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Systematic Case Studies with Challenging patients Case Formulations in Psychotherapy Research

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Many authors are concerned nowadays in building a bridge between research and practice. One of the reasons of this interest, is the importance of effective treatments with patients that bare complex and strongly reactant types of problems, who also are the most expensive to the health system and the ones that carry the major negative impact in themselves and in their significant others. These patient's characteristics may be found in different types of diagnosis, and are not exclusive of any type of diagnostic classification. In this presentation, a naturalistic case-series research with patients who share these characteristics, treated with derivatives of the Integrative Model (Fernández- Alvarez, 1992) is described. The patients' problems' and treatment processes were assessed from multiple perspectives (pre-post standardised measures, List of Problems, follow- up interviews, video-and audio records, all of them by independent practitioners). Interventions were based on case conceptualization and understanding of life personal history and context; combining taylored cognitive, cognitive behavioral and systemic interventions. Treatments' outcomes were then compared in various dimensions and processed in a statistic fashion in order to elicit some evidence in relation to factors contributing or hindering good outcome. Conclusions relevant both to clinical practice and research will be drawn.

Systematic treatment selection (STS; Beutler &. Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000)
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Wachtel, P. (1997). Psychoanalysis, behavior therapy and the relational world. New York: City (Beutler & Clarkin, 1990)University of New York.

Enough evidence supports that

For patients that bear complex and strongly reactant types of problems, are also the most expensive to the health system, and the ones that carry the major negative impact in themselves and in their significant others

Effective treatments are those capable to promote change and reduce psychological suffering.

As in Beutlers' STS model, the best match between types of intervention, patients' characteristics and therapist style, independently of the theoretical models; is what predicts better outcome (Beutler et al, 2000)

Within this vein, a naturalistic case-series research with patients who share these characteristics, treated with derivatives of the Integrative Model (Fernández- Alvarez, 1992) is described.

In this naturalistic case-series research, the patients' problems' and treatment processes were assessed from multiple perspectives (pre-post standardised measures, List of Problems, follow- up interviews, video-and audio records, all of them by independent practitioners).

Interventions were based on case conceptualization and understanding of life personal history and context; combining taylored cognitive, cognitive behavioral and systemic interventions. Treatments' outcomes were then compared in various dimensions and processed in a statistic fashion in order to elicit some evidence in relation to factors contributing or hindering good outcome.

Patients' Characteristics

severe and complex psychological symptoms; multiple problems in functioning; and more than three previous intensive treatments that were described by the patients as ineffective, typically including past hospitalizations, intensive psychotherapy, and/or pharmacology. I chose such cases in part because they incurred the highest costs in terms of patient suffering and the cost of treatment. This study became my doctoral dissertation (Scherb, 2007a) and has been described in a variety of other contexts (Scherb, 2003, 2007b, 2011, 2012).

Treatments' Characteristics

Overall, the Fernández Alvarez Integrated Model involves the integration of psychodynamic, behavioral, cognitive, and systemic concepts and strategies.

As applied to individuals with severe and persistent psychiatric disorders, the strategies can be summarized as follows:

•Identify the appropriate dysfunctional schema and tailor interventions according to level of dysfunction. This means starting from the level at which change should be easy to achieve, which includes enhancement of the patient's self–efficacy (through validation, support, empathy, skill training, etc.) in this first moment to help increase motivation.

•Focus on dysfunctional interactional patterns to identify negative interactional vicious cycles (Wachtel, 1997) that can maintain the dysfunction. Gradually, these issues need to be addressed in the context of a strong therapeutic alliance.
•Change the treatment setting if needed (for example, some undergo brief periods of inpatient treatment, while others require occasional visits to the patient's place of work).
•Change modalities if needed, and implement this in a coordinated and sequential manner.
•Include conjoint and/or family targeted sessions when necessary. These sessions need to be designed in favour of the client and should not focus on guilt or blame.
•Integrate contextual variables (institutions, community resources) into the treatment through targeted consultation when necessary, always supporting the client's social involvement.

- Promote only gradual changes, reassessing treatment goals continually.
- Include patients' and significant others' resources for change (through participation, assessment, and re–assessment).
- Provide positive reinforcement, validating the patient's personal experiencing at all times.
- Reverse the patient's victim attitude and support the gradual assumption of responsibility.
- Depathologize psychiatric patients who have undergone traditional psychiatric treatments for many years, namely hospitalization, heavy medication, and/or ECT for long periods of time. These patients often become stigmatized by their significant others and by society in general.
- Create a treatment team when necessary, in response to the special challenge of these difficult patients (Linehan, 1993).

The patients' problems' and treatment processes were assessed from multiple perspectives

pre-post standardised measures, List of Problems, follow- up interviews, video-and audio records, all of them by independent practitioners.

Treatments' outcomes were then compared in various dimensions and processed in a statistic fashion in order to elicit some evidence in relation to factors contributing or hindering good outcome.

Some results of this study so far

N=31

Multiple Regression analysis found a statistical difference ($p < 0.005$) in patient overall status at intake and in the end of treatment.

Improvement Index (symptom reduction, life functioning, no relapse, quality of relationships) at initial and final GAF.

The following cases of SONIA and M belong to this caseload.

SONIA is a finished treatment process while M is a treatment in process.

