Working With the 'Difficult' Patient: The Use of a Contextual Cognitive-Analytic Therapy Based Training in Improving Team Function in a Routine Psychiatry Service Setting

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Working With the 'Difficult' Patient: The Use of a Contextual Cognitive-Analytic Therapy Based Training in Improving Team Function in a Routine Psychiatry Service Setting

**Rosangela Caruso · Bruno Biancosino ·
Cristiana Borghi · Luciana Marmai ·
Ian B. Kerr · Luigi Grassi**

Abstract The clinical management of 'difficult' patients is a major challenge which exposes mental health teams to an increased risk of frustration and stress and may lead to professional burnout. The aim of the present study was to investigate whether a cognitive-analytic therapy (CAT) based training undertaken by a mental health team working with 'difficult' patients reduced professional burnout symptoms, improved patients' service engagement and increased the levels of team-cohesion. Twelve mental health staff members from different professional and educational backgrounds took part in five 2-hour sessions providing a basic CAT training intervention, an integrative and relational model of psychotherapy for the treatment of borderline personality disorders. Participants were administered the Maslach Burnout Inventory (MBI), the Service Engagement Scale (SES) and the Group Environment Questionnaire (GEQ) before (T0) and after (T1) CAT training, and at 1-month follow-up (T2). A significant decrease were found, at T2, on the MBI Emotional Exhaustion scores, the SES Availability subscale, the GEQ Attraction to Group-Social and Group Integration-Social, while the MBI-Personal Accomplishment scores increased from baseline. The results of this study suggest that a CAT-based training can facilitate team cohesion and patient engagement with a service and reduce burnout levels among mental health team members dealing with 'difficult' patients.

Keywords Cognitive-analytic therapy ·
'Difficult' patient · Borderline personality disorder ·
Multidisciplinary team training · Psychiatric service ·
Psychotherapy

Introduction

The clinical management of "difficult" or "hard-to-treat" patients represents, for the psychiatric team, an important and challenging issue which has been increasingly studied in recent years (Norton 1996; Koekkoek et al. 2006, 2011). The term "difficult patient" does not refer to a definite diagnostic category, but it is used to indicate a heterogeneous group of psychiatric patients—with diagnoses ranging from 'neurotic' through to complex psychotic disorders—perceived as significantly more demanding, dangerous, difficult to empathize with and likely to polarize the staff (Neill 1979; Koekkoek et al. 2006). The "difficult" label is found to be associated with behavioural characteristics of the patient, difficulties in the patient-professionals relationship and poor therapeutic outcome (Modestin et al. 1986; Koekkoek et al. 2006, 2009). Also, difficult patients are prescribed more medication, and experience longer hospitalizations than other patients (Modestin et al. 1986). In a recent literature review three subgroups of difficult patients were distinguished, specifically the "unwilling care avoiders", who often suffer from severe mental illness such as psychotic disorders; the

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"demanding care claimers", usually individuals with cluster B personality disorders or a history of substance abuse; the "ambivalent care seekers", represented by those patients who seek care from the staff but enact an ambivalent behaviour (such as patients with chronic depression or cluster B and C personality disorders) (Koekkoek et al. 2006). Usually, the therapeutic alliance between "difficult" patients and mental health staff is poor and this is associated with a negative therapeutic outcome (Horvarth and Luborsky 1993; Martin et al. 2000). Also, these patients more often than others are found to lack of appropriate treatment plans and continuity of care (Neill 1979). Working with difficult patients can be extremely stressful for mental health teams (Melchior et al. 1997; Loughrey et al. 1997; Burnard et al. 2000; Perseius et al. 2007), with the subsequent risk of developing burnout (Hare et al. 1988; Edwards et al. 2000; Jenkins and Elliott 2004). Moreover, it has been indicated that there is a correlation between high degrees of burnout and negative staff feelings towards patients, while the absence of burnout is associated with positive feelings for the patients. (Holmqvist and Jeanneau 2006).

