

Title:

**A Cognitive Analytic multicomponent psychotherapy program, for the treatment
of severe personality disorders in an Intensive outpatient Unit.**

Authors:

Mirapeix, C (*); Landin, S (); Alvarez, V (***)**.

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(*) Carlos Mirapeix. Psychiatrist, Director of the PDU.

(**) Susana Landin. Psychologist. PDU Clinical and research coordinator.

(***) Violeta Alvarez. Psychologist. PDU Training coordinator.

INTRODUCTION

The Cantabria Personality Disorders Unit (www.utp-cantabria.org) emerged as a result of the recommendations made by the experts committee for the evaluation of mental health needs in our Region for the next 5 years. They concluded that: usually interventions with this type of severe disordered patients were either inadequate or insufficient. PD are undertreated and their needs require a complex therapeutic program. The fact that the delivery of treatment need a highly specialized service was the reason for asking our Institute to run and design an intensive outpatient Unit. Our group has been working in the area of PD during the last few years (Mirapeix 1996, 1999, 2000, 2002, 2003). We build up in the public sector a specialized, cognitive analytic multicomponent and integrated treatment program, where the coherence derived of a basic theoretical frame of reference, is sustained in the cognitive analytic developments, and also supported in the bio-psycho-social model as a longitudinal integration between different levels and the schema theory as transversal integration at the psychological level. These longitudinal and transversal integration, is supported in a complex revision of the procedural sequence model into a multilevel (sequential and parallel) information processing theory that will be published elsewhere.

Severe personality disorders needs a coherent and specialized treatment team, with a coherent theory, shared training and supervision and must be integrated with other services of the mental health network. Due to the fact of the high emotional demands working with this patients, one of our specific characteristics is that all therapists in our Unit are dedicated part time. We are also developing a research program linked to the Social Psychiatry Research Unit (World Health Organization) directed by Prof. JL Vazquez-Barquero.

Our Unit is designed to treat 60 new patients every year and the length of treatment it varies between 6 and 18 months.

SOCIODEMOGRAPHIC AND CLINICAL FEATURES

At 31th of August, after 5 months of the official allocation into the new facilities and after a previous pilot phase of 1,5 years, we present some basic sociodemographic and clinical data.

The total number of patients at that date are 53 patients and their characteristics are summarized in the following table:

Insert here table 1

The basic profile of a patient in our Unit, is a medium age single women, with borderline personality disorder, that has been treated as inpatient during the last year usually for a suicide attempt, with a personal history of physical, psychological or sexual abuse.

REFERAL CRITERIA

As an intensive outpatient unit, is a third level resource for specialized treatment. Is not open to the general public and GP's can't refer directly patients to the Unit. Only specialized teams leaded by psychiatrists or psychologists can refer patients to our service.

For being referred to the unit the patient must accomplish the following criteria:

Inclusion criteria:

- Patients whose ages are between 17 and 45 years old.
- Patients must present a personality disorder as principal diagnosis. Its better they belong to Cluster B, specially with borderline personality disorder.
- With GAF as severity index. In this scale it's necessary that patients reach marks between 41 and 60.

Exclusion criteria:

- Patients who suffer active psychosis.
- Organic and/or toxic psychopathology.
- Low intellectual level.

- Drugs consumers without simultaneous treatment in a specialized Center and 6 months of drug free consumption.
- Psychopathic Personality features without high motivation for their treatment.
- Auto or heteroaggressive behaviours which require hospital treatment.

THEORETICAL BACKGROUND

Despite de complexity of different formats of therapy used in our program (individual, group, family and couples therapy), all of them shared a common understanding of the basic process under a Cognitive Analytic Therapy background (Ryle and Kerr 2002). We have introduced some innovations to bridge the gap between inner object relations and more directive interventions devoted to train skills in order to preserve alive the patient. Severe personality pathology, requiere a theoretical framework that gives sense to all the complex interventions, and the team must share a common language in order not only to understand the patients, also to potentiate the sinergy between formats, avoid collusion and splitting within the team.

Why a multicomponent program?:

- An authentic bio-psycho-social integration is needed to properly treat complex PD
- Medication as a tool to regulate homeostasis for increasing effectiveness of psychotherapy (Patients gain accessibility to a better data processing).
- It requieres different formats of psychotherapy (individual, group, family and couples).
- Socioterapy is also needed as a rehabilitation component for very disturbed patients.

