The integrated model (individual and group treatment) of Cognitive-Evolutionary Therapy for outpatients with BPD and Axis I/II comorbid disorders: outcome results and a single case report.

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ABSTRACT

Introduction: An integrated cognitive-evolutionary therapy (CET) model (double-setting CET: individual and group therapy) and individual CET were compared in terms of drop-out and improvement of symptoms in outpatients with personality disorders and/or Axis I/II?) comorbidity.

Methods: Persons 18-60 years of age with personality disorders (mainly borderline personality disorder - BPD) and/or Axis I/II comorbidity were asked to choose a treatment regimen (n=109). Double-setting CET consisted of 2 two-hour group sessions and 2 one-hour individual sessions per month. Individual CET consisted of 1 one-hour individual session per week. Both regimens lasted for 24 months. Pharmacotherapy was provided, as needed. Symptoms and social adjustment were evaluated with GAF, BASIS-32 and QoL-I. Information on history of treatment (psychotherapy, drug therapy, hospitalisations, and drop-out) and on motivation towards the current therapy, self-harming behaviour, and substance abuse was collected at 0, 12, 18 and 24 months of treatment.

Results: The control patients had more severe symptoms, worse overall functioning, more previous hospitalisations, and higher previous drop-out rates and were more likely to have BPD. The current drop-out rate was lower for the double-setting CET group (n=85) (19% vs. 65% for controls, n=24), also when limiting the analysis to BPD patients (23% vs. 60%). The double-setting CET group showed significant improvement for all evaluations (GAF, BASIS-32, QoL-I) and significantly reduced self harming behaviour and substance abuse.

Discussion: The study was limited by the clinical and diagnostic differences between the two groups. That BPD was significantly more frequent among controls may explain all of the other differences, which disappeared when comparing only BPD patients. Nonetheless, double setting CET seems to be more effective than individual CET.

INTRODUCTION

For a number of years, much attention has been placed on the problems with treatment for patients with Borderline Personality Disorders (BPD). Among BPD patients, the drop-out rate for "treatment as usual" is 50% or more; they are also at risk of suicide and self-harming behaviour, and, by definition, are difficult to manage, thus requiring much commitment on the part of both the therapist and the healthcare facility. In the past 10 years, various reproducible BPD treatment models have been developed, and their effectiveness and outcomes have been adequately evaluated, both at the end of treatment and over prolonged follow-up. From a methodological standpoint, the most interesting and valid results have been summarized in a recent metaanalysis (Leichsering and Leibing, 2003) which highlights the effectiveness of several models, including a cognitive-behavioural model (Linehan et al., 1991; 1993; 1994; 1999; Bohus et al., 2000) and a psychodynamic model (Bateman and Fonagy, 1999). These models, specifically, the Dialectical-Behavioural Therapy of Linehan (DBT) (Linehan, 1993) and the Mentalization-Based Treatment (MBT) of Bateman and Fonagy (Bateman and Fonagy, 2004), though differing in their underlying premise and modes of intervention, both rely on a multiple setting consisting of a combination of individual and group therapy. They are also both based on a structured and coherent theoretical-applicative model in which all of the therapists are an integral part of a single therapeutic regimen.

Although these models have been shown to be effective for BPD patients, in outpatient clinical practice there has been an increasing number of severe patients with comorbidity of Axis I or Axis I/II disorders. Some of these comorbidities are quite common (e.g., eating disorders associated with: panic disturbances; and/or dissociative disorders; and/or mood disorders; or BPD) (Rosenvinge et al., 2000; Zanarini et al., 1998; Oldham et al., 1995; van Hanswijck de Jonge et al., 2003; Fassone et al., 2003), and, as with BPD, they are associated with persistent compromised adaptation and psychosocial functioning. These comorbidities also strongly resemble the borderline "dimension" or so-called borderline "functioning", and though they do not completely satisfy the DSM-IV diagnostic criteria for BPD, they pose the same problems with regard to access to effective treatment, maintenance, and effectiveness in psychopathological terms and in terms of social adaptation.

It can be hypothesised that a large proportion of the patients with these comorbidities, together with BPD patients and persons with dissociative disturbances, constitute a relatively homogeneous clinical population whose psychiatric disturbances have common causes. This etiopathogenic *continuum* is characterised by intra-familial traumatic experiences (in the patient and/or caregiver) and insecure attachment (especially disorganized attachment), in addition to other factors such as emotional instability and impulsiveness (Liotti et al., 2000; Pasquini et al., 2002; Battle et al., 2004; Fassone et al., 2002; Agrawal et al., 2004; Paris, 1994). A recent review (Agrawal et al., 2004) has demonstrated an etiopathogenic *continuum* between insecure attachment and the development of BPD. In particular, the authors stress how certain types of insecure attachment (in particular "unresolved", "preoccupied-ambivalent" or "fearful" attachment, which are the corresponding adult forms of infant disorganised attachment) are quite common among persons with BPD and can be considered as phenotypic markers of vulnerability to the disorder.

In light of these considerations, we developed a cognitive-evolutionary intervention model (Ivaldi et al., 1998) for treating persons belonging to this dimensional, etiopathogenic and psychopathologic *continuum* (Ivaldi et al., 2000; Fassone et al., 2003) The model is based on the hypothesis that in patients with BPD or certain clusters of morbidity, there is a disorganisation of the attachment system (Liotti, 1994; 1999; Solomon and George, 1999; Agrawal et al., 2004) which, together with other factors (Paris, 1994; Liotti et al., 2000; Pasquini et al., 2002; Zanarini, 2000), contributes to defining the psychopathological picture and interferes with the establishment and maintenance of a therapeutic relationship. This interference derives from the fact that, in psychotherapy, attachment system is inevitably activated and that disorganised attachment results in an uncontrollable and dysfunctional increase in the chaotic nature of the relationship, resulting in interruption of treament, treatment failure, and, finally, in the patient's exhausting all of his/her treatment options. In outpatient care this might be avoided by adopting a multiple setting, in which the presence of two cotherapists (in addition to the two distinct yet integrated and coherent settings) would allow for the "dilution" and better management of the emotional load that results from the disorganized and dysfunctional activation of the attachment system (Ivaldi et al., 1998; 2000) (Liotti e coll., 2005) (Fassone et al., 2003).

The objective of the present study was to determine whether patients undergoing integrated double-setting individual-group cotherapy, compared to patients undergoing the same type of individual therapy (without individual-group therapy and with possible pharmacological support), are more likely to maintain and complete therapy and to benefit from it both clinically and in terms of psychosocial functioning. A clinical case will be also presented to highlight different aspect of the methodology of treatment.