Several interventions, such as supervisions or interdisciplinary team consultations, have been proposed as useful to reduce professional stress and burnout in professionals or multidisciplinary teams, (Koekkoek et al. 2006). However, more recent studies have shown that providing mental health professionals with a structured and coherent training, derived from psychotherapy models which have proven effective in the treatment of "difficult" patients can enable the staff to deal more effectively with the patients by reducing the level of occupational stress, increasing the professionals' therapeutic confidence and skills, and promoting the development of a common language which may facilitate team cohesion and improve the quality of care (Perseius et al. 2007; Thompson et al. 2008). In their study, Perseius et al. (2007) showed that introducing the use of dialectical behavioural therapy—a cognitive-behavioural treatment effective for borderline patients (Linehan et al. 1991)—in a sample of 22 therapists from different educational backgrounds, including nurses, mental care assistants, occupational therapists, physicians and psychologists, working with young self-harming patients with borderline personality disorders, decreased health professionals' occupational stress.

More recently, a basic training in cognitive-analytic therapy (CAT), an integrative and relational model of psychotherapy helpful in the treatment of borderline personality disorder (Ryle 1975; Chanen et al. 2008), was tested in a sample of 12 community mental health professionals (i.e. social workers and community psychiatric nurses) (Thompson et al. 2008). The authors found that the CAT programme increased participants' self-confidence

and encouraged the development of a shared model within a team of social workers and psychiatric nurses, confirming preliminary findings on the efficacy of CAT in improving the therapeutic skills and functioning of the whole psychiatric team (Kerr et al. 2007).

Since recently CAT has been introduced in Italy (Ryle 2004) and, at the same time, no study examined CAT in Italian mental health units, the aim of the present study was to evaluate if a CAT-based training intervention directed at a mental health staff dealing with complex psychiatric cases in a residential facility, had an impact on reducing stress and improving group cohesion and quality of work with "difficult" psychiatric patients.

Methods

Setting

The study was carried out in a Community Rehabilitation Unit located in Ferrara, Emilia Romagna Region, northeast Italy. This kind of facility is commonly found in our region and has been set up to provide for the residential and overall care of psychiatric patients (Neri et al. 2011). This facility is part of the University Unit of Clinical and Emergency Psychiatry, which is linked with the Integrated Department of Mental Health and Drug Abuse (DMH), NHS-Community Health Agency. It provides short- to medium-term inpatient care for patients (mainly affected by schizophrenia and severe personality disorders) with acute and sub-acute psychiatric conditions who accept treatment. The facility is staffed by twenty professionals, specifically four psychiatrists and one psychologist, who are present during the day, and twelve nurses and three occupational therapists rotating during the 24-hour period.

Participants

All staff members of the facility were eligible for the study and the only inclusion criterion was voluntary participation to a training method to improve the staff ability to deal with "difficult" patients. One senior psychiatrist belonging to the team and with a certified training in CAT, conducted the intervention. Of the remaining 19 staff members, the psychologist was on leave in that period; two social workers and four nurses refused to take part in the study, leaving a final group of 12 mental health professionals (10 women and 2 men, mean age 46.2 ± 9.4 years) who participated to the CAT training programme. They had different professions and educational backgrounds, specifically 3 (25 %) were psychiatrists, 8 (66.7 %) were nurses and 1 (8.3 %) was an occupational therapist. All of them had a considerable experience in psychiatry (20.3 ± 10.4 years).

CAT Training

Cognitive-analytic therapy is an integrative model of psychological development and therapy, which stresses the social and relational formation of the self and its 'psychopathology' (Ryle 1982, 1985, 1995, 1997, 2004; Ryle and Kerr 2002; Kerr et al. 2003). CAT describes early internalised, formative, relational experience in terms of a repertoire of *reciprocal roles* (RRs), and subsequent habitual coping or 'responsive' (Leiman 2004) behavioural patterns as *reciprocal role procedures* (RRPs). Examples of common RRs that might describe a child's early relationships with parent or other key caregivers range from at best *'properly cared for (child)-properly caring for (caregiver)'* through to at another extreme e.g. *'neglected and abused (child)–neglecting and abusing (caregiver)'*. CAT adopts a fundamentally relational focus and stresses the importance of the transformative and mutative psychological 'internalisation' within a developing 'individual' of surrounding social structures and conditions, and of interpersonal experience.