Sonia was a 44-year-old, divorced, morbidly obese woman living with her 18-year-old mildly retarded son. When Sonia came for treatment, she could not manage her son or her own basic needs and finances and had frequent angry outbursts with her family members. She was diagnosed as having bipolar disorder or cyclothymia, trichotillomania, borderline personality disorder, borderline intellectual functioning, and was on medication for these conditions. The treatment implied over 900 sessions in 10 years

The treatment was designed as a combination of intensive psychotherapy, psychotropic medication (consisting of a *carbamazepine*), family therapy, and case management, which included a referral for her son to an appropriate supportive institution.

The treatment team included a psychologist psychotherapist (the author), a psychiatrist, and an independent assessment team, with psychotherapy sessions being conducted in a variety of settings.

Case Example no. 1: SONIA – Assessment of treatment outcome

DSM-IV Diagnoses

Axis I

•296.6. Bipolar I and/or 301.13. Cyclothymia. When Sonia was referred to me by her medical doctor, she was diagnosed by the last psychiatrist with Bipolar Disorder, and was medicated accordingly. Nevertheless, after several interviews, the psychiatrist on my team decided to medicate Sonia with Actinerval (carbamazepine), which is indicated for resistant hypomania. The psychiatrist prescribed this medication plan because it was very useful in combination with the treatment strategy. As the treatment developed over time, Sonia's dose was gradually reduced. Therefore, retrospectively, we thought that Cyclothymia would be a more accurate description of Sonia's pathology.

312.39. Trichotillomania

Axis II

•301.83. Borderline Personality Disorder

V62.89. Borderline Intellectual Functioning

Axis III

•278. Obesity

Axis IV

•V61.20. Parent-Child Relational Problems

V61.9. Relational Problem Related to a Mental Disorder or General Medical Condition

Anger Control Problems

Axis V: Global Assessment of Functioning, 40

DSM V falta

Because of her long history of previous treatments, Sonia did not consent to take any standardized assessment measures, she did agree to a collaboratively developed, individualized, 27-item List of Problems and Behaviors Questionnaire (LOPBQ). With a scoring range of 0 ("problem not solved at all") to 5 (problem "totally solved") on each item, Sonia went from an average item score of .33 to one of 4.19 over the course of the first 8 years; that is, from a score of 6.7% of a maximum score to 83.8% of a maximum score.

List of Problems and Behaviors Questionnaire (LOPBQ)

This is the list of problems we built together.

Please rate how much you feel you have solved each of them in the last few weeks.

Rate from 0 to 5, where 0 means the problem remains totally unsolved, and 5 means the problem is solved.

0 = I have not solved this problem at all.

5= I have totally solved this problem, it no longer exist for me.

----A. Financial
__ B. Work
__ C. Loneliness
__ D. Separation issues
__ E. Physical problems
__ F. Stigmatization
__ G. Daily Organization
__ H. Occupational
__ I. Low self-esteem
__ J. Assertiveness
__ K. Powerlessness
__ L. Poor self-concept
__ M. Learned helplessness
__ N. Anxiety
__ O. Depression
__ P. Conflict with others
__ Q. Obessive indiscriminate anger
__ R. Excessive anger
__ S. Isolation
__ T. Hopelessness
__ U. Procastination

V. Cognitive deficits
__ W. Bizarre behaviors
__ X. Self destructiveness
__ Y. Impulsivity
__ Z. Culpability
__ AA. Thought disorders

Results on the LOPBQ

	Time of Assessment					
ist of Problems	At 6 months	At 12months	At 18 months	At 5 years	At 6 years	At 8 years
ancial	1	2	2	4	5	5
ork	0	0	0	2	5	5
neliness	1	1	2	2	3	3
paration issues	1	1	2	4	5	5
ysical problems	1	1	1	1	1	4
gmatization	1	1	2	4	5	4
ily Organization	0	1	2	4	5	4
cupational	0	0	0	4	5	4
y self-esteem	1	1	1	2	3	4
ertiveness	0	1	1	2	3	4
werlessness	0	1	1	2	3	4
or self concept	0	0	0	2	3	4
arned helplessness	0	1	1	2	3	4
xiety	0	1	2	4	3	3
pression	0	1	2	4	5	4
nflict with others	0	0	1	2	3	3
sessive indiscrim-ger	0	0	0	3	4	5
cessive anger	0	0	0	3	4	5
lation	1	1	0	2	4	4
pelessness	0	0	0	1	4	4
ocrastination	0	0	2	3	4	3
gnitive deficits	2	2	2	3	4	4
zarre behaviors	0	0	3	4	5	5
f destructiveness	0	0	3	4	4	5
pulsivity	0	0	2	3	4	5
pability	0	0	2	3	4	5
hought disorders	0	0	3	4	4	4
ore	**9**	**16**	**37**	**78**	**105**	**113**
Score Per Item	**0.33**	**0.59**	**1.37**	**2.89**	**3.89**	**4.19**

Results of treatment

During the 10 years, the therapy was gradually reduced in intensity as Sonia made gradual but dramatic changes in her self-concept, her obesity, her relationship to her family, and her ability to work and independently manage her life.

SIMILAR A 14

SIMILAR A 15

Case Example no. 2: Martha Assessment of type of intervention

Diagnosis according to the DSM V

The patient's medication in previous treatments was based on the diagnosis of ADD. (Ritalin, Neuryl, memorex vital).
The psychopharmacological treatment was organized as follows:
- Sertraline (Insertec) 2 tablets of 100 mg. Specific medication for reducing obsessions and intrusive thoughts.
- Aripiprazole (Irazen) 5 mg. Medication that facilitates the organization of her thoughts.
- Neuryl (only at night and possibly during peak anxiety).