STUDY POPULATION AND METHODS

Selection of patients

The study population consisted of all persons who in the period from January 1999 to June 2004 had sought mental health care at selected outpatient mental health care facilities in Rome, and who had been diagnosed with one of the following disorders, according to DSM IV criteria: BPD (DSM-IV criteria), in association or not with other Axis I disorders; other cluster B personality disorders in comorbidity with Axis I disorders; transversal comorbidity in Axis I (persons who simultaneously met the DSM-IV criteria for more than one disorder) or longitudinal comorbidity (persons who along time met the DSM-IV criteria for more than Axis I disorder)

All of these patients (n=129) were offered integrated double-setting individual-group cotherapy [herein referred to as "double-setting cognitive-evolutionary therapy" (CET)]. Participation was voluntary. Refusal to undergo double-setting CET occurred either because the patient did not want to participate in group therapy or because of logistical problems (e.g., patient living too far from the health facility, problems with transportation, incompatible work hours, waiting list to start group therapy, etc).

Patients with schizophrenic disorders, delirium disorders, type-I bipolar disorders, or psychoorganic syndrome were excluded from the study. We also excluded patients who during treatment were not able to have access to double-setting CET because of logistical problems yet who agreed to undergo integrated cotherapy (psychotherapy/drug therapy) (20 of the total 129 patients).

Evaluation and tools

All participants were evaluated for: a) motivation to undergo treatment (five points evalutation ranging from *unsatisfactory* '0' to *very good* '4'; b) drop-out during treatment (non-consensual interruption); c) harmful behaviour, towards self or others; and d) impulsive behaviour (alcohol/drug abuse, sexual promiscuity or aggressiveness towards others, binge eating). The following tools were used for psychometric evaluation: Global Assessment Functioning (GAF), Behavioural and Symptom Identification Scale-32 (BASIS-32) (Eisen et al., 1994; 1999); and Quality of Life Index (QoL-I). Evaluations were performed at baseline (i.e., right before beginning treatment) and at 12, 18, and 24 months into treatment. Diagnoses were performed based on the DSM-IV criteria; the diagnoses were discussed and systematically reviewed by two of the authors (G.F and A.I.). The diagnostic concordance among evaluators ranged from 0.77 to 0.82 (K).

Treatment

Double-setting CET, which was presented to the patients as a single regimen, consisted of 2 two-hour group sessions and 2 one-hour individual sessions per month (the sessions were alternated every week) (total of six hours per month). The group therapy was conducted by two co-therapists, one of whom was the same therapist who conducted individual therapy. The group, which was "open", consisted of 6-8 patients; drug-therapy was provided, as needed. Peer-to-peer clinical discussions of cases were held monthly among therapists involved in the study. All group sessions were recorded on audiotape or video tape; the recordings were available to both patients and therapists. Individual CET (used as the control treatment) consisted of 1 one-hour individual session per week (total of 4 hours per month); drug-therapy sessions were also provided, as needed. Both regimens lasted for 24 months, unless otherwise indicated. Patients were assigned to one of the two groups based on their preference.

Theory and methodology of double-setting CET

The theoretical reference model used for double setting CET was the cognitive-evolutionary model (Liotti, 2001), with particular reference to the application of the Theory of Interpersonal Motivational Systems in individual therapy (Liotti, 1994; 2001) and group therapy (Ivaldi et al., 1998; 2000). The specific tools used for this therapy have been described elsewhere (Ivaldi et al., 2000) (Ivaldi et al., 2002), (Fassone et al., 2003), (Ivaldi, 2005). Herein we briefly focus on certain characteristic aspects of the treatment model.

Therapy begins in an individual setting, where the therapist and patient draw up what can be referred to as a "contract", not only agreeing upon the objectives of therapy but also defining the setting, stressing that both patient and therapist must make the

necessary commitment for achieving results. The contract also establishes the boundaries of therapy and of the patient-therapist relationship, in addition to priorities and objectives, especially in terms of feasibility and plausibility. The contract thus represents a sort of "free zone", a shared space where patient and therapist can seek refuge and return working when the therapy becomes conflictual. The concept of a "contract" thus has a direct impact on the relational process, clearly steering it towards the development of the best possible collaborative relationship as early as the initial sessions.

Placing a patient in group therapy is an important step in treatment. The patient is gradually introduced and "accompanied" to group treatment by the therapist who performs the individual therapy and who, with a cotherapist, follows the patient for the entire duration. This configuration of the therapeutic relationship facilitates and enriches the work on the relational process, expanding the context in which interactions occur and thus favouring greater cognitive decentralization and the development of meta-cognitive functions (mentalisation process). The relationship between the patient and the individual therapist is the backbone of both individual and group therapy. The existence of a referral network involving a cotherapist represents a key resource for both patient and healthcare workers and for the success of the treatment.

The use of certain descriptive and therapeutic tools such as the Theory of Interpersonal Motivational Systems (IMS) and the Dramatic Triangle (Karpman, 1968; Ivaldi, 2004) is greatly facilitated in group therapy, where it is possible to work on interactions in the "here-and-now" and where both therapist and patient can observe the interactions of others and while doing so carve out a time and space for reflection for emotionally working-out a given experience.

The group model belongs to the intersubjective tradition (Yalom, 1997). The two therapists are actively involved in the group, showing empathy and favouring interactions and interpersonal exchanges in relation to the evolution of the group itself and facilitating the analysis of the interactions, which is mainly based on the Theory of IMS. Work is done simultaneously on the Internal Working Model of each patient and on the group as a whole, simultaneously taking into consideration the specific moment in each patient's progression and the group dynamic (Foulkes, 1976; Bion, 1959).

Among various type of interpersonal learning (*didactic*, *social skills training*, *implicit learning)*, the latest can be considered the most powerful form of interpersonal learning and it is on this type of learning that the therapist mainly focuses. The development of social skills is only one of the aspects of a more extensive and articulated learning process which takes the form of a corrective emotional experience, which tends to strongly affect the patient's dysfunctional Internal Working Model.

In double setting therapy, techniques and tools that are typically cognitive-behavioural are also used. In particular, the patients are assigned tasks, for example, how to compile self-observation forms (regarding what goes on in the group) or to do a written self-monitoring of episodes of lack of impulse control. Furthermore, approximately every six months, the predefined objectives are reviewed and may be redefined in light of the evolution of the therapy.

RESULTS

The main socio-demographic and clinical variables are shown in Table I.

Table I here

When comparing the two groups, there were differences in the initial values for VGF, BASIS-32 and QoL-I, in addition to the history of hospitalisation, drug therapy, psychotherapy, and drop-out. The two groups also differed in terms of the distribution of BPDs, which was much more common in the control group. Subjects in control group seemed to have more severe pathology, and were more prone to drop-out and impulsive behaviour and had less motivation to undergo treatment. These differences can most likely be explained by the differences in the distribution in the diagnosis of BPD. In fact, when repeating the analysis only for the persons with BPD (30 in the double setting group and 15 in the individual therapy group), there were no differences for any of the variables considered.