Why cognitive analytic?:

- A bio-psycho-social integration is at risk of being a technical eclecticism without a guiding theory.
- CAT gives the theoretical support to understand not only the pathology, also acts as a guide in developing the “individualized treatment program” at a Bio-psycho-social level.
- Helps to understand the “sequential strategic treatment program”.

- Makes sense of team and institutional dynamics. The use of Contextual reformulations.

CAT understanding gives the theoretical support to explain the pathology and acts as a guide in developing de "individualized treatment program" at the bio-psycho-social level. A pill, could be interpreted by the patient in a very different ways, inner processes and RRP's clarify the integration of the medication within the patient inner world and in the treatment context. Also CAT theory helps us to understand the "sequential strategic treatment program". The incorporation to the group programs, are not standardized, we individualized the sequence, based in a broad understanding of the sequence in the complete program. Finally CAT theory and diagramatic technology helps to make sense of the team and institutional dynamics with the use of contextual reformulations.

One of the characteristics of our program, shared with Susan Clarke's one, is that we use Linehan's Dialectical Behavioural Therapy technology. The big difference is that Sue Clarke model use a sequential approach of CAT and DBT, while we use both in an integrative package with a theoretical support on CAT procedural sequence model, re-formulated into a complex system of information processing.

Linehan's groups have proved its efficacy in helping patients to controll self destructive behaviours. They promote an increase of self care and improve the external behaviour of patients, while CAT is working with the internalized roles that gives sense to the inner world of the patient as well. Both CAT and DBT work on emotions as the central element, CAT introduces an individualized analysis of the sequential information processing. Multilevel data are processed in parallel by hidden units, personal schemas that with the interaction with other events (internal or external) activate specific states of mind, that often shift and are explendidly explained by the multiple self states theory of BPD developed by Ryle (1997). The identification of the shifting sequence, the regulation of emotional process are a basic component to treat severe personality disorders, that might be characterized by the lack of the individual's ability to regulate emotional intensity and shifting between self states.

Recent developments of Semerari (2003) theory of metacognitive disfuntions on severe personality disorders are being very useful in order to describe more accurately

this complex area of metacognition. BPD have disrupted metacognitive capacities that interfere in their lives and therapy, and produce severe symptoms like impulsivity or dissociation. Metacognitive function is defined by the capacity of individuals to make heuristic cognitive operations on their own and other people's psychological behaviour, and the capacity to use this knowledge to solve problems and to cope with specific mental states which are a source of subjective suffering. We believe that the increase of the metacognitive function represents an important *therapeutic factor* in psychotherapy, closely connected to the stability of the improvements (Semerari 2002). The author, use a very similar description used in CAT, for defining metacognitive processes, these implies regulation and control which include activities such as: defining a problem, being able to predict one's own performance, planning a cognitive activity, foreseeing the efficacy, monitoring the processes and adjusting them according to the aims that want to be achieved.

To have a metacognitive competence one needs to have a *Theory of Mind* (ToM) meaning *the capacity to represent to oneself mental events, to attribute to oneself and to others mental states and to foresee and explain the manifest behaviour on the basis of these representations* (Semerari 2002)

Some very disturbed patients with a high deficit in this metacognitive functions need a prior training in improving their ability to complex data processing before entering in a formal psychotherapeutic protocol. We are developing a specific module as a subprogram in our multicomponent approach.

THERAPEUTIC STRUCTURE

Treatment goals are: 1. Stabilisation of high risk behaviour; 2. Improvement of interpersonal and self-management skills; 3. Generalisation of new behaviour over time and in different contexts.

Our cognitive analytic multicomponent psychotherapy program are integrated by the following subprograms:

1.- Evaluation and Psychopaedagoie

- Welcome to the Unit, evaluation of risk behaviours and information about norms. Allocation of the patient to the evaluation program or simultaneous assignment to brief containment psychotherapy.