A brief, intensive "training package" was offered to the participants with the aim of delivering a working introduction to CAT model and its application to multidisciplinary staff to deal with complex psychiatric issues. Every part of this "package" was defined and organized under the supervision of one of us (I.B.K.) with a long lasting experience in CAT. The training package consisted of five 2-hour theoretical and practical sessions scheduled on a weekly basis. The first two theoretical sessions were aimed at illustrating CAT model and principles. Participants were provided with the information about CAT being rooted in a fundamentally social and relational concept of self and that early social experiences with meaningful figures are internalized by the individual as a repertoire of reciprocal roles. Reciprocal roles and their recurrent procedural enactments influence interpersonal interactions. Human psychopathology is therefore seen as highly determined by maladaptive reciprocal roles (Ryle and Kerr 2002).

The third theoretical session introduced the use of *contextual reformulation*, a CAT based technique (Kerr 1999; Ryle and Kerr 2002) which extends individual patient reformulation by incorporating systemic and contextual interactions explicitly around the patient diagram. This aims to make explicit the interactions and pressures which occur in every case but may in some cases be more critical and may contribute to the 'difficulty' of working with a particular patient. In constructing a contextual reformulation it may become clear that the difficulty lies in systemic, staff or institutional dysfunction. Such extended contextual reformulation can allow a clear representation of these various interactions which is psycho-educational for patients, staff teams as well as their parent institutions

and social systems. It may also, importantly, 'allow' and normalise expression of powerful, sometimes angry, counter transference feelings (reciprocal role enactments)—which may not normally feel permitted—on the part of various staff members, and improve communication between them thereby reducing team stresses (see examples in Ryle and Kerr 2002).

In the last two practical sessions of the programme the participants discussed together as a group under trainer's supervision and personally practised diagrams for two "difficult" patients with a formal diagnosis of borderline personality disorder. These two cases—selected for the clinical discussion among the facility inpatients—had been indicated by participants as particularly challenging, antagonising and generating stress and disagreement within the staff.

The first patient was a 32 years old female, with a childhood sexual abuse and a long lasting history of affective instability, substance abuse and self-harm. Her relational behaviour was characterised by an over-demanding attitude which leaded to increasing requests of attention and care, as well as repeated attempts to disrupt therapeutic boundaries, that appeared excessive and impossible to satisfy to the team, evoking feelings of overwhelming and exhaustion and a consequent reciprocal disengagement in staff members.

The second patient was a 28 years old female with a childhood history of parental neglect and a prevalent trait of impulsivity, generating aggressive behaviours directed to self and others. Her hostile and challenging attitudes alternated to manipulative behaviours (i.e. self-aggressive enactments in order to catch attention, or seductive attitudes aimed at obtaining staff members' indulgence), alternatively evoked feelings of anger, guilt and preoccupation thus determining splitting within the staff.

Measures

In order to verify the possible effectiveness of a basic CAT training intervention, a psychometric assessment of mental health professionals was performed before (T0) and after (T1) the CAT intervention, and at 1-month follow-up (T2). The following instrument were used to evaluate burn-out, patients' service engagement and team cohesion:

- The Maslach Burnout Inventory (MBI) (Maslach and Jackson 1986) was used to assess participants' burnout. The MBI is a 22-item questionnaire exploring feelings and attitudes towards work in three subscales (emotional exhaustion, 10 items; depersonalization, 5 items; personal accomplishment, 7 items).
- Service engagement was measured by using the Service Engagement Scale (SES) (Tait et al. 2002), a 14-item

measure consisting of statements that assess patient engagement with services which team members rate on a four-point Likert scale (from "not at all or rarely" to "most of the time"; range score 0–42, with higher scores indicating lower levels of engagement.). The scale is divided into four sub-scales assessing patients' availability, collaboration, help-seeking and treatment adherence.
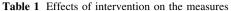
- The Group Environment Questionnaire (GEQ-Carron et al. 1985) was administered to team members in order to assess the team cohesion. The GEQ consists of 18 items scored on a 9-point scale ranging from 1 ('strongly disagree') to 9 ('strongly agree'), where higher scores reflect a lower group cohesion, and explores two major categories of group cohesion, individual attraction to group (measuring the level of attractiveness to the group) and group integration (perception of the group as a unit). Each of these two categories is divided into two sub-categories: "task" and "social", with the "task" dimension of cohesion indicating team members' capacity to work together to achieve specific team goals; the "social" aspect reflecting the degree to which the team members like each other and have good social relationships. Therefore, the questionnaire measures four dimensions of cohesion: Individual Attraction to Group-Task (ATGT); Individual Attraction to Group-Social (ATGS); Group Integration-Task (GIT); and Group Integration–Social (GIS).

Statistical Analysis

Statistical analysis was performed using SPSS 10.4 for Windows. Non-parametric analysis (Wilcoxon test) was performed to compare the data, with statistical significance set at $p < 0.05$.

Results

Mean scores and standard deviation of the measures are shown in Table 1. No significant difference was shown on the scores in the psychometric measures between T0 and T1. Statistical significant differences were found when comparing T0 to T2 scores on the MBI-Emotional Exhaustion scores (13.8 ± 13 vs. 7.2 ± 8.8; $Z = 2.7$; $p = 0.006$), MBI-Personal Accomplishment (35.2 ± 9.3 vs. 42.3 ± 5.5; $Z = 2.4$; $p = 0.006$), SES-Availability subscale scores (2 ± 1.5 vs. 0.6 ± 1.2; $Z = 2.29$; $p = 0.022$), GEQ-Attraction to Group-Social (21.4 ± 8.5 vs. 15.8 ± 4.3; $Z = 2.39$; $p = 0.017$), and GEQ-Group Integration-Social scores (18.3 ± 3.2 vs. 13.8 ± 6.5; $Z = 2.54$; $p = 0.011$).

Table 1 Effects of intervention on the measures

Measures	T0	T1	T2
Group environment questionnaire (GEQ)			
Attraction to group-task	15.4 ± 5.7	16.2 ± 4.2	13.9 ± 2.4
Attraction to group-social	21.4 ± 8.5	22.9 ± 5.3	$15.8 \pm 4.3^*$
Group integration-task	24.3 ± 9.1	23.2 ± 4.1	20.5 ± 6.7
Group integration-social	18.3 ± 3.2	18.3 ± 3.4	$13.8 \pm 6.5^*$
Service engagement scale (SES)			
Availability	2 ± 1.5	1.5 ± 1.4	$0.6 \pm 1.2^*$
Collaboration	3.5 ± 1.3	3.9 ± 1.4	3.9 ± 1.2
Help seeking	4.8 ± 1.9	4.2 ± 1.3	3.8 ± 1.9
Treatment adherence	2.9 ± 2.4	2.6 ± 2	1.7 ± 1.7
Maslach burnout inventory (MBI)			
Emotional exhaustion (EE)	13.8 ± 13	12.2 ± 9.8	$7.2 \pm 8.8^*$
Depersonalisation (DP)	2.2 ± 3.5	2.2 ± 2.1	0.7 ± 1.1
Personal accomplishment (PA)	35.2 ± 9.3	37.1 ± 6.2	$42.3 \pm 5.5^*$

* $p < 0.05$

Discussion

There is a considerable body of evidence showing that mental health professionals working with 'difficult' patients are exposed to an increased risk of frustration and stress (Melchior et al. 1997; Loughrey et al. 1997; Burnard et al. 2000; Perseius et al. 2007) which may lead to development of professional burnout (Hare et al. 1988; Edwards et al. 2000; Jenkins and Elliott 2004), which in turn is predictive of a decreased team effectiveness and of poorer treatment outcomes (Priebe et al. 2004).