Patients following the individual CET group had a greater frequency of previous drop-out [25/68 (37%) vs. 11/15 (73%) for the double-setting CET group; $p<0.01$, chi square test]. The frequency of drop-out during therapy was significantly lower in the double-setting CET group [16/85 (19%) vs. 16/24 (65%), respectively; $p<0.001$, chi square test].

Given the great differences in the distribution of diagnoses of BPD in the two groups, the observed difference in drop-out was attributed to an excess of diagnoses of BPD in the control group. In fact, as expected, persons with BPD showed significant differences with respect to the patients with other diagnoses, for the considered variables (GAF, BASIS-32, substance abuse, self-harming behaviour, estimated motivation, previous drop-out), all of which are potential indicators of a worse outcome. In particular, previous drop-out was in absolute terms more common among patients with BPD compared to the rest of the study population, independently of the treatment received during this study. We thus repeated the analysis of the drop-out rate for BPD patients only. Those undergoing double-setting CET had a significantly lower drop-out rate than the individual CET group [7/30 (23%) vs. 9/15 (60%), respectively; $p=0.02$, chi square test].

In Table II, the scores for the clinical and psychopathological variables are presented for the double-setting CET group ($n=85$) and the individual CET group ($n=24$).

Table II here

The data provided in the table stress the fact that the patients in the double-setting CET group do better than those undergoing individual CET. The subgroup of BPD patients undergoing double-setting CET also showed very significant improvement for GAF, BASIS-32, QoL-I, self-harming behaviour, and substance abuse at the end of treatment (24 months), compared to the beginning of treatment (initial GAF vs. final GAF: 47 vs.

63; initial BASIS-32 vs. final: 75 vs. 42; initial QoL-I vs. final: 4.8 vs. 7.6; initial self-harming behaviour vs. final: 5 vs. 1.2 episodes per month; initial substance abuse vs. final: 3.6 vs. 0.9 (episodes per month) ; $p<0.01$; t-test paired data).

Elsa's Clinical case: *What your eyes tell* *

The referring colleague had told me: "*Ever since she was ten she removes her eyelashes*." It was therefore no surprise when I crossed Elsa's intense and vulnerable gaze, greeting her at our first session. A precise and coquettish streak of eyeliner marks her eyes, which, notwithstanding all, appear overly exposed without protection.
Elsa is a young, 36-year-old woman, who is bright, bilingual, and gifted with remarkable artistic skills. She has changed jobs several times in her lifetime and is currently unemployed. She has been separated for approximately a year and now lives with her current partner in the house of her former husband, from whom she has no longer received any news. Elsa's sentimental life has been characterized by very tumultuous episodes, ferocious quarrels with explosions of verbal and physical violence, in which Elsa describes herself as a monstrous person, capable of harming herself and others without limits. In presenting herself in this way, Elsa transmits to me her dangerousness and fears, and, at the same time, examines me attentively to understand whether I am frightened, or whether I am capable of sending her comforting signals on the possibility of taking her in and helping her for what she is. In this exchange lies the essence of the therapeutic dialogue. It is on this that the alliance between Elsa and me will be based –indispensable bridge towards healing. Each time, that examining gaze, fearful and menacing at the same time, will expect a response from me, will read it in my eyes, beyond the words that I will say. Elsa expresses her fear of invalidating the therapy by enacting behaviors of attack and/or escape, as she is accustomed to, compulsively, in relations in general. I tell her that we must take care of this fear of hers and that our first sessions will need to define the space in which we will move and create all the possible protections for the therapeutic work ahead.

The Contract

Elsa comes to me thinking that she immediately has to face her self-harming ritual, thinking that she has to focus on that behavior in order to abandon it. Instead, in this initial phase, we decide to omit this problematic aspect, and we attempt to conduct an in-depth analysis of her request in order to formulate a therapeutic plan. In our first work sessions together, I explain how we will proceed and provide Elsa with information on the therapeutic method and its origins. We begin to share a common language and establish the bases for cooperation. Elsa is very happy to know that she can actively participate in her healing program: she feels that she can choose and decide; she feels considered; she feels less sick and impotent. We set up some strategies of protection and containment for her at-risk behaviors, which are not limited to the ritual of eyelash removal, but also include: self-provoked lesions, by means of excessive scratching, on the scalp and more rarely on the face; getting drunk and driving under the influence; and, provoking dramatic discussions. We agree that a first goal consists in her *quitting drinking* and using other drugs. We decide that, before starting to drink, Elsa has to call me and leave a message if she were to find my mobile phone switched off. This is the minimal commitment that realistically can be asked of her on this matter: allowing herself the possibility to reflect for an additional minute prior to committing a compulsive act, and allowing me to communicate with her during one of her

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*(This case was written by A. Ivaldi)

problematic states. We consider the hypothesis of adopting a pharmacological aid, by introducing, potentially, a colleague of mine, a psychiatrist, as another therapeutic figure. We articulate in a better way the concept of "therapeutic network"*, also conceived as a protective response to Elsa's behaviors of aggression and escape, through which she preventively imagines to be able to boycott the therapy. Another therapeutic element of the network we discuss is group therapy, for which Elsa expresses even greater fears than those expressed for therapy through medication. Notwithstanding her fears, Elsa understands that the network would have the important function of protecting our relationship and her therapy. We do not schedule deadlines for the introduction of the different resources into the therapeutic program, but we decide to evaluate together, at any time, the plan of action ahead, monitoring the pulse of the therapeutic relation.

The therapeutic plan therefore consists in dealing with the patient's problems, both on the behavioral and intra-psychic levels, with a focus on the therapeutic relation –bearing axis of the healing process.
The concept of 'Therapeutic Network' has been used in different contexts. In this text, I refer to the concept belonging to the Cognitive Evolutionist model of co-therapies. An exhaustive description of this concept can be found in the book: Liotti G., Farina B., Rainone A., (2005) Due terapeuti per un paziente. (Two Therapists for a Patient). Casa editrice Laterza