- Structured individual evaluation (4 sessions: psychiatric, psychologic (2) and social evaluation). Using structured instruments for research purposes.
- Patients psychopaedagogie (5 sessions covering the following topics: understanding Personality Disorder, General Schema Theory, states of mind and self states, understanding and managing high risk behaviors).
- Families psychopaedagogie (5 sessions, covering similar topics).

This phase is highly motivational and guided to promote introspection.

2.- Individual psychotherapy:

- Brief containment psychotherapy: only used in those patients in wich risk behaviours need immediate intervention to increase self-management. Supportive, paedagogic and CAT oriented to identify self destructive procedural sequences.
- Long term individual CAT: weekly sessions, high risk behavior prevention and containment, working for stablishing a case re-formulation, SSSD'r, and setting goals that would be re-evaluated every 6 months. Core schemas, reciprocal roles, significant points in early history, multiple self states, sequential diagramatic reformulations are used as tools within and outside therapy.

3.- Group programs:

- CAT group: weekly, emphasis in sharing disfunctional patterns of interpersonal relationship, reciprocal role procedures, shifts in states of mind and diagramatic reformulations. All of them could be shared in a paper screen with the entire group without using group reformulations as usual tool.
- Operational group: weekly, directive group inspired in DBT technology for teaching skills for self care. Adapted and transformed from Linehan's model, and integrated in our theoretical model, it incorporates reciprocal role understandings of skills training.
- Families Group (biweekly, advanced understanding of Severe Personality Disorders, communication skills training, symptoms and disruptive behaviours management, support, selfhelp).
- Family and couples therapy under a CAT perspective, when it is needed.

4.- Other interventions:

- Medication control, at least 20' a month.
- Socioterapy, leisure activities, working with the community, prelaboral training.
- 16 h phone accessibility program (8 am to 12 pm). Staff is trained in managing suicidal crisis and skills coaching, in order to decrease suicidal behaviour and increase generalisation of skills training, as well as the sense of containment.

These complex program needs an intense team group work. We meet weekly, planning general strategies for case management, searching for synergies between the programs and avoiding confusing, contradictory or splitted sources of information.

FINAL COMMENTS

We are very early in the development of our program, and we have a large amount of questions to be resolved. I want to share some of our concerns.

- **Clinical level:**
 - How to incorporate temperament dispositions that are genetically determined, as: risk avoidance, novelty seeking, dependency on reward and persistence (Cloninger)
 - How to deal with metacognitive disfunctions (Fonagy, Semerari)
 - We need to include a severity index for strategic planning.
 - The role of the case manager and the individual therapist.
 - CAT groups could be very emotional and overwhelm patients with low processing capacities.
 - Trauma group, still unstructured, focused on actual symptoms associated to past or present abuse, reorganisation of the trauma experience,
 - Post-Traumatic Stress Disorder interventions within a CAT framework.
 - Operational groups (DBT inspired) incorporate reciprocal role understandings of skills training need a more sophisticated development.
- **Research:**
 - The problem of randomization
 - Selection of Internationally accepted instruments
 - Inter-rater reliability of case formulation in CAT
 - Meassures of therapist adherence to treatment.

- Should we move to an international research group on CAT for PD.

- **Training and team support:**
 - Are all therapist prepared to treat severe PD?.
 - Therapist in our Unit “must” have a personal therapy.
 - Audio and video taped sessions in order to guarantee basic homogeneity in applying therapy.
 - Therapist must be supported by an intensive group work.
 - External supervision is needed

BIBLIOGRAPHY:

On request to c.mirapeix@utp-cantabria.org

Table 1

SOCIODEMOGRAPHIC DATA	
AGE	
Media	30 years
Range	18-44 years
SEX	%
Men	32.5
Women	67.5
CIVIL STATE	%
Single	62.5
Married	27.5
Divorced	10
CLINICAL DATA	
PERSONALITY DIAGNOSIS	%
BPD	67.5
Mixed	20.0
Others	12.5
PARASUICIDE BEHAVIOUR DURING THE PAST YEAR	%
Yes	57.5
No	42.5
TREATED AS INPATIENT DURING LAST YEAR	%
Yes	62.5
No	37.5
PREVIOUS PHISICAL OR PSYCHOLOGICAL ABUSE	%
Yes	42.5
No	57.5
HISTORY OF SEXUAL ABUSE	%
Yes	30.0
No	70.0