The findings of the present study indicated that a CAT-based training had a positive impact on mental health team workers, across several areas. Specifically, significant changes occurred at one-month follow up in two dimensions of burnout, namely MBI-emotional exhaustion, that decreased and MBI-personal accomplishment that increased in comparison with the baseline assessment. This seems to confirm that the structured way in which CAT helps health care professionals to understand the relational problems related to severe psychiatric disorders determine a lower level of emotional overwhelming and a higher level of effectiveness and confidence in clinical work.

CAT intervention had also a positive influence on patient-professional relationship, as measured by the SES, at 1-month follow up, In particular, the Availability subscale changed significantly indicating an improvement of the quality of the therapeutic relationship between staff members and patients. This result may have important implications by considering that the relationship between mental health professionals and their patients has been shown to be an essential factor both in psychotherapeutic

and psychiatric treatment, to have a positive impact on patients' outcomes and quality of life (Bjørngaard et al. 2007; Priebe and McCabe 2006; Catty 2004; Phelan et al. 1995), and to influence the patient's perceived efficacy of services (Haertl et al. 2009).

Furthermore, the increase in the scores of the SES Attraction to Group-Social and Group Integration–Social subscales seems to suggest that mental health staff perceived themselves as more integrated and open to social relationship within the group, as a result of CAT training intervention. Again, from a clinical point of view, the implications of this result is related to the role of team-cohesion as a critical factor in clinical practice. Several studies have highlighted that 'difficult' patients—especially those with a borderline personality disorder—tend to 'manipulate' psychiatric teams, generating splitting processes and creating conflict and disagreement among team members (Gabbard and Wilkinson 1994). Team splitting, moreover, generates burnout, as reported in a recent study exploring determinants of burnout in mental health settings (Lasalvia et al. 2009). This pointed out that mental health team burnout appears to be mostly predicted, among other factors, by the presence of a poorly cohesive work group.

Taken together, the results presented here are in line with previous research carried out by using DBT (Perseius et al. 2007), and, more interestingly for the aims of our study, CAT (Thompson et al. 2008). More structured basic training intervention directed at mental health team workers can in fact have an important role in working with 'difficult' and complex patients, by facilitating group-cohesion, increasing participants' self-assessed confidence and reducing the experience of stress in the actual treatment of patients.

In considering these results, major intrinsic limitations should be taken into account. The first, as for the other studies carried out in the field, is related to the small sample size. Further research involving a larger number of mental health professionals is mandatory to confirm the data presented here. A second important limitation is represented by the observational, non-controlled design of the study. Therefore, it is difficult to exclude the possibility that the changes we observed were produced by other non-specific factors apart from the intervention itself—such as the attention dedicated to the team and the time they employed to reflect in more detail on their relationships with the patients. Controlled studies or randomized clinical trials should be conducted to confirm what presented here. A third major limitation is that we did not assess if the training actually translated to improved patient outcomes. In fact, although we used patients' engagement as one of the outcome variables, this is not a valid measure of the clinical and rehabilitation outcomes of the "difficult patients". A fourth issue relates to the assessment of team burnout, which is lacking of the staff's feelings or counter-transference reactions. Further studies addressing how this training module can impact on counter-transference changes would be extremely useful for clinical practice. Lastly, the period following training was relatively short, and a longer follow-up, with consolidating training workshops, would have allowed further assessment of the durability of training effects.

In conclusion, although our findings are preliminary, a CAT-based training intervention and the use of contextual reformulation, by providing a safe, accessible and effective clinical and conceptual framework, can facilitate team cohesion and patient engagement with a service and reduce burnout levels among mental health team workers working with 'difficult' patients. This also provides further suggestive evidence that a significant amount of the patient complexity encountered in routine psychiatric settings may be due to relational and systemic factors which traditional psychiatric approaches do not adequately recognise or address.

Conflict of interest None.

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