Case Formulation

While these contractual elements are being jointly defined, a first hypothesis on Elsa's pathologic nucleus is forming in the therapist's mind.
Those eyes communicate volumes.
Elsa began to remove her eyelashes at age 10. She relates to have found some time ago an annotation in her diary of when she was 12, in which she reported having been greatly angered by her parents: "*… and therefore I will rip out my last two eyelashes*!" She then rips them out and pastes them on the diary's page. It looks like a *protest manifesto*. Her parents never paid much attention to this event, and to other ones equally as significant: "*They never realized! They never said anything to me*." In confrontations with her parents, her mother would tell her that she was "*un-helpable, difficult, impossible*!" These statements, over the years, led Elsa to convince herself that she was not "*capable of being loved and helped*".
<u>Elsa cannot ask for help</u>. If she does, she is wrong and others do not understand her. She is "*un-helpable*" as her mother would say. The result is always the same: "*No one can be close to her. There is no hope*." (This is what Elsa thinks in her most depressed moments)… "*Yet, there must be a possibility!*" (She thinks instead in moments when need is most pressing and the vital drive stronger.) All this then leads quickly to the origin of the vicious cycle.
In this view, her ritual acquires a different light. It no longer appears only as a self-harming gesture, but paradoxically, it becomes a "space of care" –a space in which Elsa concedes to look at herself, take "care" of herself, in which she must not really deal with anyone and she can finally relax. In other words, she dissociates.
While she rips her eyelashes, Elsa spends hours in an almost unreal space and time dimension, in which she speaks with different imaginary people, or she voices a very intense, internal dialogue between "different parts of herself". Elsa is appeased during her ritual.
Her story of attachment seems characterized by a Disorganized style (Liotti G. 1992), scarce mentalization capacity (Bateman A., Fonagy P. 2004) of parental figures, to whom it was

impossible for Elsa to truly communicate her emotions and thoughts which would not be understood but rather, redefined and invalidated (Linehan, 1993).
Elsa's uneven, rough experience of family life, fragmented by sudden relocations to different cities, and her parents' blindness to little Elsa's signals of distress have contributed to the development of the Internal Working Model (Bowlby, 1988), which, Elsa applies all the time to relationships, including the therapeutic one. Her unconscious healing plan (Weiss & Sampson, 1999) entails that she can finally entrust herself to someone and therefore seek and receive help. However, her pathogenic beliefs, her mental functioning deficits, and her unawareness prevent her from attaining this objective.
Those eyes examine me, they seek and send out signals, in hope of finding answers, but, at the same time, they suggest that Elsa fears/is certain that those answers will not be forthcoming. On the other hand, resigning to this would mean, "dying" for Elsa, who, in fact defends herself like a trapped animal.

History

In Elsa's accounts, uncertainty hovers over many aspects of her family history and, notwithstanding her attempts to gather missing information from her parents in recent times, there still remain imprecise elements and gaps in the reconstruction of her recollections. Her family on her father's side has distant Sicilian origins. After worl war II, the family moved to Tripoli, and then relocates to London, where Elsa's father will marry Matilde, Elsa's mother of English origins. Her father works in a not well-identified field, "*something having to do with engineering.*" In 1962, Elsa's parents move to Milan for her father's job and Elsa is born there. Three years later, Elsa's brother is born and, shortly thereafter, they all move back to London.
Elsa remembers spending her days at a neighbor's in that period because both parents were working. She does not remember where her brother was at that time.
In 1967, the family moves to Rome, where Elsa attends her first two years of primary school. Her father has work-related problems and the family once again moves back to England. Elsa attends her third year of primary schooling in England. The following year they move once again to Rome, at first in a lodging facility and then in a rented house. There, a unique episode of seduction by Elsa on her little two-year-old brother occurs. Elsa has never talked about this with anyone from her family. At the age of eleven, Elsa attends a British school while her father begins to work abroad and is away for long periods, as it was during primary school in Italy. It is in this period that Elsa begins to invent stories. She says she has lost her mother, has six brothers and is very wealthy. She also invents that she receives anonymous letters; she withdraws from her peers, and seeks the attention of adults. She begins removing her eyelashes when she was around fifthteen. Then, Elsa is sent in a traditional, female college south of London, therefore far away from her parents, where, she relates to have gone through a period of great distress. She invents increasingly fantastical stories. She begins to steal from stores and from her schoolmates. She begins to smoke cigarettes and marijuana. Her father continues to work abroad and he will spend a year in Sudan.
At the end of the second year, the administration of the London school recommends withdrawing Elsa from the school. From 16 to 18 years of age, Elsa attends the last two years of high school at Oxford, where she lives in a very free setting, living alone with no one to check on her. Elsa is expelled from school during the last trimester of the second year and is readmitted for her final, school-leaving examination. During her London school years, Elsa returns home to her parents at Christmas and Easter time and during the summer for eight weeks. In 1980, Elsa enrolls in university in Florence and travels around Europe. It is from this moment on that Elsa no longer lives with her parents.
Elsa attempts suicide, very probably as a demonstrative act, at age 21 and, soon after, initiates therapy, which she interrupts two months after when she had a facial hemi-paresis. From that

moment, she says, she devotes herself to an "*intense self-analysis*". She does make any progress in her university studies; she attempts to attend the Fine Arts Academy but soon after, she also abandons this, disappointed with Italian education. She very soon begins to do translations and to earn with these. She does different jobs, as a decorator, graphic designer, theatre stage designer. She does not manage to hold a job in a stable manner. When she has more time, she devotes it to her self-harming rituals. For a period, she assists the disabled and becomes the coordinator of associations studying malformations. At the moment she requests therapy, she is unemployed. Her parents live in France. Her brother, with whom she says to have a good relation, lives in Italy and is doing well.
She is devoting time to gathering information on her life, asking her parents help with this task.

The TEST: When the relation heals

There is always a crucial moment in a therapeutic course –that moment when all that up to that point had only be said, described, understood and hypothesized, and partly even shared, becomes real, dramatically, in the therapy room. This happened to me with Elsa on the day when she walked in my office, full of bruises and scratches, a leg and an arm bandaged and with a very menacing expression on her face. "*There now, look at what I am capable of doing*!" she tells me in an angered tone. Then she bursts into lamenting tears and almost whispering says, "*It's useless, it is all useless…*" Then again, with an angered tone: "*You understand that it is useless that I come her, that I explain, that we delineate a path together, when in a second I manage to do all this!*" She cries dejectedly again.
I remember that moment as if it were now. I am sitting on the sofa and progressively brace my arms to protect myself from what seems to be a full-fledged aggression; at the same time, I feel angered and also a profound sense of concern, when I observe all the marks on her face and body while she cries desperately.
I do not know what may have happened and after Elsa's initial outburst, I attempt to ask her.
"*What do you think happened*!" she answered, shocked. "*What happens all the time! I manage to ruin everything. I cannot control myself: It is monstrous what I am capable of doing. I told you that you could not help me*!" I try to point out that I still do not know what happened and Elsa, who probably perceives my sense of powerlessness, begins to reassure me: "*You have nothing to do with it. No one has anything to do with it. I am unfit! No one would want to be with me*!" She cries again.
From these brief dialogue fragments, it is evident that Elsa has activated the disorganized Internal Working Model (Liotti, 1992, 1994, 1996) and the dramatization of the Dramatic Triangle (Karpman, 1968). (Ivaldi, 1998, 2000, 2002, 2004, 2005). The patient is going through that painful experience in which she feels Victim, but at the same time Persecutor and then, moved by guilt for having mistreated me, Savior, in a quick and confusing sequence. All positions are real but Elsa is incapable of reconciling them. The difficulty to find an integration for them begins a long time ago for Elsa. The very intense experience she is going through, does not pertain to our relationship alone, the present moment, but it goes back to a repeated traumatic experience by Elsa in her attachment relationships. It is as a child, with her parents, for her particular vulnerability, that Elsa did not have the opportunity to develop her meta-cognitive functions, not fully understanding what was happening in those relations of vital importance, and not being capable therefore of integrating the different and contradictory aspects of the experience.
From what Elsa relates, I understand that the wounds she has provoked on herself are the result of a dramatic discussion with her partner. She does not remember the entire episode and is terrorized by what she was able to do and by the fact that she was in an altered state of conscience. She is scared of herself; she hates herself.

