Basal Exposure Therapy (BET)

Attachment based treatment for severely disturbed and mentally ill in-patients

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Themes

1) Introduction: the history and background of BET
2) The BET patients: characteristics, examples
3) Pilot data: BET time-series (aggregates)
4) The BET model: principles, the treatment process
5) Final comments: future perspectives on BET in relation to DMM
6) Questions?

Basal phobia

An impending fear of dissolving, falling to pieces or being engulfed in eternal emptiness or pain

(the experience of a fundamental existential threat)
The BET patients: Characteristics

- Severe generalised, psychological and psychosocial dysfunction (GAF < 30)
- Self-harm and suicide attempts
- A wide range of severe symptoms associated with both Axis I and Axis II disorders
- Delusions, hallucinations and disassociation
- Extreme levels of pathology and fluctuating symptoms with several and shifting diagnoses
- They use a cocktail of various medications
- Despite cost-intensive treatment efforts they remain low functioning

CASE 1: Female, age 28

Diagnoses prior to BET
- 307.51 Bulimia nervosa
- 309.81 Posttraumatic stress disorder
- 298.4 Psychogenic paranoid psychosis
- 300.15 Dissociative disorder or reaction, unspecified
- 298.9 Unspecified psychosis
- F 25.2 Schizoaffective disorder, mixed type
- F 43.1 Post-traumatic stress disorder

Diagnoses when transferred to the BET ward
- F 25.2 Schizoaffective disorder, mixed type
- F 63.3 Emotionally unstable personality disorder
**CASE 2: Female, age 23**

- F 25.1 Schizoaffective disorder, depressive type
- 2 years of hospital treatment prior to BET
- 7 months of in-patient BET treatment
- Discharged April 2010

**CASE 2: psychometric screening**

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Admission</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI (SCL-53)</td>
<td>133</td>
<td>59</td>
</tr>
<tr>
<td>PANSS Delusions</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>PANSS hallucinations</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>PANSS passivity/apathy</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>PANSS impulse control</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Scid II Dependent PD (8)</td>
<td>7</td>
<td>4</td>
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<tr>
<td>Scid II Paranoid PD (7)</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Scid II Borderline PD (9)</td>
<td>6</td>
<td>3</td>
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</tbody>
</table>

**CASE 2: Medication (regular and "when needed")**

<table>
<thead>
<tr>
<th>Medicament</th>
<th>Dosage</th>
<th>Administration</th>
</tr>
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<tbody>
<tr>
<td>Aripiprazol tbl</td>
<td>10 mg</td>
<td>No regular</td>
</tr>
<tr>
<td>Lamotrigine tbl</td>
<td>250+250 mg</td>
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<tr>
<td>Escitalopram tbl</td>
<td>40 mg</td>
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<tr>
<td>Chlorprothixen tbl</td>
<td>50+25 mg</td>
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<td>Zopiclon tbl</td>
<td>7.5 mg</td>
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<tr>
<td>Zuclopenthixol im</td>
<td>75 mg</td>
<td></td>
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<tr>
<td>Chlorprothixen tbl</td>
<td>100 mg</td>
<td>No &quot;when needed&quot;</td>
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<td>Clonazepam tbl</td>
<td>4 mg</td>
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<tr>
<td>Alimemazin tbl</td>
<td>40 mg</td>
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Treatment time

BET time series (n=7)

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<tr>
<th>Year</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</tbody>
</table>

Mean age at BET treatment start = 26.3 years, SD = 3.7 years

Suicidal behaviour and violence

BET time series (n=7)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Before BET (%)</th>
<th>After BET (%)</th>
<th>Z-statistic</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td>Suicide attempts</td>
<td>2.4 (0.4)</td>
<td>0.03 (0.08)</td>
<td>-2.4</td>
<td>&lt;.018</td>
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<tr>
<td>Self harm</td>
<td>8.5 (8.3)</td>
<td>0.6 (1.3)</td>
<td>-2.4</td>
<td>&lt;.018</td>
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<tr>
<td>Violence against people</td>
<td>1.0 (1.5)</td>
<td>0.0 (0.0)</td>
<td>-2.4</td>
<td>&lt;.018</td>
</tr>
<tr>
<td>Violence against objects</td>
<td>3.5 (5.5)</td>
<td>0.0 (0.0)</td>
<td>-2.0</td>
<td>&lt;.042</td>
</tr>
</tbody>
</table>

Wilcoxon signed rank test for pairwise comparisons. Frequency counts are yearly averages in the patient group for the period prior to BET and follow-up after discharge.

Global assessment of functioning – GAF

BET time series (n=7)

Bars indicate standard error of measurement, which varied from 2.5 to 5.6 GAF points across the time points.
Changes in the use of regular medications

WHO’s definition of health

• Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

• The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition

Two dimensions of treatment

Interventions that regulate affects, symptoms and behaviours

Interventions that promote self regulation

The treatment process
a) The medical model:
- Ability for self regulation is re-established by external regulation

b) The “step-by-step” ideology of institutions:
- External regulation is gradually reduced in response to the patient’s willingness and ability to take on responsibility

PROBLEMS THAT MAY OBSTRUCT THE PROCESS
a) The medical model: lacks interventions
b) The patient: lacks motivation and compliance

The basic principles of BET
- Life is a painful condition
- Life has always been painful
- Life is painful
- Life will continue to be painful
- Avoidance of pain leads to suffering and mental disorders
- Human beings create their lives by the choices they make
- Exposure and mindfulness enable us to cope with the challenges of life

Complementary external regulation

SWITCHING REGIMES
- Patient functioning
- External regulation
- Self-regulation
- Autonomy
- Dependency

OVER-REGULATION
- Boring the patient

UNDER-REGULATION
- Empowering the patient
Phobias are maintained by avoidance.

Biological switch automatic avoidance response.

Fight – flight – freeze

Phobias are maintained by avoidance.

Fear and anxiety become less frequent and the episodes last for shorter periods of time.

Expectation:
- I'm disolving!
- I'm falling to pieces!
- I'm becoming engulfed in total emptiness!
- I'll be overwhelmed by eternal pain!

Existential catastrophe!!!
The BET model – 5 phases

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Responsibility for the problem</th>
<th>Responsibility for the solution</th>
<th>Responsibility for success</th>
<th>SELF EXPOSURE</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Secure base</td>
<td>Working alliance</td>
<td>Focusing avoidance</td>
<td>Exposure</td>
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Summary: BET & the DMM

The inclusion of DMM elements helps the BET team to
1) make the hospital ward function as a secure base to the patient
2) adjust responses of the health professionals to meet the strategic needs of both Type A and Type C patients
3) refine and adjust the use of complementary external regulation as to work within the patients’ ZPD

Future development of BET may include the use of AAI to
1) further enhance the precision of BET interventions with respect to the patients’ attachment strategies
2) supplement the evaluation of BET treatment processes by the identification of changes in patients’ attachment strategies

Contact information / downloads

- Address:
  Special Section B (SSB)
  Dep. of Mental Health
  Vestre Viken Hospital Trust
  Box 83, 1309 RUD - NORWAY

- Internet / BET-downloads, PDF: [www.vestreviken.no](http://www.vestreviken.no)
  - BET manual: Basic principles and guidelines (Norwegian/English)
  - BET Phase 2: Working alliance, version 1 (Norwegian)
  - The BET model’s theoretical foundation – part 1: CYBERNETICS (Norwegian/English)

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