it helpful. In particular, patients liked the fun interactive nature of the group, as well as learning about different thinking styles and how they have an impact on their life. The positive feedback and acceptability of the intervention is promising, as poor treatment engagement is a common problem in existing psychological therapies for AN [41].

This study has some strengths worth mentioning. It is the largest case series reported in CRT group format in AN to date. In addition, the current study for the first time used DFlex as an outcome measure which seems to capture changes in both targeted cognitive areas, for example cognitive flexibility and central coherence (detail vs. bigger picture thinking). Patients’ feedback reported here will inform future studies about patients’ needs and ideas to develop the group further.

This study has a number of limitations worth addressing in future studies. One of the main limitations is the absence of a control condition. It is also important to note that all patients who took part in the CRT groups

Table 3 Synthesis of patients’ feedback on suggested improvements, presented in themes with examples

<table>
<thead>
<tr>
<th>Duration</th>
<th>Content/activities</th>
<th>Homework/handouts</th>
<th>Application</th>
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<tbody>
<tr>
<td>From 28 responses, 89% of patients commented that they felt it would have been beneficial to have more. Examples illustrating the theme: More sessions and info regarding CRT</td>
<td>This category varied but from 16 comments, the common themes were a larger variety of practical elements (38%) and more practical elements in the group (45%). A different variety of tasks if it is with the same people so it doesn’t feel repetitive More interactive things Do more practical tasks. Maybe bring in something from home life, college or work and try to solve the problem in the group using tasks discussed in sessions i.e. multitasking making an important phone call I enjoyed a wide range of activities involving mixed media, such as videos, and doing group activities. Perhaps just carry on with doing these</td>
<td>From 14 comments, about 40% of the patients felt the need for more homework, examples from this category from patients quotes include: More homework, reminder of choice, include real-life situations More information such as handouts of each session so you can refer back to them again More handouts of flexibility. More tips and help on how one can include flexibility into our lives, and highlight the benefits of doing so</td>
<td>This category was less presented in the qualitative feedback (two comments) however we included some examples from patients’ feedback: To apply different thinking styles to scenarios during the group and to highlight the consequences of too rigid/ flexible thinking More solid ideas about flexibility and ways to be flexible</td>
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<td>Run them more often and longer More sessions please—8 instead of 4 It needs to be carried out on a more regular basis e.g. 8 week-cycles Could also set people specific challenges each week Extend length of program, handbook of useful tips and practical tasks</td>
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CRT cognitive remediation therapy
also received other clinical input during the same time, including other therapeutic groups. It is also worth mentioning that a proportion of patients were weight restored before starting the intervention. As all patients were admitted to a national specialist eating disorder service due to the severity of their disorder, we decided to include patients at all stages of the treatment program. In this study, the relatively late age of onset, comorbid conditions and medication effects were not explored.

In the context of outcome measures, there is always a challenge around which outcomes are most relevant and robust to capture change in the evaluation of psychological work. As CRT predominantly addresses process of thinking, the cognitive domain was identified as the primary outcome in this study. We used DFlex [26] for the first time to evaluate self-perceived cognitive style. Previous literature [22, 24, 42] have used Cognitive Flexibility Scale (CFS) [28] which measures only cognitive flexibility and had a low Cronbach alpha in the current study. Unlike individual CRT work, where CFS has been shown to be sensitive for change [43], this has not been supported in the group evaluation studies, suggesting that CFS may only be effective in assessing change in individual work with longer duration (ten sessions).

Neuropsychological assessments would have been beneficial to evaluate the full effect of group CRT on cognitive variables; this would also aid the comparison between group data and individual format CRT, although it requires resources and time. Patients’ feedback was presented for illustrative purposes in the current study, additional qualitative studies would be beneficial for the further development of the CRT group protocols.

Conclusion

Group CRT is perceived subjectively effective for patients with AN and results indicate it improves cognitive processes during treatment. The current exploratory case series found improvements in the participants’ self-reported ability to change and provided further ideas for protocol development (e.g. bigger dose, more skills based exercises, homework). Improvement in self-evaluated cognition, confidence and increased motivation are important factors in the recovery journey. Cognitive inefficiencies are one of the maintaining factors of AN, thus patients have appreciated addressing it in parallel with nutritional rehabilitation. Increased confidence and motivation facilitates translation of cognitive changes in everyday life and CRT in group format demonstrates promising findings in this direction.

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Compliance with ethical standards

Conflict of interest

The authors declare no conflict of interest.

The patient data had been collected as part of routine clinical practice on the EDU; ethical approval was granted by an NHS Research Ethics Committee. Patients had been informed and consented about the study.

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