It is difficult to choose what to say as a therapist in such an occasion. All of Elsa's pathologic beliefs are there with us and involve me as well: "*I cannot be helped, I am worthless*" and in a rapid sequence, feelings of pain, rage, shame, humiliation, terror, sense of powerlessness follow.
I have to choose how to intervene. The situation was very complex. If I were to speak about Elsa's dangerousness and about her guilt I would commit an error, because if I were to reassure her, I would not be credible (in a sense, the facts support her case). On the other hand, if I were to confirm her self-image, I would also be wrong, because I would confirm her fears and endow her with a negative, uncontainable power, which she does not have.
Following my protective instinct, I choose a caring/protective mode, being careful at the same time, to respect the confines of our relation. For this operation, it is fundamental to refer back to the contract initially agreed upon with Elsa.

The commitment that was initially agreed upon constitutes as sort of "*zona franca*" where, in a moment of full activation of the Internal Working Model of Elsa's disorganized attachment, it becomes possible to emphasize the collaborative nature of the therapeutic relation, redesign its confines and therefore eschew the Dramatic Triangle, thereby restoring the conditions to work therapeutically. The desperate experience of powerless rage, without any way out, regarding Elsa's attachment experience and reactivated in the relation with me, should at least partly be overcome in this way.

After having told her that I was very struck by what had happened to her and that I was saddened to see her in that state, I reveal to her my difficulty to choose what to start talking about. There are many things that I would want to tell her but one above all seems to take priority and I decide to start with that.
"*Remember Elsa the commitment that you took up with me of not drinking and not committing destructive actions, rituals aside, towards you and others…*" I do not manage to finish the sentence because, at these words, Elsa jumps up enraged and responds by saying: "*Certainly! I may have taken up all the commitments in the world and I am sure that I truly believed in them, but then... something happens and... you see, I am out of myself, it is beyond my control…don't you understand*!?", with an irritated and at the same time demoralized tone.
Elsa has very probably activated her internal working model and my statement probably resounded in her like a reproach or, better yet, as her mother would say, "*You really do not want to be helped*!" This exchange is very delicate. I answer her with a decided tone, contrasting her pathologic belief of powerlessness: "*It is obvious that if you drink to the point of being drunk, you no longer respond of your actions, you are not conscious, anyone would lose control and would not remember anything. However, there is a moment, before drinking, in which you are capable of choosing and you do. We have talked about this already, do you remember*?"
Elsa still responds with rage, remembering the talk we had on the pharmacological support to aid her not to drink, and reacts with hostility and defeatism to the possibility of being helped in that manner.
I remind her that in addition to discussing medication, we had agreed on the fact that she would have had to call me prior to using alcohol or other substances. I remind her of the meaning of that commitment and its importance. At this point, Elsa does not know exactly what to say. She tries to say, stumbling over her words a little, that she had thought about it and she had not called because she did not want to bother me, but she is clearly in difficulty trying to find a convincing answer. She had minimized the importance of that commitment she took, forgetting that that could have been the only way to allow me to help her in the worst moments.
I ask Elsa in a determined way to reflect on this and to re-decide, in light of this experience, whether or not to seriously make the commitment again: "*Think about it, Elsa, do you feel up to using the telephone in this way and to being helped by a competent colleague through a*

pharmacological therapy? In light of this experience, I think this is an essential step without which I would decide to interrupt the therapy…"
Elsa interrupts me, once again. She is surprised and irritated: "*You... would interrupt the therapy… This is incredible! This is good*!"
The moment is extremely delicate. My intervention could very easily be experienced by Elsa as an abandonment, a rejection, because she truly is "*difficult and un-helpable*", as her pathological beliefs suggest. Words in this moment are not enough to reassure, to explain. The intention with which they are said is transmitted through the eyes, the facial expression, and the tone of voice. Elsa stares at me with menacing eyes ready to receive yet another desperate abandonment. I explain sadly that I would have interrupted our sessions because, without that commitment, it would have been difficult to carry out the therapeutic work. "*I am not willing to see you come here in my office, other times, wounded in this way, without being able to do anything about it. I am sorry for you but I think this would be a price too high to pay for both of us, without even having the guarantee of a reciprocal commitment towards a common goal.*"
Elsa remains silent. She is angered and at the same time taken aback by my intervention. She asks me again if I truly would have interrupted the therapy. And, I reply: "Y*es, sadly, but I would do it, because I know that it would not work, and I am not willing to worry for you without being able to do anything effective to help you, and without having the certainty that you will be with me in this enterprise, doing all you can to collaborate*." I hope that Elsa understands my position. The moment is very risky and I am fully aware of this. However, I repeat to myself that in this way we cannot go anywhere and that I do not want to run the risk of supporting the nth failure for Elsa. "*I cannot guarantee this*!," Elsa answers in an irritated manner but also still very surprised and uncertain.
I tell her that she does not have to give me an answer right away, and that, in fact, it is better that she think about this until our next session. We say good-bye and I remember a great tension at the end of the session, thinking that the therapy with Elsa could end right there or undergo a shift such that the rest of the work would have been downhill.

Elsa decides to let herself be helped

Elsa returns at the next session and will conclude her therapy after three and a half years. Today, her eyelashes have grown back and, after a series of events, she has met her husband again and is back with him. She works and is doing quite well.
We have often talked about that difficult yet decisive encounter. The next session, Elsa confesses that she had thought of never coming back again. She was very angry then and there, but as time went by, she realized that I did not want to push her away. In fact, from her recollection, she thought that I had appeared protective towards her. In addition, she remembered the commitment taken with me at the beginning, on the telephone calls and the medication. It was clear to her that she had undermined it. She returns with the intention to collaborate, but with lots of perplexities on her abilities to go through with the commitment.
I reassure her telling her that we will have all the therapy to work on her abilities to achieve the objectives and I thank her for having brought the intention to do so.
We speak at length on her doubts about the pharmacological therapy, of her fears, her prejudices, about how one feels when taking medication, and her perception that making the telephone call would reinforce her pathological belief of being "*strange and un-helpable*".
How could she have called, considering her history, above all in a moment of extreme distress, without expecting a rejection or devaluation? We speak all the session about how things went the evening when she fought with her partner; now we can try to understand together the origin of her rage in that circumstance. Elsa seems to minimize this aspect of the matter and insists in underlining her impulsive and destructive reactions in this and other situations.

Elsa is accustomed to this style. Her reasons, her motivations, and needs are in the background in relation to the consequences of her behavior. In this way, she is invalidated, and she continues to self-invalidate her own emotions. A joint work of exploration of Elsa's relational experience begins, during which we attempt to distinguish between her needs and the modalities of expression of these needs, between emotions and their significance and modular expression of those emotions.
Elsa is annoyed about taking medication because her partner has been advising her to do so for some time. Taking it would imply admitting that she is "*very ill*", as Luca would say, and accepting to finally invalidate her expressions of emotions and her reasons. Notwithstanding this, she decides to go to see a colleague and she starts a therapy with Seroxat 20mg, Tegretol 400, and Anseren 30 at night prior to sleeping. In all sessions, my colleague, a psychiatrist but, above all, a psychotherapist, spends a lot of time to explain to Elsa the function of the medication, especially in regards to its emotional functioning. Elsa learns to monitor her mood, her emotions, and becomes more aware of her needs. She stops drinking and smoking marijuana. She manages to use the telephone to seek help. This marks another important step in the therapeutic relation. Her calls, made in rare moments of suffering and anguish, which generally precede an impulsive and destructive action for Elsa, give her the possibility of experimenting closeness and a level of care adequate to her request, without the danger of receiving a negative self-image as monstrous and un-helpable. The corrective experience of receiving help without feeling devaluated for this in the eyes of the other is even more important for Elsa.*

*The non-verbal exchange and the specific attention by the therapist to Elsa's multiple communicative messages are fundamental. Much attention is given to the complexity of Elsa's experience and therefore, each time, it is important to have the ability to provide an equally complex answer which includes, by means of integration, different, and, at times, contrasting, aspects of the communication. Empathy (Kohut H., 1977, 1979), the ability to mentalize (Bateman A., Fonagy P.,2004) and to integrate on the part of the therapist can be a powerful stimulus for the patient to develop these same abilities. See Ivaldi A. "Il Triangolo Drammatico: Da Strumento Descrittivo a Strumento Terapeutico" ("The Dramatic Triangle: From Descriptive Tool to Therapeutic One") Riv. Cognitivismo Clinico, vol.1, n.2, 2004

The Group

Each important step in the therapy is marked by a rather intense activation of Elsa's profound negative experience. This also occurs when she begins group therapy. It was the group's first encounter, not only Elsa's. A colleague of mine and I grouped different patients that could benefit from a double setting, the individual and group ones, according to the cognitive-evolutionist model we put forth. (Ivaldi A., Fassone G., Rocchi M.T. 1998, 2000, 2002, 2004, 2005).
Elsa arrived late that day. While some of the more outgoing people entertain the group, I think about what might be happening to Elsa. Then she arrives, she quickly apologizes and takes a seat with the others. She is having trouble. She seems projected back into the past: her distressed expression, at times hostile, the evasive eyes, the movement of her hands, nervous and lacking harmony with the rest of the body and with her facial expressions. Two years of therapy seem suddenly erased. At the end of the session, Elsa literally runs away without saying goodbye to anyone. I am worried and, after having thought about it at length and having discussed it with my colleague, I decide to call her. It is the first time that this happens. I tell her that I am worried and that I would like to know what is happening. Elsa is happy about the phone call, even though she is very uncomfortable. Once again, she needs help but she is very scared and angered by this. She tells me that she is having trouble and that she is upset with herself for the way she faced the group. In the next individual session, we clarify what happened. We experiment, for the first time, the possibility of leaving together the individual therapy room to meet other people and returning

to it to comment on what has happened. The experience opens up interesting possibilities for therapeutic work: a setting organized in this way makes new relationship scenarios possible. The point of observation changes; it is not always the same; we observe ourselves reciprocally in different interactions. We comment in the individual session on some event we attended together. This is not quite the same as commenting on events related on by one or the other. In this case, we discuss Elsa's fear and shame; her dread of being labeled as the "*strange*" one, the "*serious*" case, the "*problematic*" one; her dread of being negatively judged by the therapist in comparison to others; and, therefore, her dread of being rejected. In subsequent sessions, Elsa will speak of her difficulties in being in a group. She will begin looking at people in the eye and, slowly, she will explore new ways of expressing herself and of asking for her needs. Elsa will reveal herself very quickly compared to other group members and that initial roadblock will be quickly overcome. In this setting between equals, she will be able to thrive from a direct confrontation with other participants and explore, through it, different interactive styles and problematic aspects of communication, directly related to her internal working model. The therapeutic course in the group setting accompanies some great changes in Elsa's life, such as her break-up with Luca. It provides Elsa with the necessary support to manage to be on her own and endure her partner's insistent attempts at restoring the old equilibrium based on tumultuous quarrels and different types of "highs". Some time thereafter, Elsa fortuitously meets her former husband, Giovanni, and, after an intense frequentation, they get back together as a couple.
This rapprochement will be extremely important for the conclusive phase of Elsa's therapy in which one will face the self-harming ritual of eyelash removal.

Eyelashes grow back

We are finally there. The moment in the therapeutic process has arrived when it becomes possible to consider putting an end to the ritual, which has been part of Elsa's daily life for years. The times of impulsive behavior, of "getting high", of living like a strange, dangerous, rejected animal are distant. Elsa conducts a more balanced life while maintaining her originality. She has managed to work constantly in the past year and now she works in advertising with her husband, utilizing her artistic skills. Our sessions are now mainly characterized by exchanges on her relational life. One speaks of emotions in an increasingly articulated way. We have gone over the history of her life, particularly her childhood and adolescence. Elsa has managed to relate her suffering as a child to that of her present life. She has begun to accept her history and to see some possibilities for not relapsing into her traumas. We have identified some sore spots for Elsa, in the affective area, which, if touched upon, still sometimes provoke impulsive reactions. At other times, they lead to a painful experience and profound distress. For Elsa, it is still very difficult to show her weakness and seek help and support in problematic times. She manages to do so with me, the group, and with her cousin Chiara, with whom she has a close relation. She is beginning to do so with her husband, to whom she has allowed herself to get closer, after getting back together with him. Still however, when faced with incomprehension, when her requests are met with frustration, Elsa reacts by reactivating her usual pathologic experience. This takes place particularly with her husband with whom the relation is closer. The last part of Elsa's therapeutic course focuses just on this difficulty to seek help and therefore to entrust oneself, strictly in relation to her ritual.
Up until now, we had dealt very delicately with her established habit of staying for hours in front of the mirror torturing her eyes, understanding that this behavior represented for Elsa much more than a self-harming behavior. It appears that the moment to abandon this behavior has arrived, without however neglecting its meaning and, more importantly, the need it expresses. We had talked many times about all this with Elsa. We knew that it would not be easy and for this reason we decide to study in depth the most appropriate and protective strategy for her. Therefore, we tackle at once both the profound meanings of the gesture and the exquisitely practical aspects –

essentially, how to stop. As a result, different types of aids come into play: the husband Giovanni gets involved declaring to be ready to participate in the operation; with Elsa we decide to consult a dermatologist and an ophthalmologist to obtain information on possible difficulties regarding eyelash re-growth. In attempting to chart the course and foresee its stumbling blocks, one difficulty above all seems the gravest for Elsa: the fear of being left alone and not being able to face possible emotional distress, which, given the importance of the operation, she imagines being very intense. We then take in consideration staying for an initial period in a clinic, Villa Margherita, where some of my colleagues work with patients with serious borderline personality disorders and other major disorders. I speak with my colleagues, who are my friends, as well as my long-time coworkers, sharing the same theoretical orientation. I explain to them my request to admit Elsa, which is a bit peculiar. The colleagues understand and agree to see her. Elsa goes to Vicenza, accompanied by her husband, and talks with my colleague who illustrates the treatment protocol and listens to her needs. They arrange for admission after the summer. Elsa returns from Vicenza with great motivation and determination. She liked the clinic and my colleague, who in speaking to her asked her about the question of seeking help. Elsa had to reflect on how she would have sought help, for which things and how, during her stay in Vicenza. My colleague's request allowed us to examine further the most delicate theme of Elsa's life. Her mother's voice resounded in our minds: "*you are un-helpable*", while we reflected on and organized a network of help for Elsa—all of us at hand, all of us ready to help.

Elsa leaves for vacation with her husband and returns with a surprise in September. She has let her lashes of the lower part of her eyes grow back. She is proud of this result, also made possible by Giovanni's closeness. Obviously, she does not go to Vicenza, while keeping open the possibility of being admitted on a need basis. In the light of these events, all the aids that had been set in place reveal themselves more as a response to Elsa's fears than an actual necessity.

Elsa is very happy but continues to be a bit anxious at the same time on her ability to complete the work she has begun. The awareness of how important it is for her to be overly reassured on her work slowly emerges. This reassurance is not really to ward off real dangers but rather probably to validate her experience. My memory brings me back to Elsa's statement, "*My parents would not notice that I would remove my eyelashes… they never realized many things that had to do with me*." This time, what is happening to Elsa cannot go unnoticed.

This time she is not alone. I am following her and I take in her apprehension each time Elsa shows it during the course of the operation. Even when I am clearly sure that there are no real dangers, I help her take precautions because I am aware of the value of that joint action, as a sign of recognition for Elsa, as healing balm on old wounds, as an emotional experience that is intense and reparatory.

The most complicated aspect in this final phase of the therapy is not so much learning to seek help, as learning to tolerate frustrations in this regard, avoiding relapsing in her negative desperate and despairing experience in which everything loses sense and everything is useless. It is starting from this past that Elsa has acted out her most destructive behaviors.

Therefore, the greatest effort with her at the end of the course is that of helping her "actualize" (Ivaldi A. 2005) her need of help and closeness. Actualize a need means distinguishing from the childhood experience of attachment and the actual experience of attachment with the different persons who take care of her (myself, her husband, her cousin and so forth), differentiating roles and contexts. We reflect together on the different meanings of an attachment relation, with a parent when a child is small and helpless and its very life depends on the care of that parent and an attachment relation with another person, to which one might relate in adult life. The relationship with a parent has no way out; there is no choice and the conditions of a child are so weak, relative to the different ages of development, to make that parental support a unique necessity for survival. The condition of an adult who seeks help because in need is different. For one thing, the person to whom one asks for help is not the only possible one, but especially, an adult is not in the psycho-physical conditions of vulnerability such to feel that his/her survival

depends from that only person one has referred to. We discuss articulately about these concepts with the objective of accepting the past traumatic experience of attachment and learning to reactivate her need for attachment by contextualizing it each time.
This last segment of the course is not as simple as it would appear. There are different problematic moments both in the individual and group settings. However, Elsa manages to complete her therapy. Her eyelashes grow back and she ends her therapy with a particularly touching group session in which, in tears, she speaks about her personal experience with each group member. She speaks to her traveling companions, leaving something with each of them and bringing something of each with her, saddened by the end of the experience which will never take place again but full of affection, gratitude and a profound sense of belonging and affiliation, chorally shared by the group.

DISCUSSION

The paper presents data on outcome results of the integrated CET therapy and describes a paradigmatic clinical case, which illustrates the method and tentatively highlights critical steps of therapeutic process. It is worthwhile noticeaing that at two year follow-up, Elsa is mantaining her gains in terms of psychosocial functioning as well as in controlling her impulsiveness and her outbursting and intense emotions. She is still in touch with her therapist by telephone, as they agreed when therapy was concluded.

In interpreting the results of this study, some of its limitations need to be discussed. In particular, randomization was not performed. Although assigning the groups based on individual preference has been done in non-randomized controlled studies, it is nonetheless a methodological limitation, in that self-selection for one of the two treatments occurs. In the present study, this point was emphasised by the observed differences between the two groups in terms of the distribution of diagnoses of BPD and other variables which are potential negative predictors of outcome and/or of increased risk of drop-out.

That the participants were evaluated by the same therapists who conducted the therapy may be another limitation, potentially affecting the validity of the results). Although the diagnostic concordance among evaluators calculated at the beginning of the study was satisfactory (k=0.78-0.81), the evaluators may have nonetheless been influenced by the fact that they also acted as the therapists in the study. Pearson's correlation were calculated on random sample of scores for different patients and coefficients were satisfactory.

Moreover, the reliability of the diagnoses, particularly for the diagnoses related to Personality Disorders may have been limited by the lack of homogeneity in the clinical sample diagnoses (diagnostic polymorphism), together with the fact that DSM-IV diagnostic criteria were used, yet structured diagnostic interviews were not. However, the diagnoses of Personality Disorder and expecially BPD were discussed and reviewed by one of the authors (G.F.) together with the colleagues who had made the initial diagnoses.

Although a two-year period is considered sufficient for obtaining appreciable results in this type of patient, the fact that treatment can be prolonged according to need introduces an element of uncertainty, in relation not only to duration but also to costs and to the commitment of the patient and the therapists.

The unsatisfactory outcome observed in the control group (especially with regard to drop-out) in part depends on the fact that we excluded patients who, though not able to access double-setting group therapy, had access to another type of cotherapy (individual

and drug therapy, double individual therapy, and individual-family therapy). The reason for exclusion lies in the scope of the study, which was that of comparing integrated cotherapy with individual therapy.

Despite the above-mentioned limitations, some interesting conclusions can be drawn. Controlled semi-naturalistic studies provide a "snapshot" of the operative and clinical reality in which various healthcare workers conduct their activity, located in diverse areas of a city of approximately 4 million inhabitants, with the advantage of providing a control group which used the same modes of recruitment (preselection, referral to a suitable care facility, evaluation, and enrolment in an ambulatory care program) and evaluation, independently of the type of treatment received. The evaluation scales have been validated and are simple to use for the therapist.

The control therapy (cognitive-evolutionary individual therapy) was performed by the same therapists. The only difference is that the patient, after having received an appropriate explanation of the methods, makes his/her own choice, often based on factors that are independent of his or her wishes (e.g., incompatibility with the patient's work schedule).

The treatment model is relatively flexible, simple, and accessible in terms of both time and commitment for nearly all patients. Thus double-setting CET can be considered as "cost-effective". As part of the package offered, the patient may undergo one or two additional individual sessions and can consult a group cotherapist if drug-therapy is needed (it would thus be better if the team consisted of one psychologist and one psychiatrist). The copresence of therapists facilitates the contact and the exchange on the evolution of both group and individual therapy, which is considered fundamental for the success of the therapy. Small teams of stable and unified therapists who share the theoretical-clinical model must be created. If any of these characteristics are missing, it is difficult to continue the therapy without risking negative consequences for the patient and the quality of the work.

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Table I. Sociodemographic and clinical variables for persons undergoing double-setting CET or individual CET

	Double-setting CET n=85 (%)	**Individual CET N=24 (%)**
Age (in years)	31.4 +/-	30.4 +/-
Gender		
Male	29 (34)	9 (62)
Female	56 (66)	15 (38)
Educational level		
Elementary school	-	-
Middle school	10 (12)	2 (8)
High school	53 (63)	17 (71)
College degree	21 (25)	5 (21)
Marital status		
Single	67 (79)	17 (71)
Married/cohabitating	13 (15)	5 (21)
Separated/divorced	5 (6)	2 (8)
Type of care facility		
Private	71 (83)	20 (17)
Public	14 (17)	4 (83)
Diagnoses in Axis I		
None	11 (13)	3 (12)
ating Disorders	30 (35)	8 (33)
Anxiety Disorders	14 (16.5)	3 (12)
Unipolar depressive disorders	23 (26)	8 (33)
Bipolar II depressive disorders	3 (3.6)	0 (-)
Dissociative disorders	8 (9)	5 (21)
OCD	10 (13)	0 (-)
Somatoform disorders	2 (2.5)	1 (4)
Sexual disorders	6 (7.5)	0 (-)
Substance abuse/addiction	7 (8.2)	6 (24)
Diagnoses in Axis II		
None	18(21)	2 (8)
BPD	30 (35)°	15 (62)°
Other cluster B personality	11 (13)	2 (8)
disorders	13 (15)	2 (8)
Cluster C disorders	4 (5)	1(4)

Cluster A disorders	8 (9)	2 (8)
Multiple Axis I/II diagnoses	65 (77)	20 (83)
Previous drug therapy	46 (54)°	18 (75)°
Drop-out from previous psychotherapy Yes No	 25 (37)° 43 (63)	 11 (73)° 4 (27)
Previous hospitalisation	10 (13)	7 (30)
Previous harmful behaviour(towards self of others) (mean episodes per month)	2.9 (+/-3.1)	3.6 (+/-3.3)
Previous substance/drug abuse (mean episodes per month)	1.4 (+/-2.7)*	3.2 (+/-3.3)*
Mean GAF (baseline)	50(+/-7)	48(+/-5)
Mean BASIS-32 (baseline)	66 (+/-15)*	74 (+/-13)*
Mean QoL-I (baseline)	5.1 (+/-2)*	4 (+/-2.3)*
Estimate of motivation towards therapy	2.6 (+/-1.1)°	1.7 (1.3)°

***p<0.01, univariate ANOVA, 95% CI; °p<0.01, chi square test, 95% CI**

Table II. Mean values for GAF, BASIS-32, and QoL-I, and the variables "self-harming behaviour" and "substance/drug abuse", at baseline and at 12, 18 and 24 months of therapy, for persons undergoing double-setting CET or individual CET

	Double-setting CET (n=85)	**Individual CET (n=24)**
GAF		
Baseline	50 (+/-7)	48 (+/-5.3)
12 months	57 (+/-8)	54 (+/-5.3)
18 months	61 (+/-7.4)	58 (+-5.4)
24 months	65 (+/-7.5)*	59 (+/-6.7)°
BASIS-32		
Baseline	66 (+/-15)	74 (+/-13.7)
12 months	54 (+/-16.6)	58 (+/-18.3)
18 months	45 (+/-12.9)	37 (+-4.7)
24 months	36 (+/-13.7)*	48 (+/-18.6)°
QoL-I		
Baseline	5.1 (+/-2)	4 (+/-2.3)
12 months	6.7 (+/-1.7)	5.1 (+/-2)
18 months	8 (+/-1.6)	6.5 (+-2)
24 months	8 (+/-1.5)*	6.6 (+/-2.7)§
Self-harming behaviour (mean episodes per month)		
Baseline	2.9 (+/-3.1)	3.6 (+/-3.3)
12 months	1.6 (+/-2)	2 (+/-2.4)
18 months	0.8 (+/-1.5)	1.6 (+-1.9)
24 months	0.7 (+/-1.3)*	2.2 (+/-1.2)§
Substance abuse (mean episodes per month)		
Baseline	1.4 (+/-2.7)	3.2 (+/-3.3)
12 months	0.8 (+/- 1.6)	1.8 (+/-1.7)
18 months	0.9 (+/-1.5)	1.1 (+-2)
24 months	0.5 (+/-1.2)*	1.3 (+/-1.9)§

*significant with respect to baseline: $p<0.001$, t-test for paired data
° significant with respect to baseline: $p<0.01$, t-test for paired data
§ $p>0.05$, not significant; t-test for paired data